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How Voice Hearers Develop More Positive Relationships with Their Voices and the Role of Encountering Books Aligned with the Hearing Voices Movement.

SECTION A: A systematic review and thematic synthesis of literature containing explorations of how voice hearers have been able to develop more positive relationships with their voices.
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SECTION B: ***"It did give me hope in a system that really just didn't have a lot of hope for me"*****. A qualitative study exploring the experience of voice hearers who have read books associated with the Hearing Voices Movement.**
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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

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A huge thank you to the participants who shared their stories with me, without whom this project would not have been possible. Their stories motivated and inspired me to keep going and will stay with me beyond this research.

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Finally, thank you to my family who have always believed in me when I haven’t always been able to do so myself, and to Richard for always being there in ways I didn’t know I needed.

Summary of the Portfolio

Section A

Presented is a systematic literature review exploring how voice hearers have been able to develop more positive relationships with their voices. A thematic synthesis approach was used to synthesis 27 papers including qualitative studies, mixed methods studies, and narrative case reports. Quality assessment was guided by the Critical Appraisal Skills Programme, Mixed Methods Appraisal Tool: Mixed Methods Checklist, and the Mixed Methods Appraisal Tool: Qualitative Studies Checklists, respectively. Five interconnected but not sequentially related superordinate themes emerged: ‘coming to see voices as less threatening’; ‘developing new ways of responding to voices’, ‘becoming more accepting and less fearful of voices’; ‘beyond voices’ and ‘facilitators’. The implications for clinical practice and future research are discussed.

Section B

Presented is a qualitative study exploring the experiences of voice hearers who have read books associated with the Hearing Voices Movement. The study explored how such reading featured voice hearers’ life stories from the perspectives of ten voice hearers, using Narrative Analysis. Results suggested that encountering alternative narratives about voice hearing, including through reading, can act as a turning point where stigmatising dominant cultural narratives of voice hearing are challenged, and more positive identities constructed. Clinical implications and directions for future research are discussed.

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Section A: Literature Review

A systematic review and thematic synthesis of literature containing explorations of how voice hearers have been able to develop more positive relationships with their voices.

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Abstract

Background: First-person accounts and empirical research indicate many voice hearers (VHs) view themselves as having interpersonal relationships with their voices, with the quality of relationship associated with emotional response of VH to voices. Developing more positive relationships has therefore been understood as one way for VHs to manage distressing voice hearing experiences (VHEs). This review aims to explore and synthesise existing research to explore how VHs have been able to develop more positive relationships with their voices.

Method: Five databases were searched and twenty-seven eligible studies included in the review. The Critical Appraisal Skills Programme, Mixed Methods Appraisal Tool (MMAT): Mixed Methods Checklist, and MMAT: Qualitative Studies Checklists were used to assess quality.

Results: Five themes emerged: 'coming to see voices as less threatening; 'developing new ways of responding to voices'; 'becoming more accepting and less fearful of voices'; 'beyond voices' and 'facilitators'.

Conclusions: Processes by which VHs developed more positive relationships with voices varied, suggesting it is important for VHs to have access to a diversity of approaches. Future research should seek to explore which approaches are helpful for who, and how to introduce VHs to different approaches given the predominance of the bio-medical model in mental health services.

Keywords: voice-hearing, relationship with voices

Introduction

A Note on Language

Terminology relating to the experience of hearing voices that others cannot hear varies, and multiple terms are used in the studies included in this review. To give an accurate representation the review will use the language adopted in the original papers when summarising or quoting directly. Outside of this, the review will use terminology associated with the Hearing Voices Movement (HVM), which promotes the multiple perspectives of people with lived experience of voice hearing. However, it is acknowledged and respected that voice hearers are not a homogeneous group, and that different people will prefer to use different terms.

Voice hearer, meaning a person who hears voices, will be abbreviated to VH and a voice hearing experience to VHE.

Voice Hearing

Voice hearing refers to the experience of hearing a voice or voices that others cannot hear (Hearing the Voice, ND). VHEs have been recorded across history and cultures, and estimates of lifetime prevalence for voice hearing in non-clinical populations range between 1% to 16% for adults, and 2% and 41% for adolescents (Longden et al., 2012).

There are many different understandings about why people hear voices, including spiritual, religious, psychological, and medical approaches. Religious and spiritual understandings of VHEs are broad, and include beliefs that voices belong to higher beings (such as angels or a deity), or the spirits of people who have died (e.g. contact from a dead relative, contact from a spirit who is using the VH as a medium) (Cook, 2019). In some cultures, such as Māori cultures, VHEs are considered a normal part of spiritual life (Taitimu et al., 2018), and in others as something to be revered (Beavan et al., 2011). Psychological approaches understand voices within the context of an individual’s life experiences, for example there is strong evidence to suggest VHEs are associated with traumatic life events (Johns et al., 2014); or as misattributions of internal cognitions (Morrison et al., 1995). Purely medical understandings of VHEs view voices as symptoms of a mental illness such as schizophrenia or schizoaffective disorder (Waters et al., 2017).

The emotional experience of voice hearing also varies significantly, ranging from positive to distressing (Beavan, 2011). Those with distressing VHEs are more likely to hear negative voice content, experience voices as intrusive, have negative beliefs about voices (e.g. believe voices are malevolent, controlling and omnipotent), have negative appraisals of VHEs (e.g. believe experiencing voices means the person is “crazy” or possessed), develop coping strategies that can be unhelpful or distressing for the VH, and are more likely to need support from services (Johns et al. 2014).

Relational Conceptualisations of Voices

Research has shown that some VHs view their voices as people, entities or parts of the self with which they have a relationship, similar to interpersonal relationships held with social others (e.g. Hayward et al., 2011). For example, VHs might name their voices, view them as having a personal identity (in some cases the voice might hold the identity of someone from the VH’s life such as a family member or past abuser), describe a struggle for power between voices and VH, or develop close personal relationships with voices where the voices provide companionship and/ or advice (e.g. Beavan, 2011; Chin et al., 2009; Romme & Escher, 2000). The quality of this relationship is associated with the emotional response of VH to their voices, with negative relationships associated with VH distress (Benjamin, 1989; Birchwood et al., 2000; Vaughan & Fowler, 2004), and evidence suggests the pattern of relating between VH and voices is influenced by VH experiences of relating to others (e.g.

Chadwick & Birchwood, 2000; Hayward, 2003; Pilton et al., 2016; Vaughan & Fowler, 2004). The relationship between VH and voices has been explored using different theoretical frameworks within academic literature, outlined below.

Chadwick and Birchwood (1994) proposed the cognitive model of voice hearing, in which voice-related distress is understood to result from negative beliefs about voices held by the VH, such as beliefs about the identity, intentions and power of voices. The role of power was further explored by Birchwood et al. (2000) within the framework of the social rank theory of psychopathology (Gilbert & Allen, 1998). This suggests depression is linked to evolutionary responses to conflict, with depressive behaviours arising from the need for humans to develop de-escalation strategies to avoid coming to harm when in conflict with more powerful others. The decision to be submissive and subordinate to a social other results from a comparison of relative resources including power, abilities, and degree of social cohesion, with this process of comparison leading to social rankings. Birchwood et al. (2000) found VH perceptions of voices as malevolent or benevolent, powerful or benign were influenced by past and present experiences of relationships, with power and rank differences between VH and voices mirroring power and rank differences between the VH and others in their lives. Birchwood et al. (2004) found evidence to suggest power differentials between VHs and voices are grounded in core interpersonal schemas, which develop through experiences of relationships and go on to inform patterns of relating throughout a person's lifetime.

Birtchnell's relating theory (1996, 2002) has also been used to understand the relationship between VHs and voices. Birtchnell conceptualises relating styles as occurring across two intersecting axes: 'power' on the vertical axis, which has 'upper' and 'lower' at each pole; and 'proximity' on the horizontal axis, which has 'distant' and 'close' at each pole. The four positions represent different goals: closeness; distance; upperness (gaining advantage); and lowerness (seeking protection and help). Each goal is relationally adaptive depending on context, for example seeking distance is appropriate if the social other presents a threat. Birtchnell distinguishes between positive (“competent”) and negative (“incompetent”) relating, with relating competence understood as the ability to move between different positions as needed, developed through gaining sufficient experiences of each state of relatedness. A number of studies have explored the relationship between VHs and voices using this framework, for example Vaughan and Fowler (2004) found distressing VHEs were associated with negative relating styles (dominant relating by voices and submissive and distant relating by VHs) and Hayward (2003) found correlations between the relating styles of VHs to their voices and social others on both axes.

Finally, the relationship between VH and voices has been explored using Bowlby’s (1969) attachment theory. Attachment theory suggests infants are born with an innate drive to form emotional bonds with caregivers in order to survive. Early experiences of caregiving influence an individual’s interpersonal functioning and ability to manage emotions throughout their lifetime, with positive experiences of caregiving resulting in secure, and deficient experiences of caregiving leading to insecure attachment styles. There is evidence to suggest insecure attachments are associated with distressing VHEs, for example Pilton et al. (2016) found insecure-anxious attachment styles were associated with voice severity and distress.

Dissociation and Voices

As mentioned above, there is a strong body of evidence linking “psychotic symptoms”, including voice hearing, to traumatic events (e.g. Read et al., 2004, 2005, 2008) and in particular childhood sexual abuse with “hallucinations” (i.e. the experience of seeing, hearing and feeling things others cannot; Read et al., 2003). Dissociation models of voice hearing suggest the link between trauma and voice hearing could be the result of dissociative processes, defined as the “lack of normal integration of thoughts, feelings and experiences into the stream of consciousness and memory”, understood to be a protective response to threatening and overwhelming events (Bernstein & Putnam, 1986, p. 272). Dissociation models propose that voices represent dissociated parts of the self, which are caused by and reflect traumatic experiences. (Corstens et al., 2012; Longden et al., 2012; Romme & Escher, 1993, 2000). These models find evidence in empirical research examining the link between trauma, “hallucinations” and dissociation, for example Varese et al., (2011) found that participants experiencing “hallucinations” reported higher dissociative tendencies and childhood abuse in comparison to “healthy and non-hallucinating” controls. Dissociation was found to positively mediate the effect of childhood trauma on hallucination-proneness, with the mediating role particularly strong for sexual abuse in comparison to other types of trauma.

Following on from this, dissociative models of voice hearing argue that voices are a significant experience which should be explored, in contrast with purely medical models which view voices as biological symptoms to be treated with medication (Corstens et al., 2012). Such models advocate for directly engaging with voices in order to explore and integrate traumatic unassimilated experiences, facilitate understanding between VH and voices, and develop more positive ways of relating. This is supported by evidence suggesting VHs who engage with their voices are less distressed and have improved functioning in comparison to VHs who do not (Mawson et al., 2010; Rome et al., 2009; Shawyer et al., 2007; Veiga-Martinez et al., 2008).

Changing Relationships with Voices

Advances in psychological therapies for distressing voices reflect the understanding that many VHs view themselves as being in a relationship with their voices, that the nature of this relationship is associated with the emotional response to VHEs, and that developing more positive and constructive relationships with voices can be a helpful way of mitigating VH distress, with a number of therapeutic approaches now containing elements that target the relationship between VH and voices.

Cognitive approaches to voice hearing, such as Cognitive Therapy for Command Hallucinations (CTCH), support VHs to challenge their beliefs about voices with the aim of reducing voice-related distress and enabling VHs to respond to voices differently, for example changing beliefs about the omnipotence of voices to enable VHs to resist commands (Birchwood et al., 2018; Chadwick & Birchwood, 1994). Both AVATAR Therapy (AT; Leff et al., 2014) and Virtual Reality-assisted Therapy (VRT; Percie du Sert et al., 2018) use computer generated representations of voices, controlled by a therapist, to support VHs to practise new ways of responding to voices and experience a shift in response from representations of voices within therapy (e.g. the representation beginning to take a more positive stance towards the VH). Relating Therapy (RT) aims to help VHs understand their relationship with their voices by exploring their patterns of relating with others throughout their lifetime and encourages them to practise new ways of responding to voices and social others through experiential role plays (Hayward et al., 2017). The Making sense of Voices (MsV; Steel et al., 2020) approach, also known as Experience Focused Counselling (EFC; Schnackenberg et al., 2017), and the Talking with Voices (TwV; Longden et al., 2021) approach have both developed from the HVM, and support VHs to talk directly to their voices in order to develop an understanding of their voices, try out new ways of relating, and develop more constructive relationships. Similarly, Compassion Focused Therapy for Psychosis (CFTp), which was developed in collaboration with members of the HVM, supports VHs to develop an understanding of voices within the context of their life experiences, and uses this new understanding to support VHs to develop compassionate responses towards themselves and their voices (Heriot-Maitland, 2020).

Empirical evidence suggests engaging with these approaches can bring about changes in beliefs about the omnipotence and malevolence of voices (AT, Leff et al., 2013; CTCH, Birchwood et al., 2018; VRT, Percie du Sert et al., 2018); reduce VH compliance with commands (CTCH, Birchwood et al., 2018); improve assertive communication of VH to voices (AT, Leff et al., 2013; RT, Hayward et al., 2017; VRT, Percie du Sert et al., 2018); reduce voice-related distress (AT, Craig et al. 2018; CFTp, Heriot-Maitland, 2020; CTCH, Birchwood et al., 2018; EFC, Schnackenberg et al., 2017; RT, Hayward et al., 2009 and 2017; VRT, Percie du Sert et al., 2018); and associated depression (CFTp, Heriot-Maitland, 2020; VRT, Percie du Sert et al., 2018); and increase VH acceptance of voices (AT, Craig et al. 2018; VRT, Percie du Sert et al., 2018).

Review Rationale and Aims

Systematic reviews have been conducted into interpersonal interactions between VH and voices (Paulik, 2011), AT (Aali et al., 2020), and the use of virtual reality in “psychosis” (Rus-Calafell, 2017); and a recent scoping review mapped emerging literature and reviewed the empirical evidence for dialogical approaches to voice hearing (approaches which view voices as entities with which VHs have an interpersonal relationship, encompassing AT, VRT, RT, MsV/EFC and TwV; Middleton, 2021). However, no review to date has specifically examined the processes by which VHs have been able to develop more positive relationships with their voices. This review aims to explore and synthesise existing research, including research conducted with treatment and non-treatment seeking VH participants, to answer the question: “How have VHs been able to develop more positive relationships with voices?”. The review therefore has the following two aims:

i. To review existing research which includes information about how VHs have been able to develop more positive relationships with their voices.
ii. To explore how VHs have been able to develop more positive relationships with voices.

Positioning Statement

The author of this review has worked clinically and, for the purpose of this thesis, has spoken to numerous VHs who view themselves as being in relationship with their voices and have been able to reduce distress by navigating their relationships with voices in more positive ways. The author therefore holds the position that this is a helpful approach, however, they also believe different approaches can be helpful for different people and that ideological positioning should not take precedence over VH preferences (for example if an individual finds it helpful to view their voices as a symptom of a mental illness, this should be respected). The author took part in a bracketing interview with the primary supervisor of the project to examine assumptions and biases, with the aim of mitigating the impact researcher bias might have on the review.

Method

Search Terms

Preliminary exploratory searches were conducted in October and November 2021 to generate search terms. This process highlighted the abstract nature of ‘relationship’, and the need for an operational definition to use when screening papers for inclusion (described below). Initial search terms included synonyms for the words/ phrases ‘voice hearing’, ‘change’ and ‘relationship’, however these terms did not yield some papers known to be relevant to the review as, although the papers described a change between VH and voices which fitted the operational definition of relationship, they did not use relational terms to describe this change. Therefore, to increase the chance of relevant papers being included in searches, synonyms for "relationship" were not included in the search terms. Final search terms are displayed in Table 1.

Table 1

Search Terms Used for Review

Search Terms- combined with AND
Hear* voice* OR auditory hallucination* OR verbal hallucination* OR auditory verbal hallucination*
Chang* OR shift* OR adjust* OR transform* OR evolv*

Eligibility Criteria

Full inclusion and exclusion criteria are outlined in Table 2. During the initial exploratory searches, a decision was made to exclude papers employing purely quantitative methodology as quantitative papers showing a change in relationship with voices did not contain enough detail about how this change came about. For example, a paper might demonstrate that power dynamics between the VH and voices had changed following engagement with a type of therapy, but not explore the mechanisms of change.

The operational definition of 'relationship' was generated through a review of papers elicited in the initial exploratory searches and discussion between the author and primary supervisor. For the purposes of the review, 'relationship' was defined as a change in:

- the way VH and/ or voices behave towards each other (e.g. how VH and/or voices speak to each other).
- the way VH and/or voices regard each other (e.g. a shift from fear of voices to acceptance).
- the power dynamics between VH and voices.

Change must result from something happening *between* VH and voices, for example a paper describing voices stopping solely as the result of VHs taking medication would not be included as the change in behaviour of the voices did not take place within a relational framework.

Table 2

Inclusion and Exclusion Criteria

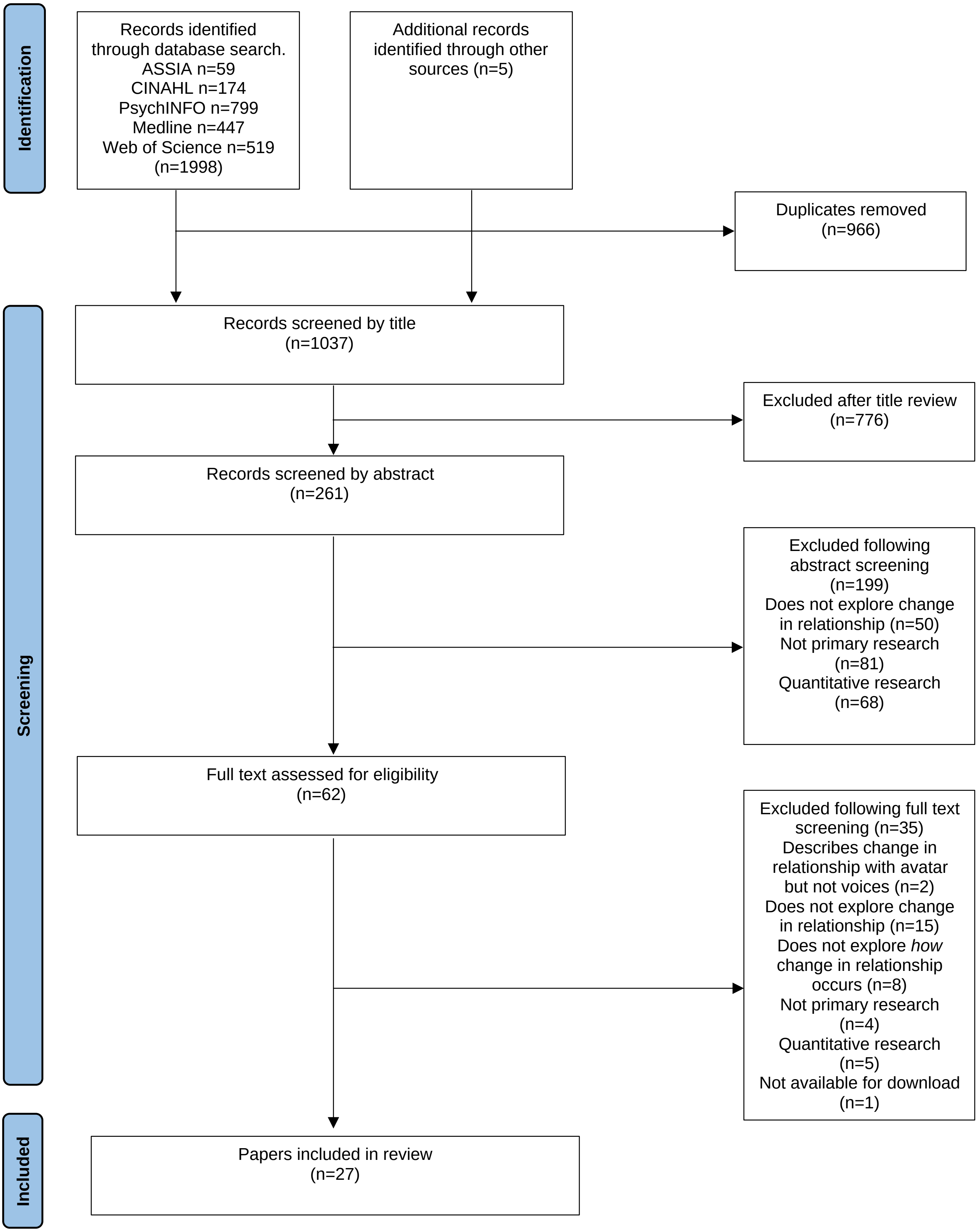
Inclusion Criteria	**Exclusion Criteria**
The paper must include at least one statement about how a change in relationship with voices has been brought about, with relationship being defined as a change in: • the way VH and/ or voices behave towards each other (e.g. how VH and/or voices speak to each other). • the way VH and/or voices regard each other (e.g. a shift from fear of voices to acceptance). • the power dynamics between the VH and their voices.	Papers employing purely quantitative methodology.
English language papers. Peer reviewed.	Non-English language papers.

Literature Search

An electronic search was conducted in December 2021 of the following databases: ASSIA (Applied Social Sciences Index and Abstracts), CINAHL, MEDLINE, PsychINFO and Web of Science. After screening and excluding papers that did not fit the criteria, 22 papers were elicited (see Figure 1 for a PRISMA diagram outlining the literature search process). An additional five papers known to be relevant to the review through preliminary reading were added. Due to the large number of papers generated, the decision was made not to conduct a hand search of the reference lists of the 27 elicited papers. This decision was informed by Thomas and Harden (2008, p. 3) who suggest reaching “conceptual saturation” may be more important than including all relevant papers when synthesising qualitative research as, unlike conducting a metanalysis of quantitative research, the number of papers included in review will not impact results if the papers contain the same concepts. Following analysis, conceptual saturation was deemed to have been met by the 27 papers included in the review, therefore further hand searches of reference lists were not conducted.

Figure 1

PRISMA Flowchart of Search and Selection Process



Method of Synthesis

Thematic synthesis, following the process outlined by Thomas and Harden (2008), was used to synthesise results from the papers as follows:

1. An initial reading of each paper was conducted to identify findings relevant to the current review. This initial stage was added as the majority of papers included were not specifically about change in relationship between voices and VH but did include relevant findings. Identification of the relevant findings was conducted by the author and reviewed by the primary supervisor (example of relevant findings displayed in Appendix A).
2. Relevant findings were coded line by line, with many lines being given multiple codes. Throughout this process a bank of codes was created, and the code bank was refined through repeat readings of the papers.
3. Codes were reviewed for similarities and differences and organised into descriptive themes.
4. Analytic themes were generated by using descriptive themes to answer the research question and “go beyond” the data included in the original papers. (Thomas & Harden, 2008, p. 7).

Results

Twenty-seven studies were identified: 17 employed qualitative methodology, three mixed methods, and seven were narrative case reports. Fifteen studies aimed to explore the experience of participating in an intervention designed to promote recovery from distressing VHEs, four aimed to investigate Hearing Voices Groups (peer support groups which developed from and are organised around the goals and values of the HVM; Corstens et al., 2014), and eight explored experiences of VHs more generally (e.g. experiences of VHEs over time, experiences of coping with VHEs), including two which focused on the experiences of VHs who had attended HVGs. Summaries of papers are displayed below: qualitative (Q) studies in Table 3, mixed methods (MM) studies in Table 4, and narrative case reports (NCR) in Table 5.

Table 3

Summary of Qualitative Studies Included in Review

Study	Title	Aim	Sample	Design and Methods	Analysis	Key Findings	Key Quality Issues
Bogen-Johnston et al., (2019)	"It's just a bit like a rollercoaster": a longitudinal qualitative study exploring a model of the phases of voice hearing.	To compare findings from a longitudinal study with existing models of voice hearing to generate a framework for a revised model of voice hearing over time.	12 voice hearers (VHs) recruited from an Early Intervention in Psychosis (EIP) Service in the UK. Participants were currently hearing voices, had been hearing voices for at least the past three months, and voices did not result from organic illness or substance abuse.	Longitudinal mixed methods design. Semi-structured interviews conducted at nine-month intervals at four time points over three years.	Stage 1 analysis used thematic analysis to generate themes. Stage 2 analysis generated a potential framework for a revised model of voice hearing over time.	Framework included the following: - A common pathway from onset of voices to disclosure of voice hearing experiences (VHEs) and accessing help, triggered by a worsening of voices. - Common pathway then diverged to three pathways: 'voices stop', 'voices continue but beliefs change', 'voices continue but beliefs do not change'. - Within the 'voices stop' pathway, cessation of voice hearing was attributed to a factors including medication, therapy and opportunities to discuss VHE. - 'Voices stopping but beliefs changing' was facilitated by engaging in CBT and supportive discussions with others, and enabled voice hearers to move from a passive to an active	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - More than one analysist used and respondent validation utilised. - Findings explicit and evidence for and against researcher arguments discussed. Weaknesses: - Purposive sampling from EIP services was used therefore all participants had engaged with treatment which was not reflected in the research question. - Analysis did not reach the point of saturation. - Demographic details of participants not reported.

						response style towards voices. -For participants in the ‘voices continue but beliefs do not change’ pathway, voices continued to be experienced negatively leading to increased need for support from services. Participants in this group had not had access to supportive and non-judgemental conversations about voice hearing with others, unlike the previous two groups.	
Clements et al., (2019)	“I’m not telling an illness story. I’m telling a story of opportunity”: Making sense of voice hearing experiences.	To explore how VHs who have engaged in Hearing Voices Groups (HVGs) understand their voice hearing experiences.	Five VHs who attended HVGs in Australia. Age range: 30-62 Average duration of voice hearing: 28 years.	Qualitative. Semi-structured interviews.	Thematic Analysis	An overarching theme of ‘tension and recalibration’ was identified. Five further interrelated themes were elicited: ‘beliefs about voices’; ‘navigating the relationship with my voices’; ‘learning to live with my voices’; ‘rediscovering myself with my voices’; ‘influences to understanding my voices’. Recovery was defined as being able to	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - More than one analyst used. - Findings explicit and evidence for and against researcher arguments discussed. Weaknesses: - Convenience sampling from one HVG was used which

						navigate relationships with voices in more positive and helpful ways, facilitated by a deepened understanding of voices aided by attendance of HVGs. Voice hearing was understood by all participants as an opportunity for personal growth.	limits generalisability. - No mention of the use of respondent validation - Demographic details of participants, other than age, not reported.
de Jager et al. (2016)	Investigating the lived experience of recovery in people who hear voices	To investigate the process of recovery over time for people who hear distressing voices.	Twelve VHs living in Australia: four men and seven women. Age: 23-63 (M=47, SD=12.6) Ethnicity: Asian= 1; White= 10 Six participants were recruited from the HVN New South Wales (HVNNSW) and five from the Australian Schizophrenia Research Bank.	Qualitative. Narrative interviews.	Narrative Analysis.	Two recovery typologies were identified: - 'Turning toward/ empowerment' involved normalising VHEs, developing voice related skills, integrating voices into daily and life and transforming identity. - 'Turning away/ protective hibernation' involved using resources to "survive" voice hearing experiences, with an emphasis on the importance of medication. The importance of services being responsive to an	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - Researchers sought feedback from an expert panel and respondent validation was utilised. - Findings explicit and evidence for and against researcher arguments discussed. Weaknesses: - Lack of diversity of participants.

						individual’s recovery style was highlighted.	
Dos Santos and Beavan (2015)	Qualitatively exploring hearing voices network support groups	To explore the experiences of attendees of an Australian HVG.	Four participants, two men and two women, recruited from the HVNNSW. All were currently hearing voices. Age: early 30s to late 50s. Three participants had a diagnosis of schizophrenia, and one had a diagnosis of bipolar disorder.	Qualitative. Semi-structured interviews.	Interpretive Phenomenological Analysis	Three superordinate themes with subordinate themes emerged from the data. 1) The superordinate theme ‘first experiences first discoveries’ was identified with the subthemes ‘secrecy at onset of voices’; ‘discovering the group through other’; ‘first experience of the group’. 2) The superordinate theme ‘within the groups’ was identified with subthemes ‘social connections’; the importance of sharing’; ‘the importance of feedback’; supportive nature of the group’; ‘process and role of facilitators’; ‘other group members’; ‘the importance of attending’. 3) The superordinate theme ‘beyond the group’ was identified with the subthemes ‘willingness to share	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - Contradictory data included in themes. - More than one analysist used - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - Study unable to utilise respondent validation - Ethnicity of participants not reported.

						with others'; 'improvement in self-esteem'; 'relating to the voices'; sense of agency in recovery'.	
Goodliffe et al., (2010)	Group person-based cognitive therapy for distressing voices: Views from the hearers	To explore the experiences of people who attended a person-based cognitive therapy group for distressing voices.	18 VHs, 12 women and six men, living in the UK. Age range: 30-59. All participants had a diagnosis of schizophrenia or schizoaffective disorder and had been experiencing medication-resistant and distressing voices for at least two years. Ethnicity: Latin American = 1; White British = 16; White European = 1.	Qualitative. Focus groups based on semi-structured interview schedule.	Grounded Theory	Four categories were elicited. Two described the context for reflection and change in the group: 'sharing negative characteristics of hearing voices' and 'developing a group identity'. Two related to concepts underpinning the intervention: 'learning to cope with voices' and 'development of sense of self beyond voices'.	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient. - Different perspectives and researcher bias discussed. - Findings explicit and evidence for and against researcher arguments discussed. Weaknesses: - Ethics process unclear. - Respondent validation not utilised and it is not clear whether more than one analysist was used. - Lack of diversity of participants.
Hayward et al., (2018)	Relating Therapy for distressing voices: Who, or what, is changing?	To generate understandings about who or what is changing in relationally based therapies for distressing voices by exploring the experience of voice	Nine participants (three men and six women) living in the UK who had been hearing distressing voices for at least one year and had received a course of RT.	Qualitative. Semi-structured interview, based on the Change Interview (Elliott, Slatick & Urman, 2001).	Thematic Analysis	Three superordinate themes emerged from the data: 1) The superordinate theme 'changes in me' was identified with subthemes 'feeling stronger'; 'standing up	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient. - Different perspectives included.

		hearers who had engaged in a therapy pilot for relating therapy (RT).	Age range: 24-61 (M=45). Ethnicity: Asian/ British= 1; Mixed= 1; White British= 7. Diagnosis: borderline personality disorder= 3; depression= 1; OCD =1; schizophrenia spectrum disorder= 4.			for myself'; 'connecting with others'. 2) 'Changes in Voices' 3) '…and those role plays!' Findings highlighted that changes in the VH and voices was brought about through the adaptation of a different, more assertive communication style towards voices.	- More than one analyst used. Weaknesses: - Recruitment strategy not outlined. - Evidence against findings not discussed. - Respondent validation not utilised. -No discussion of potential impact of researcher bias and assumptions. - Lack of diversity of participants.
Hayward and Fuller (2010)	Relating Therapy for people who hear voices: Perspectives from clients, family members, referrers and therapists	To explore the experience and usefulness of RT from the perspective of clients, family, referrers and therapists.	Ten participants: three therapists who had offered RT as part of a therapy pilot, three VHs who had participated in RT as part of the therapy pilot, two relatives of clients within the therapy pilot, two referrers of clients to the therapy pilot. Therapists: two female and one male; all fell within the age range 40-49; all identified as White British. Clients: two female and one male; two fell within the age range 20-39 and	Qualitative Semi-structured interviews	Interpretative Phenomenological Analysis	Five superordinate themes with subthemes were identified: 1) The superordinate theme 'engaging with the relational framework' was identified with the subthemes 'an intuitive model of voice hearing'; 'assessment of relating styles'; 'openness and honesty'. 2) The superordinate theme 'therapists' approach' was identified with subthemes 'therapeutic	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient. - Different perspectives and researcher bias discussed. - More than one analysist used and respondent validation utilised. - Findings explicit and evidence for and against researcher arguments discussed. Weaknesses:

		one in the age range 40-49; all identified as White British; all were taking antipsychotic medication. Relatives: one male and one female; one fell within the age range 50-59 and one was over 60; both identified as White British. Referrers: two male; both fell within the age range 50-59; one was Chinese and one White British.		relationship' and 'non-judgmental about psychotic experiences'. 3) The superordinate theme 'developing a new relating style' was identified with the subthemes 'developing understanding'; 'drawing on positive relating styles'; 'assertiveness training'; 'bringing the dialogue into the room'. 4) The superordinate theme 'challenge to change' was identified with the subthemes 'perceived risks within therapy'; 'entrenched relating styles'. 5) The superordinate theme 'impact of change' was identified with the subthemes 'voice-hearer relationship'; 'acceptance of voices'; 'mental health and perceptions of self'; 'independence-seeking'; 'social relationships'; 'hopefulness and the possibility of change'.	- No discussion of recruitment strategy. - No discussion of potential influence of researcher bias and assumptions. - Respondent validation not utilised. - Does not mention ethical approval. - Lack of diversity of participants.

						Authors concluded that results offered tentative support to the therapeutic focus of changing the relationship with distressing voices in order to bring about positive change.	
Hornstein et al., (2021)	The diverse functions of hearing voices peer-support groups: findings and case examples from a US national study	To explore and develop an understanding of the diverse functions of HVGs.	111 members of HVGs across America. Gender: Men= 31; Non-binary= 8; Women= 60. Race/ ethnicity: Black/ African-American= 7; Hispanic/ Puerto Rican= 6; Multiracial= 15; White= 65; Other/ unspecified= 5.	Qualitative. All participants completed a mostly open-ended questionnaire and a subset of 15 participants took part in follow up interviews.	Phenomenological Analysis.	The following key and distinctive elements of HVGs were identified through questionnaire responses and interviews: ‘prioritising of self-determination’; ‘de-emphasising behavioural targets or pressure to change’; ‘respecting and welcoming multiple frameworks of understanding’; ‘cultivating curiosity about perplexing experience in any form’; ‘fostering egalitarian collaboration and genuine relationships among members seen as “experts by experience”’.	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives are included. - More than one analysist used. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - Recruitment strategy not discussed. - No discussion of potential influence of researcher bias and assumptions. - Respondent validation not utilised. - Insufficient data presented.

Hornstein et al., (2020)	How do hearing voices peer-support groups work? A three-phase model of transformation	To investigate the mechanisms by which HVGs function.	113 members of HVGs across America. [NB: demographic questions were not completed by all participants] Gender: Non-binary= 8; Men = 31; Women = 62 Age range: 19-79 (M = 42.3) Race/ Ethnicity: Black/ African-American= 8; Hispanic/ Puerto Rican= 6; Multiracial= 15; White= 66; Unspecified= 5	Qualitative. All participants completed questionnaires and a subset of 15 participants took part in follow up interviews.	Thematic Analysis and Grounded Theory	Unique elements of HVGs were identified and organised into a three-phase model of transformation in HVGs: Phase 1: Discovery (‘discovering a unique context where voices can be explored without consequences’; ‘learning that many people hear voices and experiences vary widely’; ‘discovering a sense of curiosity and safety to talk about personal experiences’) Phase 2: Reframing (‘articulating contextual variations and distinctive characteristics of voices; exploring their meaning, purpose and origin’ leading to ‘trying out new ways of responding to voices’; ‘negotiating new relationship to voices’; ‘building greater confidence and self-efficacy from new ways of relating to voices’; ‘finding that voices themselves may change’)	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives are included. - More than one analysist used. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - No discussion of potential impact of researcher biases and assumptions. - Respondent validation not utilised. - Insufficient data presented to illustrate model.

						Phase 3: Change (‘undertaking important life projects’; ‘taking new chances outside the group’; ‘using continued availability of the group to deal with setbacks’)	
Milligan et al., (2012)	Time changes everything? A qualitative investigation of the experience of auditory verbal hallucinations over time	To explore key issues associated with hearing voices over time.	Six participants recruited through an EIP service in the UK. Gender: Men= 5; Women=1. Age range: 17-30 All participants had experienced an episode of psychosis with auditory verbal hallucinations within the past 12 months.	Qualitative. Semi-structured interviews.	Interpretative Phenomenological Analysis	The following themes which describe a trajectory through VHEs were identified: ‘negative trigger’; ‘voice-affect interactions’; ‘the rejection phase’; ‘crisis-induced change’; ‘discovering, adjusting, and trying to cope’ (containing the subthemes ‘self: learning through experience’; ‘others: the importance of relationships’; ‘services: aids to coping’); ‘new understandings’.	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - More than one analysist used. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - All participants were recruited from an EIP service meaning some VH perspectives may not have been included. - Respondent validation not utilised.

							-Ethnicity of participants not reported.
Moore et al., (2020)	Client experiences of blending a coping-focused therapy for auditory verbal hallucinations with smartphone-based ecological momentary assessment and intervention.	To explore participants' experiences of a novel intervention which combined face-to-face therapy sessions with ecological momentary assessment and intervention (EMA/I) digital technologies. The aim of the intervention was to improve coping in people who hear voices. Participants had taken part in a pilot RCT for the intervention.	Twelve participants who completed the intervention in Australia, three male and nine female. Age range: 25-60 All had a diagnosis of schizophrenia (n=8) or schizoaffective disorder (n=4), as assessed by the Mini International Neuropsychiatric Interview (Sheehan et al., 1998). Three identified as being from a minoritized ethnic group. All but one participant were taking antipsychotic medication, with a mean chlorpromazine-equivalent dose of 577 mg (SD = 292 mg).	Qualitative. Semi-structured interviews.	Thematic Analysis	Four main themes were generated: 'therapy experience changed by digital technology'; 'valuing face-to-face component'; 'preference for different phases of the digital technology'; 'not as bothered by voices'. EMA/I technology was found to deepen the therapeutic relationship as it enabled participants to communicate a more accurate picture of their experiences to therapists. Participants found EMA/I technology useful for gathering information and implementing coping strategies.	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - More than one analysist used. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - Respondent validation not utilised.
Ng et al., (2012)	Recovering from Hallucinations: A qualitative study of coping with voices hearing of people with schizophrenia in Hong Kong	To explore how people with a diagnosis of schizophrenia in the Chinese sociocultural context of Hong Kong cope with the	Twenty participants, twelve men and eight women. Age range: 22-55 (Mean age of men= 44.1; mean age of women= 277)	Qualitative. Semi structured interviews.	The following process is described: - Transcripts were coded. - Observations, reflections and	Different ways of coping with voices were identified including: changing social contacts, manipulating voices, changing perception	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented.

		experience of hearing voices.	All participants heard voices and had received a diagnosis of schizophrenia. All participants were taking antipsychotic medication.		remarks were noted and cross-referenced with sociodemographic information. - Data werre examined to identify similarities and differences. - Common themes were identified.	towards and meaning of voices.	- Different perspectives are included. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - No discussion of potential impact on researcher bias and assumptions. - Not made clear whether more than one analyst or respondent validation was utilised. - Ethnicity of participants not reported.
Payne et al., (2017)	Hearing Voices Network Groups: experiences of eight voice hearers and the connection to group processes and recovery	To investigate change processes within HVGs by exploring how attendees experience change within the group.	Eight participants, four women and four men, living in the UK. Age range: 26- 60 (M= 47.88) Ethnicity (self-defined): Black British = 1; British = 2; European = 1; White British Jewish = 1; White British = 2; White English = 1	Qualitative. Semi-structured interviews.	Interpretative Phenomenological Analysis	Four superordinate themes emerged from the data: 'healing: connecting with humanity'; 'group as an emotional container'; 'making sense of the voices and me'; and 'freedom to be myself and grow. Participants highlighted safety, exploration and group ownership as important components of HVGs.	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives are included. - More than one analysist used and respondent validation utilised. - Findings are explicit and evidence for and against researcher

							arguments are discussed. Weaknesses: - Not clear how participants were recruited. - No discussion of potential impact of researcher bias and assumptions.
Racz et al., (2017)	The experience of voice hearing and the role of self-help group: An interpretative phenomenological analysis	To explore the way VH make sense of their voice hearing experiences.	Eleven VHs recruited from the Semmelweis Community Psychiatry Centre (Hungary) Awakenings Foundation voice hearers’ self-help group. Gender: female= 7; male= 4. Age range: 31-57.	Qualitative. Semi-structured interviews.	Interpretative Phenomenological Analysis	Four superordinate themes emerged: ‘the role of the voice’; ‘the relationship between the voice and ‘I’’; ‘the role of the self-help group’; ‘the role of the voice hearing method’. Attendance of the self-help group played a significant role in participants developing an understanding of and learning to live with voices.	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives are included. - More than one analysist used. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - No discussion of potential impact of researcher biases and assumptions. - Respondent validation not utilised. - Ethnicity of participants not reported.

Ruddle (2017)	Qualitative evaluation of a cognitive behaviour therapy Hearing Voices Group with a service user co-facilitator	To evaluate a Cognitive Behaviour Therapy (CBT) Hearing Voices Group which piloted co-facilitation with a service user and practitioner.	Eight participants of a CBT hearing voices group in the UK who had been hearing distressing voices at least weekly. Gender: Female= 2; Male = 5. Age range: 36-59 (M= 49.14) Ethnicity: Black British = 2; Caribbean= 1; Indian/ British Indian= 1; White and Black Caribbean= 1; Other mixed/ mixed unspecified= 1; Other White/ mixed European= 1 Six participants had received diagnoses of schizophrenia; and one had received a diagnosis of schizoaffective disorder. The service user co-facilitator was also interviewed.	Qualitative. Semi-structured interviews.	Thematic Analysis.	Three superordinate themes with subthemes emerged from the data. 1) The superordinate theme ‘getting something from the group- what helps?’ was identified with the subthemes ‘being in a group’; ‘service user co-facilitation’; ‘personal factors’; ‘group set-up’. 2) The superordinate theme ‘getting something from the group- what hinders?’ was identified with the subthemes ‘personal factors’; ‘the group’s limitations’; ‘society doesn’t help’. 3) The superordinate theme ‘making changes’ was identified with subthemes ‘new perspectives’; ‘feeling inspired’ (by the service user co-facilitator) and ‘coping better’. The inclusion of a service user co-facilitator was identified as	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - More than one analysist used. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - Respondent validation not utilised.

						contributing to positive experiences of the group.	
Schnackenberg et al., (2018)	Experience Focussed Counselling with voice hearers as a trauma-sensitive approach. Results of a Qualitative Thematic Enquiry.	To explore whether Experienced Focussing Counselling (EFC) can be considered trauma-sensitive when compared to treatment as usual (TAU).	Fourteen voice hearers living in Germany and their respective mental health professionals. EFC Group (n=9) Mean age= 43.89 (SD= 9.61). Gender: Female= 5; Male= 4. Primary diagnosis: Emotionally unstable personality disorder= 1; Schizoaffective disorder= 1; schizophrenia =7. TAU Group (n=5): Mean age= 43.80 (SD= 7.89). Gender: Female= 3; Male= 2. Primary diagnosis: Schizoaffective disorder= 1; schizophrenia =4.	Qualitative. Semi-structured interviews.	Applied Thematic Analysis	The following themes were identified: ‘trauma-related’; ‘dealing with emotions’; ‘processes of working with voices’; intra- and interpersonal life’; ‘coping related’. Findings showed EFC was considered helpful for understanding and processing trauma related distress. The same was not found for TAU.	Strengths: - Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives and researcher bias discussed. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - Not clear whether more than one analysis was used and respondent validation not utilised, however participants were given a summary at the end of their interview with an opportunity to correct. - Ethnicity of participants not reported.
Steel et al. (2020)	Voice hearers’ experiences of the	To explore and report the	Fifteen VHs recruited through an NHS setting.	Qualitative	Responses to each question are	Positive outcomes of the approach related to	Strengths:

	Making Sense of Voices approach in an NHS setting	experience of VHs who received the Making Sense of Voices intervention in an NHS setting as part of a case series.	[NB: Demographic information about three participants is not reported] Gender: Female= 8; Male= 4 Age range: 25-63 (M= 48.5) Ethnicity: Asian or Asian British- Pakistani= 1; Black or Black British- African: 1; White British= 10 Diagnosis: emotionally unstable personality disorder= 2; psychosis not otherwise specified= 2; schizoaffective disorder= 2; schizophrenia= 6	Semi-structured interviews conducted as exit interviews following treatment.	reported, and responses are grouped into categories.	developing a better understanding of VHEs and gaining a greater sense of control over voices. Some participants did not report a positive experience of engaging with voices.	- Appropriate design and data collection. - Analysis clear and sufficient data presented. - Different perspectives are included. - More than one analysist used. - Findings are explicit and evidence for and against researcher arguments are discussed. Weaknesses: - No discussion of potential impact of researcher biases and assumptions. - Inadequate data presented for some research questions. - Respondent validation not utilised.

Table 4

Summary of Mixed Methods Studies Included in Review

Study	Title	Aim	Sample	Design and Methods	Analysis	Key Findings	Key Quality Issues
Hazell et al. (2020)	Patient experience of Guided self-help CBT intervention for VoicEs (GIVE) delivered within a pilot randomized controlled trial	To explore the experience of accessing GIVE, a brief form of Cognitive Behavioural Therapy for Psychosis (CBTp) targeting voice-related distress, within a randomized control trial (RCT).	Nine participants living in the UK. Participants were all currently hearing distressing voices and had been for at least the past year. Participants could not have a primary diagnosis of substance misuse and voices could not be causally linked to an organic illness. Gender: Female=5; Male=3; Other= 1 Ethnicity: White British= 8; White Other= 1	Mixed methods. Interview combining the trial experience interview schedule (Notely et al. 2015) and the Change Interview guide (Elliott et al., 2001). The Change Interview includes a quantitative element.	Qualitative data were analysed using Thematic Analysis. Quantitative data were summarized using descriptive and frequency statistics.	Five themes emerged from the data: ‘changes that I have noticed’; ‘I am not alone’; ‘positive therapy experiences’; ‘I want more therapy’; ‘helping myself’. Key changes post-treatment were improved self-esteem and improved ability to cope with voices. Changes were facilitated through the use of self-help and accessing support in and out of therapy sessions.	Strengths: - Design is appropriate and rationale is clearly explained. - Meta-inference adequately answers research question Weaknesses: - Limited information is given about the quantitative component of the study. - Inconsistency between qualitative and quantitative results not adequately addressed. - Sample is limited in terms of ethnicity. - No discussion of potential impact of researcher biases and assumptions.

Mourgues et al. (2020)	Development of Voluntary Control Over Voice-Hearing Experiences: Evidence From Treatment-Seeking and Non-Treatment-Seeking Voice-Hearers	To identify key factors in the evolution of control over VHE in treatment and non-treatment seeking VHs.	Fifteen VHs living in America. Seven treatment seeking voice hearers recruited from the Connecticut Hearing Voices Network (HVN). Eight non treatment seeking voice hearers recruited from spiritual and psychic/ medium communities in New England and New York.	Mixed methods. Semi-structured interviews, questionnaires and self-report measures: - Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962). - Launay-Slade Hallucinations Scale-Revised (LSHS-R; Waters et al., 2003). - Beliefs About Voices Questionnaire-Revised (BAVQ-R; Chadwick et al., 2000). - Peters et al. Delusion Inventory (PDI; Peters et al., 1999). - Chapman Anhedonia Scale (PhA; Chapman et al., 1976), Perceptual Aberration Scale (PER; Chapman et al., 1978), Magical Ideation Scale (MI;	Grounded Theory Non-parametric analysis: - Mann-Whitney tests used to compute mean rank differences. - Chi-square tests used to compute proportion differences. - Holm-Bonferroni used for multiple-comparisons correction.	Five stages in the development of control over voice hearing experiences were identified across treatment seeking and non-treatment seeking participants: ‘voice onset’; ‘making sense of the experience’; ‘turning point’; ‘support seeking; acceptance’.	Strengths: - Qualitative and quantitative components of study well integrated in results and discussion. - Meta-inference adequately answers research question. - Inconsistencies between quantitative and qualitative results adequately addressed. Weaknesses: - Inadequate recruitment strategy meaning some perspectives may not have been included. -Demographic information about participants not reported.

				Eckblad et al., 1983). - Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al., 1997)) - Brief Multidimensional Measurement of Religiosity and Spirituality (BMMRS; Curcio et al., 2015)			
Rosen et al. (2015)	Self, voices and embodiment: A phenomenological analysis	To explore first-person descriptions of the relationship between subjects and their voices.	Twenty participants recruited from the university of Illinois at Chicago. All were actively experiencing auditory verbal hallucinations. Gender: Female= 13; Male= 7. Mean age= 41. Ethnicity: African-American= 17; Caucasian= 2; Hispanic=1. Diagnosis: bipolar with psychosis= 3; schizophrenia= 17.	Mixed methods. Clinical measure: modified version of the Maastricht Interview for Voice Hearers (Escher, Romme & Hage, 2000).	Demographic data and quantitative data from the Maastricht Interview were analysed through mean scores, Analysis Of Variance (ANOVA) and Chi-Square tests. Qualitative data were analysed using Interpretative Phenomenological Analysis.	Analysis found relationship between self and voices was underpinned by three foundational domains: ‘interpretation/ understanding of origin’; ‘distinct interpersonal identities’ and ‘locus of control’.	Strengths: - Use of mixed methods design appropriate and rationale explained. - Qualitative and quantitative components of study well integrated in results and discussion sections. - Meta-inference adequately answers research question. Weaknesses: - All participants were receiving psychiatric

support and taking medication which is not reflected in the research question.
- No discussion of potential impact of researcher biases and assumptions.

Table 5

Summary of Narrative Case Reports Included in Review

Study	Title	Aim	Sample	Design and Methods	Analysis	Key Findings	Key Quality Issues
Barrowcliff (2008)	Cognitive-Behavioural Therapy for Command Hallucinations and Intellectual Disability: A Case Study	To report the use of Cognitive Behavioural Therapy targeting command hallucinations with an individual with an intellectual disability.	A 22 year old man living in the UK with diagnoses of foetal alcohol syndrome and mild intellectual disability (diagnosed using the Weschler Intelligence Scale for Children, third edition (WISC-III; Wechsler, 1991)). The participant first reported experiencing auditory hallucinations aged 14.	Case study.	Description of intervention and outcomes reported by author. Reporting of outcome measures obtained at pre and post intervention and three and six month follow ups: - Positive and negative syndrome scale (PANSS; Kay et al., 1987). - Psychotic Symptom Rating Scale-Auditory Hallucinations (PSYRATS-AH; Haddock et al., 1999). - Social comparison scale for intellectual disabilities (SCS-ID; adapted from Birchwood et al., 2000). - Beliefs about voices questionnaire (BAVQ; Chadwick & Birchwood, 1995).	Reduction in positive symptoms post treatment, which was maintained at three and six month follow ups. Reduction in belief about omnipotence of the voice post treatment brought about through challenging the voice in sessions.	Strengths: - In depth description of formulation, intervention and outcomes. - Paper reports outcome measures which corroborate author descriptions. Weaknesses: - Lack of direct qualitative data from participant. - No discussion of why this particular case was chosen to illustrate the intervention. - Does not mention ethical approval. - No discussion of potential impact of researcher biases and assumptions. - Ethnicity of participant not reported.

Chadwick and Birchwood (1994)	The omnipotence of voices: A cognitive approach to auditory hallucinations NB: Data relevant to this review is contained in Study 2 of two studies described in the paper. All information presented in this table is pertaining to study 2.	To outline and provide evidence for a cognitive approach to understanding and treating drug-resistant auditory hallucinations in people with a diagnosis of schizophrenia. Study 2 specifically focuses on illustrating how core beliefs about voices can become a target for treatment by describing the use of cognitive therapy with four VHs.	Four women experiencing drug-resistant and distressing auditory hallucinations. Age range: 29-59 (M= 40.75). All met DSM-III-R criteria for schizophrenia or schizoaffective disorder (American Psychiatric Association, 1986).	Case study.	Description of intervention and outcomes reported by authors.	Changes in beliefs about voices' omnipotence, identity and purpose were reported, together with a reduction in associated distress, increase in adaptive behaviour and fall in voice activity. Authors report change in beliefs was brought about through testing out beliefs.	Strengths: - In depth description of formulation, intervention and outcomes. - Authors are appropriately tentative about conclusions due to limitations of methodology. Weaknesses: - Lack of direct qualitative data from participants - No discussion of why these particular cases were chosen to illustrate the intervention. - Does not mention ethical approval. - No discussion of potential impact of researcher biases and assumptions. - Ethnicity of participants not reported.
Dellazizzo et al. (2018)	Avatar Therapy for persistent auditory verbal hallucinations: a case report of a peer research assistant on his path to recovery	To report the use Avatar Therapy (AT). The client was a peer research assistant and contributed to the research and writing of the report.	A male VH in his early 50s living in Canada.	Case report.	Description of intervention and outcomes reported by client (peer research assistant) and authors.	The client experienced a reduction in fear of voices followed by a reduction in VHEs. This was brought about through a process of challenging the reality of voice content, understanding voices within the context of life	Strengths: - Paper co-written by participant, therefore in-depth qualitative data is provided. Weaknesses: - No discussion of potential impact of

						experiences, and practicing more confident ways of relating to the voice in sessions.	researcher biases and assumptions. - Ethnicity of participant not reported.
Heriot-Maitland and Levey (2021)	A case report of compassion-focused therapy for distressing voice-hearing experiences.	To describe the use of Compassion Focused Therapy with a woman who hears voices.	A woman who reported hearing voices for 35 years.	Clinical case report.	Description of intervention and outcomes reported by client and practitioner.	Through therapy the client developed a compassionate self-identity which was used to engage with therapeutic tasks including communicating with voices, engaging with trauma related distress and resolving emotional conflicts. The client reports developing the ability to show compassion towards herself and voices, facilitated by an enriched understanding of voices, leading to a reduction in distress.	Strengths: - Paper co-written by participant, therefore in-depth qualitative data is provided. Weaknesses: - No discussion of why this particular case was chosen to illustrate the intervention. - Does not mention ethical approval. - No discussion of potential impact of researcher biases and assumptions. - Ethnicity not reported.
Leff et al., (2014)	Avatar therapy for persecutory auditory hallucinations: What is it and how does it work?	To describe Avatar Therapy and discuss possible mechanisms of change, drawing on case reports from participants of a RCT, the full results of which are published in a separate paper.	Sixteen patients experiencing persecutory auditory hallucinations who had participated in an RCT evaluating the efficacy of Avatar Therapy.	Case Report	Description of intervention and outcomes reported by author.	The following possible explanations for the effectiveness of Avatar Therapy were identified: ‘face validity of the patient’s experience’; ‘the effect of establishing a dialogue with the avatar’; ‘patients’ relationship with the avatar’; ‘the avatar modifies its character over time’; ‘helping patients to overcome fear of their persecutors’; ‘the	Strengths: - Quotes from therapy sessions provided. Weaknesses: - Lack of direct data from participants (e.g. no completion of post-treatment interviews). - No discussion of why this particular case was chosen to illustrate the intervention. - Does not mention ethical approval.

						experience of gaining control over the avatar'; 'making the patient aware of the link between their low self-esteem and the critical statements of the voices'.	- No discussion of potential impact of researcher biases and assumptions. - Ethnicity not reported.
Paulik et al., (2013)	Cognitive Behavioural Relating Therapy (CBRT) for Voice Hearers: A Case Study	Presentation of a novel intervention named Cognitive Behavioural Relating Therapy, which combines elements of Cognitive Therapy for Command Hallucinations and Relating Therapy.	A woman in her late 30s living in Australia who started hearing voices and was diagnosed with schizophrenia aged 26. The participant was taking a monthly depot injection of zuclopenthixol decanoate (250mg).	Case study.	Description of intervention, outcomes, and experience of therapy described by authors. Inclusion of verbatim quotes from therapy sessions. Reporting of outcome measures: - Psychotic Symptom Rating Scale-Auditory Hallucinations (PSYRATS-AH; Steel et al. 2007). - Voice Power Differential (VPD) Scale and Social Power Differential (SPD) Scale (Birchwood et al., 2000). - Depression Anxiety and Stress Scale-21 (DASS; Lovibond & Lovibond, 1995). - Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965).	Participant began to engage with voices and started being more assertive with voices and others. Post-treatment reduction in voice-related distress, depression, anxiety and stress, and improvement in self-esteem. No improvement in perceived power of voices, however this was inconsistent with participant's reports of improvements in assertiveness towards voices.	Strengths: - Paper reports outcome measures which corroborates author description of outcomes. Weaknesses: - Lack of direct qualitative data from the participant to support findings. - No discussion of why this particular case was chosen to illustrate the intervention. - Does not mention ethical approval. - Ethnicity not reported.

Valmaggia et al., (2007)	Attention training with auditory hallucinations: A case study.	Illustrating the use of Attention Training to treat auditory hallucinations in an outpatient setting.	A 25 year old man living in The Netherlands who reported first experiencing psychotic symptoms at the age of 21 following use of illicit substances.	Case study.	Description of intervention and outcomes qualitatively reported by therapists. Quotes and transcripts from sessions. Reporting of outcome measures: PSYRATS-AH (Steel et al. 2007).	Eight sessions of attention training resulted in change in perceived control of voices and a reduction in intensity and frequency of voices.	Strengths: - Extensive quotes from therapy sessions are provided to illustrate descriptions. - Outcomes reported using reliable and validated measures. Weaknesses: - Qualitative outcomes described by authors rather than provided directly from the participant. - No discussion of why this particular case was chosen to illustrate the intervention. - No mention of ethical approval. - Ethnicity not reported.

Quality Review of the Papers

Qualitative studies were critiqued using the Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research (displayed in Appendices B and C). This included Bogen-Johnsten et al. (2019) and Hornstein et al. (2021) which employed qualitative mixed methods designs. The other three mixed methods studies were appraised using the Mixed Methods Appraisal Tool (MMAT): Mixed Methods Checklist (Hong et al.2018; Appendices D and E), and case reports were appraised using the MMMAT: Qualitative Studies Checklists (Hong et al. 2018; Appendices F and G), which is designed to be used with a range of qualitative research methods including case studies.

Research Question and Design

Research aims are clearly stated and research design was appropriate in all studies. Barrowcliff (2008) did not explain the rationale for research design, however the use of mixed methods was appropriate for the research question.

Recruitment and Participants

None of the NCRs, with the exception of Dellazizzo et al. (2018), explain why a particular case or cases were chosen to illustrate the intervention outlined in the paper, for example there is no discussion of why a particular client was chosen for the report over others. This is clearer in Dellazizzo et al. (2018) as the VH engaging in therapy was a peer research assistant who had co-written the paper; the first of his kind in the service.

Hayward et al. (2018), Hayward and Fuller (2010), Hazell et al. (2020), Leff et al. (2014) and Schnackenberg et al. (2018) are follow up studies and papers from RCTs, and Hornstein et al. (2021) presents further analysis of data presented in another paper. For these papers participants are the same as those in the original study, which is appropriate for study aims, however the recruitment strategies of the original studies are not adequately explained. Three other follow up studies, (Moore et al., 2020; Steel et al., 2020; Valmaggia et al., 2007) give adequate details about the recruitment strategies for the original studies.

In five of the papers, recruitment strategy was not appropriate for the aims of the study. Bogen-Johnston et al. (2019), Milligan et al. (2012) and Rosen et al. (2015) purport to be exploring the experiences of VHs in general, however Bogen-Johnston et al. (2019) and Milligan et al. (2012) only recruited from Early Intervention in Psychosis Services and all participants in Rosen et al. (2015) were receiving support from mental health services, meaning some VH perspectives may not have been included (e.g. non treatment-seeking VHs). Similarly, Mourgues et al. (2020) aims to explore experiences of treatment and non-treatment seeking VHs, however participants were recruited from relatively narrow groups (members of HVGs and psychic medium groups respectively) therefore some perspectives may be missing (e.g. VHs receiving treatment other than attending a HVG and VHs with religious understandings of voices). Clements et al. (2019), which aimed to explore how VHs who have engaged in HVGs in Australia understand their VHEs, only recruited from one HVG. HVGs are non-prescriptive meaning there will be a range of experiences across groups (Hornstein et al., 2020) therefore only recruiting from one HVG risks missing out on a range of perspectives. The remaining papers provide adequate information about recruitment, and recruitment strategy was appropriate for the aims of the research.

Ethnicity of participants was not reported in 15 papers (see Tables 3, 4 and 5), all participants were white in Hayward and Fuller (2010) and Hazell et al. (2020) and participants of colour constituted less than 10% of participants in de Jager et al. (2016) and Goodliffe et al. (2010). Seven papers reported a greater diversity of participants (see Tables 3, 4 and 5) however white participants still made up the majority, with the exception of

Rosen et al. (2015) which is the only paper that reported a greater number of participants of colour in comparison to Caucasian participants.

Ethical Issues

Ethical issues are addressed to varying degrees (see Table 6). Eight papers do not mention gaining ethical approval from an appropriate body, meaning it is not clear whether authors were supported to consider and address ethical issues throughout all stages of the research, and whether the ethics of the design came under appropriate scrutiny (British Psychological Society, 2021).

Informed consent is mentioned by 16 papers and confidentiality by five. Five papers show they have given consideration to the wellbeing of participants, including the potential for distress and the comfort of participants during the interview. Dos Santos and Beavan (2015) and Hornstein et al. (2020) highlight measures taken to ensure potential participants did not feel pressured to take part in the study, and Moore et al. (2020) mentions that all participants received a voucher as a recognition for their time and contribution.

Table 6

Consideration of Ethical Issues Demonstrated by Each Paper

Design	Paper	Mention of ethical approval	Mention of informed consent	Mention of confidentiality	Demonstration that wellbeing of participants has been considered
Qualitative	Bogen-Johnston et al. (2019)	✓	✓	✗	✗
	Clements et al. (2019)	✓	✓	✗	✓
	de Jager et al. (2016)	✓	✓	✗	✓
	Dos Santos and Beavan (2015)	✓	✓	✓	✗
	Goodliffe et al. (2010)	✗	✗	✗	✗
	Hayward et al. (2018)	✓	✗	✗	✗
	Hayward and Fuller (2010)	✗	✗	✗	✗
	Hornstein et al. (2021)	✓	✗	✗	✗
	Hornstein et al. (2020)	✓	✓	✓	✗
	Milligan et al. (2012)	✓	✓	✓	✓
	Moore et al. (2020)	✓	✓	✗	✗
	Ng et al. (2012)	✓	✓	✗	✓
	Payne et al. (2017)	✓	✗	✗	✗
	Racz et al. (2017)	✓	✗	✗	✗
	Ruddle (2017)	✓	✓	✓	✗
	Schnackenberg et al. (2018)	✓	✓	✗	✓
	Steel et al. (2020)	✓	✗	✗	✗
Mixed Methods	11) Hazell et al. (2020)	✓	✗	✗	✗
	18) Mourgues et al. (2020)	✓	✓	✗	✗
	23) Rosen et al. (2015)	✓	✓	✗	✗
Narrative Case Report	Barrowcliff (2008)	✗	✗	✗	✗
	Chadwick and Birchwood (1994)	✗	✗	✗	✗
	Dellazizzo et al. (2018)	✓	✓	✗	✗
	Heriot-Maitland and Levey (2021)	✗	✗	✗	✗
	Leff et al. (2014)	✗	✓	✗	✗
	Paulik et al. (2013)	✗	✓	✓	✗
	Valmaggia et al. (2007)	✗	✗	✗	✗

Data Collection and Analysis

Qualitative studies. The method of data collection and form of data is clear for all qualitative studies. All interviews were recorded and transcribed and all studies give adequate descriptions of how data were analysed or described. The majority of papers provide sufficient data to illustrate results with the exceptions of Hornstein et al. (2021), Hornstein et al. (2020), and Steel et al. (2020), meaning the fit between data and results is harder to gauge for these studies.

Mixed Methods Studies. All mixed methods studies provide adequate descriptions of form of data and analysis, with appropriate forms of quantitative and qualitative analysis used. Mourgues et al. (2020) and Rosen et al. (2015) provide sufficient data to illustrate results, and Hazell et al. (2020) provides sufficient qualitative but not quantitative data. All papers appear to integrate data from both components of the study to answer the research question well, however this is harder to determine for Hazell et al. (2020) due to the lack of quantitative data provided.

Case Reports. Chadwick and Birchwood (1994) and Leff et al. (2014) mainly rely on author descriptions of formulation, intervention and outcomes. Each paper provides some quotes from therapy sessions, however these are limited therefore it is not possible to examine the validity of author descriptions.

Barrowcliff (2008), Paulik et al. (2013) and Valmaggia et al. (2007) are also mainly comprised of author descriptions with some quotes from therapy sessions (extensive quotes are provided in Valmaggia et al. (2007), however all three provide data from outcome measures as well. Outcome measures used are reliable, validated, appropriate, and results fit with author descriptions.

Dellazizzo et al. (2018) and Heriot-Maitland and Levey (2021) are co-written by intervention participants, meaning the description of formulation, intervention and outcomes provided by the practitioners are expounded upon and corroborated by in-depth descriptions written by participants.

Quality and Assurance

Quality and assurance issues are addressed to varying degrees (see Table 7). Sixteen papers do not include any discussion of the potential for researcher beliefs, assumptions and positioning to bias research, nor mention any steps taken to mitigate this. There is therefore a greater risk that these studies may have been impacted by researcher bias, limiting the accuracy and credibility of the research (Cutcliffe, 2003). Of the papers that did discuss this issue, two enhanced reflexivity through reflexive interviews and discussions (Milligan et al., 2012; Moore et al., 2020), two through the use of a reflexive diary (Clements et al., 2019; Milligan et al., 2012), and two attempted to limit the impact of researcher bias through the inclusion of multiple perspectives by consulting with experts by experience and/ or profession during analysis (Bogen-Johnston et al., 2019; Mourgues et al., 2020).

In order to enhance the credibility of findings, thirteen studies used more than one analysist, three used respondent validation, and three consulted with independent researchers or panels during analysis. Schnackenberg (2018) did not use respondent validation; however participants were given a summary of the discussion at the end of the each interview with an opportunity to give corrections.

All case reports used triangulation to varying degrees. As discussed above, Dellazizzo et al. (2018) and Heriot-Maitland and Levey (2021) were co-written by participants, meaning detailed accounts written by the participants are included which corroborate the accounts of practitioners. Both participants also had the opportunity to review the papers before publication, which suggests they had opportunities to correct any details that had been misreported. Barrowcliff (2008), Paulik et al. (2013) and Valmaggia et al. (2007) include outcome measures which provide triangulation for some author descriptions. Barrowcliff et al. (2008) also highlights anecdotal information provided by the participant’s parents which corroborates author descriptions and outcome measure scores, however direct quotes are not provided. Chadwick and Birchwood (1994) and Leff et al. (2014) provide limited quotes from participants, meaning there are minimal opportunities for triangulation. It should be noted that none of the case reports discuss the potential impact of researcher bias, which makes the lack of direct data provided in Chadwick and Birchwood (1994) and Leff et al. (2014) more concerning, particularly as there is bias inherent within the aims of the papers (to illustrate the use of a particular therapeutic model with VHs).

Table 7

Consideration of Quality and Assurance Issues Demonstrated by Each Paper

Design	Paper	Demonstrates that potential impact of researcher bias has been considered	More than one analysis	Respondent validation utilised	Use of independent consultants during analysis
Qualitative	Bogen-Johnston et al. (2019)	✓	✓	✓	×
	Clements et al. (2019)	✓	✓	×	×
	de Jager et al. (2016)	✓	×	✓	✓
	Dos Santos and Beavan (2015)	✓	×	×	✓
	Goodliffe et al. (2010)	✓	×	×	×
	Hayward et al. (2018)	×	✓	×	×
	Hayward and Fuller (2010)	×	×	×	✓
	Hornstein et al. (2021)	×	✓	×	×
	Hornstein et al. (2020)	×	✓	×	×
	Milligan et al. (2012)	✓	✓	×	×
	Moore et al. (2020)	✓	✓	×	×
	Ng et al. (2012)	×	×	×	×
	Payne et al. (2017)	×	✓	✓	×
	Racz et al. (2017)	×	✓	×	×
	Ruddle (2017)	✓	✓	×	×
	Schnackenberg et al. (2018)	✓	×	×	×
	Steel et al. (2020)	×	×	×	×
Mixed Methods	11) Hazell et al. (2020)	×	✓	×	×
	18) Mourgues et al. (2020)	✓	✓	×	×
	23) Rosen et al. (2015)	×	✓	×	×
Narrative Case Report	Barrowcliff (2008)	×	×	×	×
	Chadwick and Birchwood (1994)	×	×	×	×
	Dellazizzo et al. (2018)	×	×	×	×
	Heriot-Maitland and Levey (2021)	×	×	×	×
	Leff et al. (2014)	×	×	×	×
	Paulik et al. (2013)	×	×	×	×
	Valmaggia et al. (2007)	✓	×	×	×

Synthesis

Thematic synthesis elicited five interconnected but not sequentially related superordinate themes- ‘coming to see voices as less threatening; ‘developing new ways of responding to voices; ‘becoming more accepting and less fearful of voices’; ‘beyond voices’ and ‘facilitators’- with respective subthemes. Superordinate themes, subthemes, codes and example quotes are displayed in Appendix H.

Coming to See Voices as Less Threatening

Papers containing this this theme are displayed in Table 8.

Origin of Voices. Participants across twelve papers (Q= eight, MM= one, NCR= three) described a change in beliefs about the origin of voices, either moving from a belief that voices are externally generated, (e.g. the voices of a deity or demons) to a belief that voices are internally generated (e.g. voices are an expression of painful emotions that are not being acknowledged or expressed by the self), or shifting from a purely medical understanding of voices (e.g. voices are a symptom of an illness) to a bio-psycho-social understanding (e.g. voices stem from experiences of trauma). This shift was brought about by a number of different processes including learning new perspectives about voice hearing through therapy or attending HVGs; exploring voices, enabling participants to make connections between their voices and life experiences; normalising the content of VHE, enabling participants to accept that voices could be reflective of internal states; and examining evidence around the belief in voices as external entities.

Developing new understandings about the origin of voices facilitated different responses and attitudes from participants towards voices, such as showing compassion, which in one case reportedly resulted in the voices softening their tone and quieting down (Heriot-Maitland & Levey, 2012); setting boundaries and resisting commands; experiencing a reduction in distress around VHEs; recognising and appreciating the adaptive functions of voices; and feeling more in control and developing a new belief in the ability of the self to effect change within the voice hearing relationship. This change in understanding about the origin of voices could also bring about a reduction in VHEs.

It should be noted that Mourgues et al. (2020) interviewed participants recruited from spiritual and psychic/ medium communities who had been able to navigate positive relationships with voices and who believed their voices were spiritual entities, demonstrating that a shift from external to internal understandings of VHEs is not essential for developing more positive relationships with voices.

Perception of Voices. Participants in seven papers (Q=5, MM=1, NCR=1) outlined how developing a greater understanding of the meaning, purpose and intention of voices enabled them to change their relationship with voices. Participants described a process of tuning in to voices to interpret what they were trying to convey, and through this process beginning to view voices as helpful. Voices could offer support, advice, and encouragement; hold space for difficult emotions; draw participants' attention to areas of concern in their lives; and enable them to develop a deeper understanding of themselves.

Change in Beliefs About Omnipotence of Voices. Twelve papers (Q= five, MM= one, NCR= one) described participants engaging in a process of evaluating evidence, rationalising, testing, and challenging voices which brought about a shift in beliefs about the omnipotence and/ or veracity of voices. This included reflecting on past experiences where voices have said something would happen which didn't come true, carrying out an experiment within a therapy session to test the power of a voice, or learning new effective coping strategies which demonstrated they did have control over VHEs. This process led to a shift in power dynamics between voices and VHs, resulting in VHs being able to assert themselves in relation to their voices, disregard or ignore the voices, or be able to refuse commands. Participants also experienced a reduction in voice-related distress and an improvement in self-worth as they no longer believed negative voice content about themselves. In some instances, voices became less intrusive and voice activity decreased.

Table 8

Papers Containing the Superordinate Theme 'Coming to See Voices as Less Threatening'

Subtheme			Papers
Origin of voices	Change in beliefs about the origin of voices.		**Q:** Bogen-Johnston et al. (2019); Clements et al. (2010); Hornstein et al. (2021); Milligan et al. (2012); Ng et al. (2012); Payne et al. (2017); Schnackenberg et al. (2018); Steel et al. (2020) **MM:** Rosen et al. (2015) **NCR:** Barrowcliff (2008); Chadwick and Birchwood (1994); Heriot-Maitland and Levey (2021)
	Facilitators of change	Learning new perspectives about voice hearing through attending therapy or HVGs	**Q:** Clements et al. (2019); Hayward and Fuller (2010); Hornstein et al.(2021) **NCR:** Chadwick and Birchwood (1994)
		Exploring voices and making connections between voices and life experiences	**Q:** Schnackenberg et al.(2018) **MM:** Hazell et al. (2020) **NCR:** Heriot-Maitland and Levey (2021)
		Normalising the content of VHEs	**NCR:** Barrowcliff (2008)
		Examining evidence	**NCR:** Chadwick and Birchwood (1994); Rosen et al. (2015)
		Engaging with a relational conceptualisation of VHEs	**Q:** Hayward and Fuller (2010)
	Impact of new understanding of origin of voices	Participants having a more compassionate response to voices	**Q:** Hornstein et al. (2021) **NCR:** Heriot-Maitland and Levey (2021)
		Participants setting boundaries with voices	**Q:** Hornstein et al. (2021)
		Participants resisting voice commands	**MM:** Rosen et al. (2015) **NCR:** Chadwick and Birchwood (1994)
		Reduction in distress	**Q:** Hayward and Fuller (2010); Schnackenberg et al. (2018); Steel et al. (2020) **NCR:** Barrowcliff (2008); Chadwick and Birchwood (1994); Heriot-Maitland and Levey (2021)

		Gaining an appreciation for the adaptive functions of voices	**Q:** Hornstein et al. (2021); Steel et al. (2020) **NCR:** Heriot-Maitland and Levey (2021)
		Feeling more in control	**Q:** Bogen-Johnston et al. (2019); Hayward & Fuller (2010); Ng et al. (2012); Schnackenberg et al. (2018); Steel et al. (2020) **MM:** Rosen et al. (2015) **NCR:** Chadwick and Birchwood (1994); Heriot-Maitland and Levey (2021)
		Reduction in frequency of VHEs	**Q:** Hornstein et al. (2021); Schnackenberg et al. (2018)
Perception of voices	Change in relationship through developing a greater understanding of the meaning, purpose and intention of voices		**Q:** Clements et al. (2019); de Jager et al. (2016); Hornstein et al. (2021); Racz et al. (2017); Steel et al. (2020) **MM:** Mourgues et al. (2020) **NCR:** Heriot-Maitland and Levey (2021)
	Recognising voices as helpful through listening and interpreting what they say		**Q:** Clements et al. (2019); de Jager et al. (2016); Hornstein et al. (2021) **MM:** Mourgues et al. (2020) **NCR:** Heriot-Maitland and Levey (2021)
	Helpful qualities of voices	Offering support, advice, and encouragement	**Q:** Clements et al. (2019); Racz et al. (2017) **NCR:** Heriot-Maitland and Levey (2021)
		Holding space for difficult emotions	**Q:** Clements et al. (2019); Milligan, McCarthy-Jones (2012); Steel et al. (2020) **NCR:** Heriot-Maitland and Levey (2021)
		Drawing participants' attention to areas of concern	**Q:** de Jager et al. (2016) **MM:** Mourgues et al. (2020)
		Enabling participants to develop better understandings of themselves	**Q:** Clements et al. (2019); Hornstein et al. 2021; Racz et al. (2017) **MM:** Mourgues et al. (2020) **NCR:** Heriot-Maitland and Levey (2021)
Change in beliefs about omnipotence of voices	Evaluating evidence, rationalising, testing and challenging voices to bring about a change in beliefs about the omnipotence of voices.		**Q:** de Jager et al. (2016); Goodliffe et al. (2010); Hayward and Fuller (2010); Milligan et al. (2012); Moore et al. (2020) **MM:** Hazell et al. (2020); Rosen et al. (2015) **NCR:** Barrowcliff (2008); Chadwick and Birchwood (1994); Dellazizzo et al. (2018); Paulik et al. (2013); Valmaggia et al. (2007)
	Ways of examining evidence	Reflecting on past experiences where voices have said something would happen which did not come true	**Q:** Goodliffe et al. (2010); Milligan et al. (2012); **MM:** Rosen et al. (2015)
		Carrying out an experiment during therapy	**NCR:** Barrowcliff (2008)

	Learning new effective coping strategies	**NCR:** Valmaggia et al. (2007)
Impact of change in belief about omnipotence of voices	Enabling participants to assert themselves in relation to voices	**Q:** Bogen-Johnston et al. (2019); Goodliffe et al. (2010); Hayward and Fuller (2010)
	Enabling participants to disregard or ignore voices	**Q:** Moore, Williams et al. (2020) **MM:** Hazell et al. (2020) **NCR:** Chadwick and Birchwood (1994)
	Enabling participants to resist commands	**MM:** Rosen et al. (2015) **NCR:** Dellazizzo et al. (2018);
	Reduction in voice-related distress	**NCR:** Barrowcliff (2008); Chadwick and Birchwood (1994); Dellazizzo et al. (2018)
	Improvement in self-worth	**NCR:** Dellazizzo et al. (2018)
	Voices becoming less intrusive	**NCR:** Barrowcliff (2008); Chadwick and Birchwood (1994)
	Reduction in voice activity	**NCR:** Chadwick and Birchwood (1994); Dellazizzo et al. (2018)

Developing New Ways of Responding to Voices

Papers containing this this theme are displayed in Table 9.

Attending to Voices. At the most basic level, for VHs to change the way they respond to voices they have to first acknowledge and listen to them. Participants in eleven papers (Q= seven, MM= two, NCR= two) described a shift from ignoring voices to attending to and listening to them, which enabled participants to learn more about the intention of voices; learn more about themselves; feel more in control; experience less anxiety around VHEs; start to find contact with voices comforting; and start the process of asserting themselves, setting boundaries and challenging voices. The act of simply listening to voices and giving them opportunities to be heard was found to be key in several instances, for example one participant in Rosen et al. (2015, p. 6) explained: “I’ve learnt they didn’t really want anything. They just wanted to be heard”.

Quality of Interaction. Papers suggest that the quality of engagement with voices is key, with VHs learning to interact with voices in more positive and helpful ways.

Participants in seven papers described becoming more assertive with their voices (Q= five, MM= one, NCR= one), with some participants developing this more assertive stance independently, some through contact with peer support groups, and others through engagement in therapy. Processes that helped participants develop more assertive communication styles included exploring and understanding patterns of relating within the context of life experiences, learning from positive experiences of relating to others, learning assertive statements, learning to shift tone of voice used with voices from gentle to assertive, and practicing being assertive towards voices in therapy. Becoming more assertive with voices enabled participants to challenge voices, negotiate and advocate for their own needs, feel more in control, and shift the power balance between VH and voices. It also brought about a change in voices, with voices becoming more positive and quietening down. However, it should be noted that one participant in Hayward et al. (2018) experienced an increase in the intensity of voices as they took a more assertive stance, which they understood as the voices' response to feeling threatened in the session. It is not clear how this progressed beyond therapy.

Some participants also described the importance of being respectful towards voices (Q= two), which could lead to mutually respectful relationships between VH and voices. One participant (Hayward et al., 2018) described how giving the voice an identity enabled her to maintain a respectful rather than aggressive manner when responding assertively, with the voice becoming more positive in response.

Three papers (Q= two, NCR= one) describe VHs developing more compassionate responses, facilitated by developing an understanding of voices within the context of life experiences and starting to view voices as parts or expressions of the self. The participant-author of Heriot-Maitland and Levy (2021), who had been engaging in CFTp, described how responding to voices in a soothing and compassionate way led to the voices becoming kinder, gentler, and in some instances dispersing.

Negotiating and Setting Boundaries. Participants across nine papers described a process of starting to negotiate and set boundaries with voices (Q= one, MM= one, NCR= one). This included scheduling times to engage with voices, with voices quietening down outside of these times in return; setting boundaries about the content of voices; and participants integrating critiques and suggestions made by voices into their lives, for example one participant (de Jager et al., 2016) started donating to charity in response to criticism from one of his voices that he was selfish with money. In some instances this process enabled participants to develop mutually beneficial relationships with voices, with voices being given opportunities to be heard and VHs learning, receiving advice, receiving complements, and gaining companionship from their voices.

Table 9

Papers Containing the Superordinate Theme 'Developing New Ways of Responding to Voices'

Subtheme			Papers
Attending to voices	Shift from ignoring voices to attending to and listening to them		**Q:** Clements et al. (2019); de Jager et al. (2016); Hornstein et al. (2021); Hornstein et al. (2020); Ng et al. (2012); Racz et al. (2017); Steel et al. (2020) **MM:** Mourgues et al. (2020); Rosen et al. (2015) **NCR:** Heriot-Maitland and Levey (2021); Paulik, Hayward and Birchwood (2013)
	Impact of listening to voices	Learning about the intention of voices	**Q:** Racz et al. (2017) **MM:** Rosen et al. (2015)
		Participants learning more about themselves	**Q:** de Jager et al. (2016); **NCR:** Heriot-Maitland and Levey (2021)
		Feeling more in control	**MM:** Rosen et al. (2015)
		Experiencing less anxiety about VHEs	**Q:** Racz et al. (2017)
		Participants starting to find contact with voices comforting	**NCR:** Paulik et al. (2013)
		Participants starting to assert themselves, set boundaries and challenge voices	**Q:** Clements et al. (2019); de Jager et al. (2016); Racz et al. (2017)
	Highlighting the importance of giving voices an opportunity to be heard		**Q:** Clements et al.(2019); Hornstein et al. (2021); Hornstein et al. (2020) **MM:** Rosen et al. (2015)
Engaging with voices	Engaging and communicating with voices enabling VHs to change their relationship with voices		**Q:** Bogen-Johnston et al. (2019); Clements et al. (2019); de Jager et al. (2016); Hayward et al. (2018); Hayward and Fuller (2010); Steel et al. (2020) **MM:** Mourgues et al. (2020) **NCR:** Barrowcliff (2008); Dellazizzo et al. (2018); Heriot-Maitland and Levey (2021); Paulik et al. (2013)
	Impact of communicating with voices	Enables participants to assert themselves and challenge voices	**Q:** Bogen-Johnston et al. (2019) **NCR:** Barrowcliff (2008); Dellazizzo et al. (2018)
		Developing a better understanding of voices	**NCR:** Heriot-Maitland and Levey (2021)

		Enabling participants to negotiate and set boundaries	**Q:** Hayward et al. (2018); Hayward and Fuller (2010)
		Participants feeling more in control	**Q:** Steel et al. (2020)
		Experiencing a reduction in VHEs	**Q:** Steel et al. (2020)
Quality of interaction	Participants becoming more assertive with voices		**Q:** Hayward et al. (2018); Hayward and Fuller (2010); Hornstein et al. (2021); Hornstein et al. (2020); Ng et al. (2012) **MM:** Hazell et al. (2020) **NCR:** Leff et al. (2014)
	How participants developed assertiveness skills	Independently	**Q:** Ng et al. (2012)
		Through contact with peer support groups	**Q:** Hornstein et al. (2021); Hornstein et al. (2020)
		Through engagement with therapy	**Q:** Hayward et al. (2018); Hayward and Fuller (2010) **MM:** Hazell et al. (2020) **NCR:** Leff et al. (2014)
	Processes that enabled participants to become more assertive with voices	Exploring and understanding patterns of relating within the context of life experiences	**Q:** Hayward and Fuller (2010)
		Learning assertive statements	**Q:** Hayward et al. (2018); Hayward and Fuller (2010)
		Changing tone of voice	**Q:** Hayward et al. (2018)
		Practicing in therapy	**Q:** Hayward et al. (2018) **MM:** Hazell et al. (2020) **NCR:** Leff et al. (2014)
	Impact of participants becoming more assertive with voices	Challenging voices	**Q:** Hayward et al. (2018)
		Participants negotiating and advocating for their own needs	**Q:** Hayward et al. (2018) **NCR:** Leff et al. (2014)
		Feeling more in control	**Q:** Hayward and Fuller (2010)
		Shifting the power balance between VH and voices	**Q:** Hayward and Fuller (2010) **MM:** Hazell et al. (2020)
		Voices becoming more positive	**Q:** Hayward et al. (2018)
		Voices quietening down	**Q:** Hayward et al. (2018); Hayward and Fuller (2010)
	VH being respectful towards voices		**Q:** de Jager et al. (2016); Hayward et al. (2018)
	VH being respectful towards voices leading		**Q:** de Jager et al. (2016)

	to mutually respectful relationships		
	Developing a compassionate stance towards voices		**Q:** Hayward and Fuller (2010); Hornstein et al. (2021) **NCR:** Heriot-Maitland and Levey (2021)
	Ways of developing compassion towards voices	Understanding voices within the context of life experiences	**NCR:** Heriot-Maitland and Levey (2021)
		Viewing voices as parts or expressions of the self	**Q:** Hayward and Fuller (2010) **NCR:** Heriot-Maitland and Levey (2021)
Negotiating and setting boundaries	Changing relationship with voices through negotiating and setting boundaries		**Q:** Clements et al. (2019); de Jager et al. (2016); Hayward et al. (2018); Hayward and Fuller (2010); Hornstein et al. (2021); Hornstein et al. (2020); Ng et al. (2012) **MM:** Mourgues et al. (2020) **NCR:** Leff et al. (2014)
	Ways of negotiating	Scheduling times to engage with voices	**Q:** Clements et al. (2019); de Jager et al. (2016); **NCR:** Leff et al. (2014)
		Setting boundaries about the content of voices	**NCR:** Leff et al. (2014)
		VH integrating critiques and suggestions made by voices into their lives	**Q:** de Jager et al. (2016)

Becoming More Accepting and Less Fearful of Voices

Papers described participants developing different attitudes and emotions towards their voices and VHEs (Table 10).

Developing Acceptance. Participants across eight qualitative papers described moving from a position of wanting to eradicate their voices to an acceptance that the voices were a part of their life and a recognition that it is possible to live life with voices. This was facilitated by change in understanding of the origin and meaning of voices, and through the influence of others including professionals and other VHs. By accepting voices, participants were able to start learning how to manage voices through engaging in therapy and learning new ways of relating. However, conversely one participant (Steel et al. 2020) highlighted that knowing it is possible to get rid of voices helped reduce voice-related distress.

Change in Emotional Response. Participants in ten papers described experiencing a reduction in fear, anxiety and distress around voices (Q= four, MM= three, NCR= three). This was the result of attending peer support groups or therapy where voices were normalised, which lead to VHs accepting voices and experiencing a reduction in fear; developing a greater understanding of the origin and intention of voices; engaging with voices; challenging voices or feeling more powerful in relation to voices; and learning it is possible for voices to stop. For some participants voice content did not change but the appraisal of voices did, with VHs not becoming so emotionally affected by what voices were saying. Reduction in fear enabled VHs to start standing up to their voices, feel more powerful in relation to voices and in one case led to a significant reduction in VHEs.

Table 10

Papers Containing the Superordinate Theme 'Becoming More Accepting and Less Fearful of Voices'

Subtheme			Papers
Developing acceptance	Change in relationship with voices through an acceptance of voices		**Q:** Bogen-Johnston et al. (2019); Clements et al. (2019); Dos Santos and Beavan (2015); Goodliffe et al. (2010); Hayward and Fuller (2010); Hornstein et al. (2021); Ng et al. (2012); Ruddle (2017)
	Facilitators of developing acceptance towards voices	Change in understanding of the origin and meaning of voices	**Q:** Bogen-Johnston et al. (2019); Clements et al. (2019); Goodliffe et al. (2010); Milligan et al. (2012)
		Influence of professionals	**Q:** Ng et al. (2012)
		Influence of other VHs	**Q:** Ruddle (2017)
	Impact of accepting voices	Learning to manage voices through engaging in therapy	**Q:** Bogen-Johnston et al. (2019); Ng et al. (2012)

		Learning to manage voices through learning new ways of relating to voices	**Q:** Clements et al. (2019); Hayward and Fuller (2010); Ng et al. (2012)
Change in emotional response	Reduction in fear, anxiety and distress around VHEs		**Q:** Hayward and Fuller (2010); Hornstein et al. (2021); Moore et al. (2020); Racz et al. (2017) **MM:** Hazell et al. (2020); Schnackenberg et al. (2018); Steel et al. (2020) **NCR:** Dellazizzo et al. (2018); Heriot-Maitland and Le (2021); Paulik et al. (2013)
	Facilitators of reduction in fear, anxiety and distress	Attending peer support groups or therapy where voices were normalised	**Q:** Hayward and Fuller (2010); Hornstein et al. (2021); Schnackenberg et al. (2018); Steel et al. (2020)
		Developing a new understanding of the origin and intention of voices	**Q:** Hayward and Fuller (2010); Steel et al. (2020) **NCR:** Heriot-Maitland and Levey (2021)
		Engaging with voices	**NCR:** Heriot-Maitland and Levey (2021); Paulik et al. (2013)
		Challenging or feeling more powerful in relation to voices	**Q:** Hayward and Fuller (2010); Racz et al. (2017) **NCR:** Dellazizzo et al. (2018)
		Learning that VHEs can stop	**Q:** Steel et al. (2020)
	Change in appraisal of voices		**MM:** Hazell et al. (2020); Moore et al. (2020); Schnackenberg et al. (2018)
	Impact of reduction in fear of voices	VHs able to stand up to voices	**NCR:** Dellazizzo et al. (2018)
		VH feeling more powerful in relation to voices	**Q:** Hayward and Fuller (2010)
		Reduction in VHEs	**NCR:** Dellazizzo et al. (2018)

Beyond Voices

For some participants, making changes not directly related to VHEs brought about a shift in relationship with voices (Table 11).

Participants in de Jager et al. (2016) described how negative voices often preyed on their anxieties and vulnerabilities, which meant learning how to manage anxiety made their voices less believable or distressing when they tried to amplify VH concerns.

Improvements in self-image (such as self-acceptance, self-forgiveness, and improvements in self-esteem) helped bring about a change in relationship with voices for participants in three papers (Q= one, NCR= two), in some cases reducing VHEs or enabling participants to disregard negative voice content. Development of self-esteem occurred through examining evidence, such as asking friends and family for a list of positive attributes, and through experiences of relating to others in a HVG. Leff et al. (2014) described how improvements in self-esteem were brought about through a planned shift in avatar response from negative to positive and supportive, which in turn brought about a reduction in negative voice content.

Table 11

Papers Containing the Superordinate Theme 'Beyond Voices'

		Papers
Learning to manage anxiety.		**Q:** de Jager et al. (2016)
Improvements in self-image		**Q:** Hornstein et al. (2020) **NCR:** Dellazizzo et al. (2018); Leff et al. (2014)
Impact of improvements in self-image	Reducing negative voice content	**NCR:** Leff et al. (2014)
	Enabling VH to disregard negative voice content	**NCR:** Dellazizzo et al. (2018)
Facilitators of improvements in self-esteem	Examining evidence	**NCR:** Dellazizzo et al. (2018); Leff et al. (2014)
	Through having the experience of relating to others in a HVG	**Q:** Hornstein et al. (2020)
	Through avatar therapy (planned shift in avatar response to participant from negative to positive and supportive	**NCR:** Leff et al. (2014)

Facilitators

Papers containing this this theme are displayed in Table 12.

Engagement in Therapy. Fifteen papers (Q= seven, MM= one, NCR= seven) described participants engaging in therapy in which they were able to explore their VHEs and learn ways of managing voices, including changing the way they responded to voices and testing and challenging beliefs about voices. Six papers (Q= three, NCR= three) described bringing the voice into the therapy room through role plays, empty chair exercises, the use of avatars, or encouraging the participant to listen and engage with voices during sessions. This helped VHs start challenging voices, practice responding to voices in different ways, and develop greater understandings of their voices. For some participants this process reduced the fear of voices, shifted power dynamics between voices and VH, and enabled them to start responding more assertively.

Influence of Others. Papers described ways in which other people in participants' lives supported them to develop more positive relationships with voices.

Seven papers (Q=6, MM=1) described the impact of attending groups, including HVGs and group cognitive therapy. Group attendance helped to normalise and introduce new perspectives about voice hearing, leading to an acceptance of voice hearing and reduced fear of VHEs. For one participant (Dos Santos & Beavan, 2015) this was complemented by reading books and learning about theory around VHEs. Participants were also able to learn how to manage their relationships with their voices from other members of a group, or learn about new ways of relating to others and themselves through participating in groups. Participants in Goodliffe et al. (2010) described a process where the opinions of group members started to take precedence over the voices, shifting power and authority away from voices. Hornstein et al., 2020 also described how, for one participant, attending groups gave their voices an opportunity to be heard, which resulted in them becoming less aggressive and invasive.

Participants were also able to draw on experiences of relating to and interacting with others to change their interactions with voices, reflecting on positive relationships they already had with others or experience new ways of relating to others in group settings. This could then be transferred to their interactions with their voices.

During Avatar therapy VHs are asked to provide a list of qualities provided by friends. The participant-author of Dellazio et al., (2018) described how this helped him to challenge negative voice content, reducing fear of the voice, changing beliefs about the omnipotence of the voice, and enabling him to respond more assertively.

Table 12

Papers Containing the Superordinate Theme ‘Facilitators’

Subtheme			Papers
Engagement in therapy	Engaging in therapy facilitating change in relationship		**Q:** Goodliffe et al. (2010); Hayward et al. (2018); Hayward and Fuller (2010); Moore et al. (2020); Ruddle (2017); Schnackenberg et al. (2018); Steel et al. (2020) **MM:** Hazell et al. (2020) **NCR:** Barrowcliff (2008); Chadwick and Birchwood (1994); Dellazizzo et al. (2018); Heriot-Maitland and Levey (2021); Leff et al. (2014); Paulik et al. (2013); Valmaggia et al. (2007)
	Ways of bringing voices into the room	Role plays	**Q:** Hayward et al. (2018); Hayward and Fuller (2010) **NCR:** Heriot-Maitland and Levey (2021); Paulik et al. (2013)
		Empty chair exercises	**Q:** Hayward and Fuller (2010) **NCR:** Paulik et al. (2013)
		Avatars	**NCR:** Dellazizzo et al. (2018); Leff et al. (2014)
		Listening to and engaging with voices during sessions	**Q:** Steel et al. (2020) **NCR:** Barrowcliff (2008); Heriot-Maitland and Levey (2021); Paulik et al. (2013)

	Impact of bringing voices into the room during therapy	Challenging voices	**NCR:** Barrowcliff (2008); Dellazizzo et al. (2018)
		Practicing responding to voices in different ways	**Q:** Hayward et al. (2018); Hayward and Fuller (2010) **NCR:** Dellazizzo et al. (2018); Heriot-Maitland and Levey (2021); Leff et al. (2014)
		Developing understanding of VHEs	**Q:** Hayward et al. (2018) **NCR:** Dellazizzo et al. (2018); Heriot-Maitland and Levey (2021); Steel et al. (2020)
		Reduction in fear of voices	**NCR:** Dellazizzo et al. (2018)
		Shift in power dynamics between voices and VH	**NCR:** Barrowcliff (2008); Dellazizzo et al. (2018); Leff (2014)
		Enabling VH to start responding to voices more assertively	**Q:** Hayward et al. (2018) **NCR:** Dellazizzo et al. (2018); Leff et al.(2014)
Influence of others	Impact of attending groups	Normalising and learning new perspectives about voice hearing leading to an acceptance of voices	**Q:** Clements et al. (2019); de Jager et al. (2016); Hornstein et al. (2021); Hornstein et al. (2020); Ruddle (2017) **MM:** Mourgues et al. (2020)
		Reduction in fear of VHEs	**Q:** Dos Santos and Beavan (2015); Hornstein et al. (2021)
		Learning new strategies to manage voices	**Q:** Clements et al. (2019); Goodliffe et al. (2010); Hornstein et al. (2021); Hornstein et al. (2020) **MM:** Mourgues et al. (2020)
		Learning new ways of relating to oneself and others	**Q:** Hornstein et al. (2020)
		Giving voices and opportunity to be heard	**Q:** Hornstein et al. (2020)
	Drawing on experiences relating to and interacting with others to change interactions with voices	Through reflecting on positive relationships with others	**Q:** de Jager et al. (2016)
		Through experiencing new ways of relating to others in groups	**Q:** Hornstein et al. (2020)
	Challenging negative voice content using a list of positive qualities written by others		**NCR:** Dellazizzo et al. (2018)

Discussion

This review aimed to explore how VHs have been able develop more positive relationships with their voices through a review and thematic synthesis of relevant research. Synthesis elicited five interconnected superordinate themes: ‘coming to see voices as less threatening’; ‘developing new ways of responding to voices; ‘becoming more accepting and less fearful of voices; ‘beyond voices’ and ‘facilitators’. There is no clear order in which one theme influences another, for example some papers suggest a change in beliefs about voices enables VHs to respond to voices in a different way, and other papers suggest a change in response to voices can bring about a change in beliefs. Broadly speaking, two different approaches can be identified from the results, however these were not mutually exclusive:

1. **VHs engaging with voices in order to develop mutual understanding and more positive relating on both sides.** Participants who benefited from this approach were able to develop understandings of their voices within the context of life experiences and/ or develop greater understandings of the intention of voices, thus leading to a change in perception of voices (i.e. voices as holding a protective function) and in some cases the construction of mutually beneficial relationships. This approach is in keeping with dissociative understandings of voice hearing in which voices are understood to be dissociated parts of the self with which it is beneficial to engage (Corstens et al., 2012). This approach was also helpful for participants who held spiritual beliefs about voices (Mourgues et al., 2020) as it enabled them to understand what spirits wanted, and from there be able to work together with the spirits and negotiate boundaries.

2. **VHs examining evidence in order to shift power dynamics (either to a more equitable relationship or to take power away from voices entirely).**
   Participants who benefited from this approach were able to disregard voices, or in some cases found voice activity decreased, and there tended to be less of a focus on understanding and learning from voices. This approach fits with a cognitive understanding of voice hearing in which voices are understood to be a sensory stimulus that VHs hold beliefs about (Beck & Rector, 2003), as opposed to dialogical approaches in which voices are understood to be parts of the self or entities with which VHs have an interpersonal relationship (Middleton, 2021).

These results may be understood with reference to different psychological processes found to be important for reducing distress in different contexts. Firstly, the processes of reframing and normalising VHEs were identified as being helpful, for example reframing VHEs as stemming from trauma (something happening to the individual) as opposed to a biological illness (something being “wrong” with the individual). This is in keeping with previous research (e.g. Roxburch & Roe, 2014) which highlights the process of reframing as being instrumental for reducing VH distress. Secondly, within the dissociative model of voice hearing tuning in, listening to, and communicating with voices can be understood as providing opportunities for working through trauma or attending to dissociated emotions and parts of the self (Middleton, 2021). This fits with the understanding that ‘avoidance’ (e.g. of thoughts, memories, bodily sensations, emotions, aversive stimuli) functions to exacerbate distress, and that ‘approach’, although potentially increasing distress in the short term, can work to alleviate distress in the long term (Fernández-Rodríguez et al., 2018). The importance of approach as opposed to avoidance finds further evidence in the work of Vaughan and Fowler (2004) which suggests VHs who attempt to distance themselves from voices are more likely to have distressing VHEs than those who communicate with their voices.

Implications

This review suggests that developing more helpful relationships between VHs and voices can have a number of beneficial impacts for VHs including having more positive VHEs, improved self-esteem, and greater self-understanding. The process by which paper participants were able to change their relationships with voices varied, however at the most basic level attending to and exploring voices was important. This is in keeping with approaches to voice hearing, such as the HVM approach, which view voices as meaningful and encourage VHs to engage with voices, in contrast to purely bio-medical approaches in which voices are viewed as symptoms of a medical disorder which should be eradicated rather than explored (Corstens et al., 2012).

The current review, existing research, and first-person accounts of VHs demonstrate that the experience of voice hearing is broad (e.g. Johns et al., 2014; Romme et al., 2009) and that different VHs wishing to facilitate a change with their VHEs benefit from different approaches. It is therefore important for VHs to have access to information about different approaches to voice hearing. Furthermore, it would be beneficial for future research to examine who benefits from which approaches, in order to enable services to tailor treatment and support more effectively.

Limitations

The review was able to include a broad range of perspectives and experiences encompassing treatment and non-treatment seeking VHs, VHs with religious and spiritually informed beliefs about voices, and VHs who understood their voices within the context of life experiences. However, no papers explicitly explored the experience of VHs who changed their relationship with voices whilst continuing to understand them as a religious experience (Chadwick & Birchwood, 1994, described the experience of a woman who believed her voice was an Islamic prophet, however treatment focused on challenging this belief). Although evidence suggests VHs with religious beliefs about voices are more likely to have positive VHEs (e.g. Cottam et al., 2011; Davies et al., 2001) the belief in voices as a deity or demon may present a unique challenge to the approach of trying to change relationships with voices for those who do have negative VHEs, due to beliefs about the omnipotence of beings or the importance of piety.

Secondly, the review includes studies conducted in a number of different countries however there was a lack of diversity of participants, or the ethnic background of participants was not reported in the majority of studies. It is therefore not clear how well the experience of people from different ethnic backgrounds and cultural beliefs were explored in the review. This is an important area for exploration due to findings that the experience and understanding of voice hearing varies across cultures (e.g. Luhrmann et al., 2018).

Finally, although synthesis included information about negative changes in relationships with voices where apparent (e.g. one participant in Hayward et al., 2018, who experienced an increase in voice intensity during therapy after taking a more assertive stance towards voices), the papers elicited by searches focused on how positive, rather than negative, changes in relationship between VHs and voices occurred. As such, no papers were excluded solely on the basis that they discussed negative – but not positive – ways in which a person's relationship with their voices have changed. Because of this, the review may be presenting an overly one-sided account of the process of attempting to change relationships between voices and VHs. Furthermore, as the review has focused on an overview of the different ways positive change can come about, rather than an in-depth exploration of this process, it has not expounded upon the potentially complicated nature of this approach (e.g. potential distress caused by tuning into critical or derogatory voices). It is not the intention of the review to present this as an easy or uncomplicated process, rather to highlight the different ways positive change can come about.

Future Research

In light of the limitations of the current review, future research should explore the experience of VHs who have developed more positive relationships with their voices with a wider range of participants, including VHs from different ethnic and cultural backgrounds and those who hold religious beliefs about voices. As discussed above, it would also be beneficial to explore whether VHs with particular VHEs, beliefs or histories benefit from particular approaches in order to tailor services. Finally, the current review suggests that the approach of engaging with voices can be beneficial, and this approach is popular within service user movements (Longden et al., 2013). However the predominant understanding and treatment for psychosis is informed by the bio-medical model in which voices are seen as symptoms to be eradicated rather than understood (Steel et al., 2019), suggesting many VHs receiving support from mental health services are not being introduced to a way of thinking about voices that could be beneficial. It would therefore be helpful for future research to explore ways of introducing VHs to different approaches to VHEs, for example through peer support, literature, or online media. In light of the HVM and related books aimed at the general public, another possible research area would be to explore whether some people come to change their understanding of voices by discovering such books.

Conclusion

The present review sought to review and synthesise qualitative literature which contained an exploration of how VHs have been able to develop more positive relationships with voices. Synthesis elicited five interconnected superordinate themes with subsequent subthemes: ‘coming to see voices as less threatening’; ‘developing new ways of responding to voices; ‘becoming more accepting and less fearful of voices’; ‘beyond voices’ and ‘facilitators’. Findings are in keeping with previous literature which suggests exploring VHEs and developing more positive relationships with voices can have beneficial impacts for VHs. However, there was limited discussion of the potential negative impacts of attempting to change relationships between VHs and voices in papers included in the review, meaning synthesis may present an overly one-sided account of this practice. The process by which participants were able to navigate their relationships with voices was broad, therefore it would be beneficial for future research to explore who benefits from what approach and why in order to tailor services for those seeking support with negative VHEs. Future studies should also further investigate the experience of VHs from more diverse backgrounds, as well as those who hold religious beliefs about voices. Finally, exploring how VHs can gain access to approaches to voice hearing that differ from the bio-medical model would also be beneficial due to the dominance of the bio-medical model in many mainstream mental health services.

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NB: Asterix (*) indicates paper included in the review.

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Section B: Empirical Paper

"It did give me hope in a system that really just didn't have a lot of hope for me". A qualitative study exploring the experience of voice hearers who have read books associated with the Hearing Voices Movement.

Word Count: 7975 (200)

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

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Abstract

Introduction: Dominant cultural narratives portray voice hearers (VHs) as having a disabling illness from which they are unlikely to recover, and as violent and criminal. The incorporation of such views into VH life stories can lead to negative voice hearing experiences and reduced hope for the future. This study explored the experiences of VHs who have encountered alternative narratives of voice hearing through reading books associated with the Hearing Voices Movement.

Methods: Narrative interviews were used to elicit stories from ten VH participants. Narratives were analysed using literary and experience centred and culturally-oriented narrative analysis.

Results: Stigmatising dominant narratives of voice hearing were present in nine narratives and an alternative community narrative, associated with the HVM, was present in nine. Turning points were identified.

Discussion: Encountering alternative narratives about voice hearing, including through reading, can act as a turning point where stigmatising narratives of voice hearing are challenged and more positive identities constructed.

Keywords: Voice-hearing, written recovery narratives, stigma

Introduction

The construction and telling of stories is understood to be a key way people make sense of the world around them, shape their identities, and express meaning to themselves and others (Mischler 1986; Murray, 2003). Adame and Hornstein (2006, p. 136) write that "throughout their lives, people consciously and unconsciously create narrative to organise the chaos of existence into a coherent story", including the construction of their own life story "that relates the past to the present and imagines possible story lines of the future". This personal narrative tells us the story of "how I have become what I am" (Wang et al., 2015, p. 89) and informs our sense of self (Bruner, 1990; Polkinghorne, 1988).

Dominant Cultural Narratives and Stigma

Rappaport proposed three parallel levels of narrative encompassing societal/ cultural, community, and individual perspectives. 'Dominant cultural narratives' are those communicated by mainstream institutions within a culture (e.g. religious and educational institutions, mass media) and inform the values, beliefs and identities of people living within that culture. 'Community narratives' are stories told by members of smaller groups, formed through the telling and re-telling of shared experiences and knowledge, which tell members important information about themselves. Finally, 'personal stories' are an individual's understanding and/or communication of their life experiences which informs their sense of identity (Monkowski & Rappaport, 2000; Rappaport, 2000). It has been hypothesised that the human fear of the unknown and desire to find order and meaning can lead individuals to draw on dominant cultural narratives to make sense of personal experiences (Casey & Long, 2003; Rappapport, 2000), however these dominant narratives are not unbiased. Murray (2003) argues that societal narratives represent the interests of those with power and can be used to maintain social discipline, and Monkowski and Rappaport (2000) suggests those in power maintain dominant cultural narratives about marginalised groups, which can be internalised and incorporated into personal stories with both positive and negative consequences. The appropriation of a dominant narrative into one's personal story can become a "self-fulfilling prophecy" in which an individual's identity and choices are shaped by the expectations held about them due to their membership of a marginalised group (Rappaport 2000, p. 20).

The concept of internalising stigmatised dominant cultural narratives finds parallels in research on internalised stigma. Stigma has been defined as "a social construction referring to the devaluation of, negative attitudes towards, and tendency to negatively evaluate a person because of a mark or sign of defect" (Reddyhough et al., 2021, p. 1032) and has been conceptualised as existing at three interrelated levels. Social or public stigma is the perpetuation of widely held stereotypes about marginalised groups; institutional or structural stigma refers to the rules, policies and procedures that discriminate against and lead to the oppression of marginalised groups; and internalised or self-stigma describes the identification with and application of public stigma to oneself as a member of a marginalised group (Corrigan et al., 2005; Livingston & Boyd, 2010).

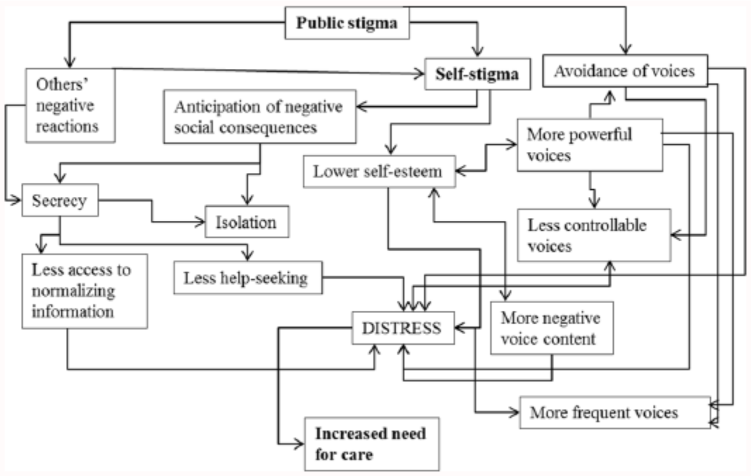
Stigmatised Narratives of Voice Hearing

The experience of voice hearing (hearing a voice or voices that other people cannot hear) has been understood in different ways, including as a spiritual or paranormal experience, as a psychological response to trauma or difficult life experiences, as a misattribution of internal cognitions, and as a result of biochemical imbalances (Hearing Voices Network, ND). The emotional experience of voice hearing is broad, with some voice hearers (VHs) having positive or benign voice hearing experiences (VHEs), and others having distressing VHEs that may result in a need for support or treatment from mental health services (John's et al., 2014). VHEs have typically been understood as a symptom of mental illness in Western cultures, however some research has suggested the majority of VHs do not have a diagnosable mental illness (Johns et al., 2002; Lawrence et al., 2010; Linden et al., 2011). Despite this, dominant narratives in Western cultures associate VHEs with mental illness (typically with a diagnosis of schizophrenia or other psychotic disorders), suicidal ideation, violence and criminal behaviour (Vilhauer, 2015). Due to the association of voice hearing with schizophrenia, VHs are likely to be affected by dominant narratives that portray people with a diagnosis of schizophrenia as dangerous and unpredictable, as needing to remain on antipsychotic medication for their lifetime, and as being likely to experience a continual deterioration in functioning from which they are unlikely to recover (Bowen et al., 2019; May, 2008; Wood et al., 2014).

Research suggests the internalisation of stigmatising dominant narratives about voice hearing might play a causal role in the experience of negative, as opposed to benign or positive, VHEs. Following a narrative literature review, Vilhauer (2017) proposed a pathway (Figure 1) in which internalised stigma causes a reduction in self-esteem, resulting in voices being experienced as more powerful, intrusive and less controllable due to the perceived inferiority of the VH. Distressing VHEs are then more likely to result in decreased functioning and an increased need for treatment. Furthermore, stigmatised experiences are more likely to be avoided, therefore an awareness of the stigma around voice hearing is likely to lead to the attempted avoidance of VHEs, which has been associated with increased frequency and intensity of voices. Finally, awareness of stigmatised narratives makes it less likely VHs will report their VHEs, presenting a barrier to support and treatment should it be needed, including access to normalising accounts of voice hearing and/ or others who share their experiences. This proposed pathway is consistent with cognitive models of voice hearing in which appraisal of VHEs is understood to impact voices, with negative beliefs about voices leading to more distressing VHEs (Chadwick & Birchwood, 1994).

Figure 1

Potential Pathways Between Stigma and the Need for Care for VHs, Identified by Vilhauer (2017)



Re-storying

Just as the appropriation of stigmatised dominant narratives into one's personal story can lead to a stigmatised identity and negative outcomes, the opportunity to reshape personal stories can be empowering and liberating, depicted by Rappaport (2000) as "turning tales of terror into tales of joy" (p. 7). This is the approach taken in Narrative Therapy (NT), which is based on the premise that our lives are shaped by the stories we tell about ourselves and are told about ourselves by others. NT understands lives to be multi-storied, meaning multiple stories occur at the same time in an individual's life, and different stories can be told about the same thing depending on how events are linked together and interpreted, influenced by the values and beliefs held by an individual and the context in which they are living. The dominant story constructed impacts the individual's identity, the choices they make, and ultimately their future. NT seeks to deconstruct 'problem-saturated narratives', which emphasise the problem and omit the strengths and values of the individual, in order to uncover and bolster alternative narratives that highlight strengths. Re-storying or re-authoring personal stories in this way is understood to free people from problem identities and open up new possibilities (Morgan, 2000; White & Epston, 1990). Empirical evidence suggests NT can be helpful when used with different populations across a variety of settings, including supporting primary carers of people with a diagnosis of schizophrenia (Zhou et al., 2020) and older adults living with chronic pain (Chow & Fok, 2020). This approach is in keeping with research on recovery processes for those experiencing mental health difficulties, which highlights the importance of moving from an illness-dominated identity towards a more empowered sense of self (Davidson & Strauss, 1992), defined by Roe (2001) as a transformation from “patienthood” to “personhood”.

The Hearing Voices Movement and Hearing Voices Groups

Casey and Long (2003) describe how the desire to find new meaning through sharing stories with others who have had similar life experiences has contributed to the development of service user and psychiatric survivor movements. By coming together and sharing stories, stigmatised dominant narratives can be challenged, new community narratives formed and personal stories re-authored:

> Sharing our stories finally gave us the courage to believe that we are not mad: we are angry… our distress and anger is often a reasonable and comprehensible response to real life situations which have robbed us of our power and taught us helplessness. (Wallcraft 1996, p.191, quoted in Casey & Long, 2003).

The Hearing Voices Movement (HVM) is a service user/ psychiatric survivor-led movement that works to “question, critique, and reframe traditional biomedical understandings of voice-hearing; develop coping and recovery frameworks; redefine the ownership of power and expertise; and promote political advocacy for the right of those who hear voices" (Corstens et al., 2014, p. 285). The HVM is broad and welcomes a wide range of perspectives, however it is underpinned by a core set of values (displayed in Table 1), which could be said to constitute a community narrative of voice hearing.

Table 1

Underpinning Values of the Hearing Voices Movement as Outlined in Corstens et al., 2014

1	Voice hearing is believed to be a natural part of the human experience, and all people are believed to have the potential to hear voices. Voice hearing is therefore not understood to be an abnormal or pathological experience.
2	Different beliefs and explanations for voice hearing are accepted and valued.
3	People are encouraged to develop their own understandings of their VHEs.
4	It is believed that most VHEs can be understood within the context of an individual's life experiences.
5	Working towards an acceptance of voices is viewed as being more helpful than attempting to suppress or eliminate them.

Hearing Voices Groups (HVGs) are peer-support groups that developed out of the HVM and have spread to 30 countries over five continents (Corstens et al., 2014). The groups are guided by shared values and principles rather than adhering to a prescribed format, therefore the experience of participating in HVGs is broad. In general, however, they provide opportunities for people to explore their VHEs, and to support and be supported by others with shared experiences (Hornstein et al., 2021; Hornstein et al., 2020). Research has highlighted many benefits of attending HVGs including forming social networks, developing new understandings of VHEs, learning ways of managing voices, feeling less distressed by VHEs, feeling more empowered and self-confident, and having fewer hospital admissions (Beavan et al., 2017; Dos Santos & Beavan, 2015; Longden et al., 2018; Oakland & Berry, 2015; Payne et al., 2017).

After analysing feedback from 113 members of HVGs across America, Hornstein et al. (2020) proposed a model to explain how HVGs enable transformations, encompassing the following three phases: discovery; reframing; and change. The model highlights how through hearing the stories, experiences and knowledge of others, individuals are introduced to a variety of perspectives about voice hearing that differ from the messages they have received from mental health (MH) professionals, society and mass media. This, together with being in an environment where people feel safe talking about their voices, enables members to explore and reframe their understanding of their VHEs, and in some cases be encouraged to try new ways of responding to and working with their voices. This process of discovery, exploration and reframing can lead to transformations within and outside of the group, such as VHEs becoming less distressing and the development of "deeper, more satisfying" interpersonal relationships (Hornstein et al., 2020, p. 7). In narrative terms, HVGs provide an opportunity for members to encounter personal stories and community narratives that challenge dominant cultural narratives about voice hearing, enabling them to re-story their own experiences, which can lead to new opportunities.

Written Mental Health Recovery Narratives

Another way in which individuals can discover alternative narratives is through reading. Recent research has examined the impact of reading recovery narratives, defined as "first-person accounts of recovery from mental health problems that refer to events or actions over a period of time" for people diagnosed with different mental health conditions (Rennick-Egglestone et al., 2019a, p. 670). Rennick-Eggelstone et al., (2019b) identified both helpful and harmful outcomes of reading recovery narratives. Helpful outcomes included connectedness, validation (normalising of experiences and learning that mental health problems are a shared experience), hope (about the future and human nature), empowerment (to share personal narratives, to challenge systems, and to make personal change), appreciation (of positive aspects of life and of the challenges other people have experienced), reference shift (a change in belief about the possibility of recovery and how this might come about), and stigma reduction. Harmful outcomes included inadequacy (the belief that other people have made a better recovery), disconnection (from those who have been able to experience recovery or who are experiencing less distress), pessimism (about the possibility of recovery, problems of society, and the perceived lack of value of sharing personal stories), and burden (borne of concern for the narrator). Three particular benefits of receiving recorded recovery narratives (e.g. written in books as opposed to being told in person) were identified: gaining access to narrators that are not otherwise available; having control over access to the narrative (e.g. being able to stop reading if it becomes overwhelming); and freedom from the potential social burden that can occur when receiving a recovery narrative in person.

Recorded recovery narratives are increasingly available in books and online (Rennick-Eggestone et al. 2019b) and much of the literature produced by different service user/ survivor groups is in the form of first-person accounts (Casey & Long, 2003). Much literature has been published by people associated with the HVM, which includes first-person accounts of VHEs as well as information about voice hearing and ways of managing voices.

The Present Study

The present study is based on the premise, as discussed heretofore, that dominant cultural narratives of voice hearing can be stigmatising, and that the awareness of and incorporation of such narratives into personal stories can lead to negative outcomes for VHs, including more negative VHEs and reduced hope for the future. The HVM offers alternative narratives about voice hearing and HVGs are one way of introducing people to these ideas, with empirical evidence suggesting that attending HVGs can enable group members to challenge dominant narratives of voice hearing and re-story their experiences. Another way of introducing people to alternative narratives is through reading, and numerous books have been published by people associated with the HVM. The present study therefore aims to explore VH experiences of reading books written by people associated with the HVM and to see how such reading features in their personal stories. The study will address the following questions in relation to VHs who have identified that they have encountered this type of book:

- What stories do participants tell about reading books associated with the HVM and how does this reading feature in their stories?
- Do dominant cultural narratives and community narratives feature in these stories and if so, how?
- Are there any turning points depicted in participant’s narratives and if so, what changes are described?

Method

Design

The present study has a non-experimental qualitative design and employs narrative methodology. There is no one definition of narrative, however narrative can be broadly understood as the telling of a sequence of events that has been constructed in such a way to convey meaning (Riessman, 2008). Narrative is shaped by the narrator, who decides which information to include, how to describe it, how to link particular events and how events are interpreted and explained. Therefore, the use of narrative analysis will help gain insight into how participants have understood and made sense of events, enabling an exploration of the impact of dominant and alternative narratives on the construction of meaning (de Jager et al., 2016). Analysing narratives as a whole also helps to illuminate change over time, which will allow for an exploration of any change that narrators describe, and how, if at all, they link such change to reading books (May, 2002).

Epistemological Position

The underlying epistemological position of the study is social constructionism, in which knowledge and meaning are understood to be constructed within individual, social, cultural, political and historical contexts. Social constructionism holds that there is no overarching 'truth' reflecting the nature of the world, rather understanding is the product of the way the world has been represented through language. As reality is understood to be socially constructed it is influenced by the context within which a particular understanding has developed. Knowledge is therefore not understood to be absolute, meaning it is possible for more than one reality, or accounts of reality, to exist at the same time, and for understandings of reality to change over time. (Burr & Dick, 2017; Van Niekerk, 2005).

Participants

Recruitment

The following organisations were contacted and agreed to share the research advert (Appendix I) via social media and/ or email: the Hearing Voices Network (HVN), the London HVN, the National Paranoia Network, the National Survivor User Network (NSUN), Mad in the UK. Individual HVGs were also contacted, and a number agreed to share the advert via social media and/ or amongst group members.

Inclusion and Exclusion Criteria

To be eligible for inclusion participants had to be aged 18 or above, identify as a VH (either currently or in the past), be able to take part in an interview and give informed consent in English, and have read at least half of one of the books displayed in Table 2. The list of books was compiled through discussion with supervisors and an expert by experience who acted as a research consultant, and internet searches including reviews of recommended resources on relevant websites.

Table 2

Books Read by Participants Prior to the Study

Title	Authors	Date published	Summary
Hearing Voices, Living Fully: Living With the Voices in My Head	Claire Bien	2016	A memoir of the author's experience of voice hearing and an exploration of ways of understanding voice hearing beyond the medical model.
Recovery: An Alien Concept?	Ron Coleman	1999	The story of the author's journey of recovery as a VH, and critique of the mainstream medical approach to recovery.
Working with Voices II: Victim to Victor	Ron Coleman and Mike Smith	2002	A self-help book written for VHs and those supporting them.

Young People Hearing Voices	Sandra Escher and Marius Romme	2010	A book written for young people who hear voices and their parents/ carers. The book provides information about different understandings of voice hearing and ways of living with and managing VHEs, including first person accounts.
Learning From the Voices in My Head	Eleanor Longden	2013	A memoir of the author’s experience of voice hearing and exploration of ways of understanding voice hearing beyond the medical model.
Accepting Voices	Marius Romme and Sandra Escher	1993	A book presenting Romme and Escher’s approach to voice hearing, explaining the principle of accepting voices through the stories of VHs.
Living With Voices: 50 Stories of Recovery	Marius Romme, Sandra Escher, Jacqui Dillon, Dirk Corstens, Mervyn Morris	2009	A collection of 50 stories written by VHs who have recovered from the distress of hearing voices through an ’accepting’ and ‘making sense of voices’ approach.

The information sheet suggested that it may not be advisable for potential participants to take part if they were experiencing acute distress or thought it might be distressing to talk about their experiences.

Participant Characteristics

Eleven people participated in the study, however one dataset was excluded due to the participant being unable to elaborate on points made during the interview (e.g. saying the book they read was “helpful” but not being able to elaborate on which parts were helpful or how) and so not fulfilling plausibility criteria as outlined by Elliott (2002). Including this dataset would have risked introducing an element of bias, such as the possibility of the participant saying what they thought was expected of them.

Participants were asked to complete a short questionnaire including questions about demographic and contextual information (e.g. contact with mental health services) prior to interview. Information from this questionnaire is displayed in Table 3. Further contextual information, not contained in the questionnaire but mentioned by the majority of participants, is displayed in Table 4.

Table 3

Participant Characteristics Collected Through Questionnaire

Demographic/ Contextual Information		Number of Participants
Age	18-24	0
	25-34	1
	35-44	6
	45-54	2
	55-64	0
	65+	1
Gender identity (self-defined)	Female	6
	Gender fluid/ non-binary	1
	Male	3
Nationality	American	2
	British	6
	English/ German	1
	Spanish	1
Country of residence	United Kingdom	8
	United States	2
Ethnicity (self-defined)	White British	5
	White European	1
	White Jewish	1
	White	3
Have been given a diagnosis of a mental health condition	Yes	10
	No	0
Have been prescribed medication for an emotional or psychological problem, or addiction	Yes	10
	No	0
Have received treatment or therapy (other than medication) for an emotional or psychological problem, or addiction	Yes	9
	No	1

Table 4

Further Participant Characteristics Discussed During Interviews

Participant	Association with Hearing Voices Movement (HVM).	Level of Education	Books Read
Em	Learnt about the HVM while doing research for an assignment at university. Initially ordered the books as they became interested in setting up a Hearing Voices Group (HVG) in their area (they have not done so for various reasons but believe it would be beneficial to have a HVG in the area).	Bachelor's degree	'Accepting Voices', 'Living with Voices: 50 Stories of Recovery', 'Recovery: An Alien Concept?', 'Working with Voices II: Victim to Victor'
Lottie	Spoke about "being part of a Mad Community" but did not explicitly discuss association with the HVM.	Started Bachelor's degree but was unable to finish due to intensifying experiences of voices and distress.	'Accepting Voices'
Jeremy	Has attended a HVG.	PhD	'Accepting Voices', 'Living with Voices: 50 Stories of Recovery', 'Working with Voices II: Victim to Victor'
Anna	Mentioned attending a HVG on one occasion. Anna described finding out about the HVG through the National Survivor User Network (NSUN).	Not discussed.	'Living with Voices: 50 Stories of Recovery'
Beth	Has attended HVGs and is a HVG facilitator.	Beth was doing a PhD at the time of interview.	'Living with Voices: 50 Stories of Recovery', 'Young People Hearing Voices', 'Learning from the Voices in my Head', 'Hearing Voices, Living Fully', 'Recovery: An Alien Concept?', 'Working with Voices II: Victim to Victor'

Peter	Has been part of the HVM in the past, including attending HVGs and giving talks at HVGs. Peter described having taken a step back from involvement with the HVM for various reasons but was considering ways he might become involved again in the future.	Started a university degree but was unable to finish due to intensifying experiences of voices and distress.	‘Accepting Voices’, ‘Living with Voices: 50 Stories of Recovery’, ‘Recovery: An Alien Concept?’, ‘Working with Voices II: Victim to Victor’
Jackie	Did not mention direct association with the HVM. Has attended a course run by Ron Coleman and Karen Taylor.	Master’s degree.	‘Accepting Voices’, ‘Living with Voices: 50 stories of recovery’, ‘Learning from the Voices in my Head’, ‘Recovery: An Alien Concept?’
Bea	No association with the HVM. Learnt about the current research project through NSUN.	Bachelor’s degree. Started an MSc but was unable to complete due to a period of mental ill health.	‘Recovery: An Alien Concept?’
Felicity	Has attended HVGs	Not discussed.	‘Learning from the Voices in my Head’, ‘Recovery: An Alien Concept?’, ‘Working with Voices II: Victim to Victor’
Dominic	Started a HVG at a day centre he was attending.	Started Bachelor’s degree but was unable to complete due to intensifying experiences of voices, unusual beliefs, and distress.	‘Living with Voices: 50 Stories of Recovery’,‘Recovery: An Alien Concept?’, ‘Working with Voices II: Victim to Victor’

Procedure

Ethical Considerations

Ethical approval was granted by the Salomon's Institute for Applied Psychology, Canterbury Christ Church University, ethics panel (Appendix J) and an end of study report submitted to the panel following completion (Appendix K). The British Psychological Society's Code of Human Research Ethics (Oates et al., 2021) was followed throughout.

All participants had access to the information sheet (Appendix L) and opportunities to ask questions in advance of the interview to ensure informed consent. Prior to interview, participants were asked to fill out a consent form (Appendix M) and a questionnaire including questions about demographic and contextual information, which were kept separate to protect confidentiality. Interview transcripts were anonymised and participants chose or were given pseudonyms: Em; Lottie; Jeremy; Anna; Beth; Peter; Jackie; Bea; Felicity; and Dominic.

Before interview participants were given the option of providing contact details for someone who could be contacted on their behalf should they become distressed, and were reminded that they could stop the interview without giving reason and take as many breaks as needed. In most instances this prompted a short conversation about how comfortable participants felt about sharing their story and strategies for managing wellbeing.

Participants were given a £10 gift voucher as an acknowledgment of their time and contribution.

Interviews

Six interviews took place over online conferencing platforms, one over the phone, and two in person at community centres. Dominic requested a written rather than spoken interview, and his interview comprised an email exchange over several weeks. The other interviews lasted between 29 minutes and two hours (M=73 minutes). Jackie was accompanied by a friend who supported her to tell her narrative and shared her own experiences of having a son who hears voices. Peter, Em, and Jackie provided answers to follow up clarification questions via email after their interviews.

In keeping with narrative methodology, interview questions were kept open to allow participants to tell their narrative in their own way and to limit the impact of researcher assumptions (e.g. Fehér, 2011). An initial question was asked to prompt participants to tell their story and follow up questions were asked for clarification or to elicit a complete timeline. Example questions are displayed in Table 5. A timeline was drawn out during interview to identify and fill any gaps in the narrative as per de Jager et al., 2016.

Table 5

Example Interview Questions

First question (asked of all participants)	Please could you tell your story, starting at a time before you read any of the books, what it was like coming across the books and what happened next.
Example follow up questions	What happened next? What happened between… and …? Could you please say a bit more about…?

Analysis

Narrative research encompasses a diversity of approaches, and there is no step-by-step guide for how to undertake narrative analysis (Mishler, 1995; Reissman, 2008). For this study, analysis was informed by the social constructionist approach of Colbert et al., (2013) and O’Brien (2014), who used narrative analysis to explore whether an art gallery-based group for people with an experience of psychosis helped modify dominant cultural narratives of psychosis within participants’ personal stories.

Interviews were transcribed, and each transcript read and re-read multiple times to aid the process of ‘immersement’ with each story (McCormack, 2004). Stories were then chronologised to examine any change over time and to allow the sequence and progression of themes to emerge (Squire, 2013). A short summary of each story including a beginning, middle and end was constructed (Appendix N).

The first stage of analysis comprised literary analysis (Murray, 2003) in which the following was considered:

- Genre: The type of story told by participants. This was informed by Llewelly-Beardsley et al. (2019), who identified four types of genre following an extensive systematic review of mental health recovery narratives (displayed in Table 6).
- Core narrative: A short phrase chosen to provide a summary of the story.
- Tone: The way the narrator told their story and the subjective response this elicited in the researcher.
- Positioning: The researcher’s perception of what the narrator hoped to achieve through sharing their story, and how this was achieved.

Table 6

Types of Narrative Genre in Mental health Recovery Narratives, identified by Beardsley et al., 2019

Type of Genre	Description
Escape	Comprising “narratives of escape from and resistance to abuse, threat, stigma and persecution” (p. 12). This can include escape from oppressive and stigmatising identities, beliefs, systems, institutions, and treatments.
Endurance	Comprising narratives of “loss, trauma, difficult circumstances and/ or seemingly insurmountable odds” (p. 12). The narrator may describe current experiences of distress, and success is described in terms of surviving or keeping going.
Endeavour	Comprising narratives “incorporating positive aspects, coping strategies and/ or plans, and an acceptance of difficulties as an ongoing factor of recovery” (p. 12).
Enlightenment	Comprising “narratives of transformation” with discovery described as “a journey of exploration or discovery, leading to empowerment and/ or self-actualisation” (p. 12). Illness/ trauma is viewed as an ultimately positive experience as it has enabled the narrator to gain new perspectives.

Second, experience-centred and culturally oriented analysis was conducted, which examined narratives within the context of cultural and social influences (Squire, 2011). The following were considered:

- The presence and influence of dominant cultural narratives about voice hearing (e.g. cultural, religious, psychological, medical).

- The presence of turning points within narratives, including those that led to the construction of more positive and empowering personal stories.
- The presence of community narratives associated with the HVM.

Excerpts of Lottie’s transcript and the corresponding analysis are displayed in Appendices O and P.

Reflexivity and Quality Assurance

Narratives are understood to be co-constructed between narrator and audience, with the narrator deciding what can and cannot be spoken about, what can be taken for granted or warrants further explanation, and what message the story should convey, based on the audience. Furthermore, the prior knowledge and assumptions held by the audience will influence the questions they ask, and therefore what the narrator is prompted to talk about (Riessman, 2008). That the audience in this instance was a post-graduate student employed by the NHS who will be going on to have a career in mental health services is likely to have influenced how each story unfolded, and a broader audience may also have been held in mind by participants such as the possibility of the research being published and read by practitioners, academics, and policymakers.

A bracketing interview with the lead researcher and primary supervisor took place before interviews were conducted to uncover any assumptions and biases that could influence data collection and analysis. This enabled personal beliefs about the helpfulness of the HVM to be made transparent, leading to a discussion about the importance of attending to aspects of participant stories that might take a more critical stance towards the HVM. The lead researcher also kept a research diary (Appendix Q).

All participants were given the opportunity to view the summary of their stories, with all but Jeremy and Felicity providing respondent validation. Minor corrections were given in two instances and summaries edited accordingly. Interview transcripts and story summaries were cross checked by the primary supervisor, and interviews, story summaries, and literary and experience-centred and culturally oriented analysis were discussed.

Results

Narratives

From the ten narratives that were elicited, one master narrative was identified, with three exceptions. The master narrative is displayed in Table 7 which encompasses elements of enlightenment, escape and endeavour genres.

Table 7

Master Narrative, Identified Across Seven Participant Narratives

Beginning	Participants tended to begin their stories with a description of how they first started experiencing voices, with four participants connecting their voices with trauma or difficult life experiences. Participants then went on to describe contact with mainstream mental health services, with all participants describing negative experiences including enforced treatment, misdiagnosis, over-medication, participants' own thoughts and experiences not being explored or being actively undermined, being given an overwhelmingly negative prognosis for the future, and a fear of talking about voices due to possible negative consequences. Within this, four participants also highlighted more positive experiences they had with certain mental health professionals, for example those who were supportive or signposted participants to the HVM. For many participants there followed a

period of reduced functioning due to the effects of medication; being kept in hospital; internalised messages that they would not be capable of engaging with education, work or volunteering; or the impact of negative VHEs and difficulties with mental health.

Middle The middle part of stories tended to focus on coming across alternative narratives about voice hearing for the first time. For four participants their main introduction to these ideas was through reading the books, for two through coming into contact with the HVM (attending a HVG and a chance encounter with an HVG facilitator), for one through seeing Eleanor Longden speak at her university, and for one through a therapist who was not connected to the HVM but had developed an alternative approach to working with voices through previous experiences both personal and professional. Those participants who had encountered alternative narratives before reading the books came across them at later stages, either through their own research or through being signposted to resources by members of the HVM (e.g. after attending HVGs). The books then served to corroborate ideas they had previously encountered through other sources.

Through engaging with alternative narratives about voice hearing, participants gained renewed hope for the future; started to explore and understand their VHEs; and started learning strategies for working with their voices, with all participants describing improvements with their VHEs (e.g. having more positive VHEs, changing relationships with voices, experiencing a reduction in voices). Some participants also highlighted additional factors that helped facilitate change (before and after encountering alternative narratives of voice hearing) including experiences that gave them renewed confidence in their own abilities (e.g. being invited to give talks, accessing training and education), and contact with other practitioners or support groups (e.g. a nutritionist, attending a Wellness Recovery Action Plan group). Six participants described going on to access education, find employment, take up voluntary positions, and become active members of different organisations.

	During the narratives all participants spoke about attempting to make changes to their prescribed medication, some prior to encountering alternative narratives about voice hearing and some after. Two participants stopped taking their medication altogether, four spoke about reducing or changing their medication, and one spoke about having difficulties with their mental health after trying to come off their medication so deciding to continue taking it in the long term. Four participants spoke about regaining cognitive function after stopping or changing their medication, which enabled them to implement strategies or think through for themselves how to manage difficulties.
End	The end of each narrative tended to comprise reflections both on how things were at the time and thinking forwards to the future. Some participants also reflected on wider themes including medication, voice dialoguing, research, limitations of mental health services, limitations of the HVM approach to voice hearing and difficulties with incorporating those ideas into NHS services, and the impact of austerity policies in the UK.

Anna, Jackie, and Bea provided alternative narratives (displayed in Table 8). Each narrative corresponded with the master narrative in the beginning stages, with all three participants describing initial experiences of voice hearing and going on to talk about negative experiences of mental health services. Following this, their narratives diverged. Genres are displayed in Table 9.

Table 8

Alternative Narratives Told by Three Participants

Bea	Bea described how her voices stopped after being prescribed medication, and how she subscribed to the view, communicated by mental health professionals, that the voices were symptoms of an illness which could be treated by taking medication long term. The voices were not explored or mentioned by mental health professionals again, other than when checking for signs of relapse. Bea went on to describe the limited expectations that were held for her after she was

	given a diagnosis, and how this led to different professionals discouraging or actively attempting to stop her from trying to get a job or go to university. However, through her own determination and support from a helpful tutor she attended college, completed a university degree, and went on to take up different educational and voluntary positions. Bea first came across ‘Recovery: An Alien Concept’ after being sent the recruitment advert for this study by NSUN, and reading it prompted her to explore the meaning of her voices for the first time. She came to the realisation that the voices had echoed criticism that was being levelled at her by her family around the time she first started hearing voices, and she started to talk to her sister about her VHEs for the first time after twenty years.
Anna	Anna described how she first came across ‘Living with Voices: 50 Stories of Recovery’ in 2019 after being discharged from hospital and wanting to find books about voice hearing. Anna found the book through searching on the internet, and initially found it helpful as it normalised her experiences and presented a more positive depiction of voice hearing in comparison to those she had previously encountered. However, her voices “got in the way” and she was unable to finish the book or continue engaging with the ideas. Anna described continuing to have negative VHEs and her narrative suggested she was still struggling with negative perceptions of herself and a sense of hopelessness about her future. However, she counteracted this by talking about things she would like to do with her life, and after telling her story she suggested she would like to re-read the book and write her own story to start making sense of her experiences.
Jackie	Jackie spoke about the impact of being given a diagnosis of paranoid schizophrenia (which she disputed) including being prevented from working and engaging with valued activities by professionals and being required to take medication which greatly reduced her functioning. As a result of this she found her relationship with her voices, which had initially been “fine” and sometimes helpful, deteriorated and became harder to manage. Jackie attempted to persuade professionals that she did not need to take medication, however she

found the more she advocated for herself the more professionals insisted medication was needed. She remained on medication for 23 years, eventually coming off all medication three years prior to her interview for the current study. Jackie read the books after she had come off her medication, discharged herself from her community mental health team, and “escaped psychiatry”. For Jackie, the books were helpful for demonstrating that other people had been able to find “a way back to you” after living with the “sick role” for so long.

Literary Analysis

Results of the literary analysis are displayed in Table 9. As described above, all narratives described contact with mental health services, and all but one were explicitly critical of aspects of treatment (Peter was not overtly critical but did describe a fear of talking about his voices to his psychiatrist). Participants were angry at their treatment, and nine narratives contained elements of protest, challenge or questioning about mainstream mental health services (MMHS). Following this, six participants either implied or explicitly expressed wanting to take part in the research project in the hope that contributing to a body of research about alternative approaches to voice hearing might help inform treatment approaches and/ or attitudes towards VHs.

Transformations were described during participant narratives, which tended to be transformations from an illness or stigmatised identity that had been imposed and, in some cases, internalised, towards more positive and empowered identities. Experiences of distress or trauma (including contact with MMHS) tended not to be viewed as positive in themselves as per the enlightenment genre, however participants did identify how these experiences had gone on to shape them and their lives, including their political beliefs, interpersonal relationships, and career choices.

Table 9

Results of Literary Narrative Analysis

Participant	Genre	Core narrative	Tone	Positioning
Em	Escape and Enlightenment	"I'm learning to love myself"	Thoughtful, protesting, challenging, questioning.	Advocating for change through sharing personal experiences.
Lottie	Escape and Enlightenment	"It ['Accepting Voices'] did give me hope in a system that really didn't have a lot of hope for me"	Thoughtful, questioning.	Advocating for change through sharing personal experiences.
Jeremy	Escape, Endeavor and Enlightenment.	"that ['Accepting voices'] was just completely mind-blowing I mean, so the whole thing about this new, new approach to, to voices"	Thoughtful, questioning.	Advocating for change through sharing personal experiences.
Anna	Escape and Endurance	"I need to find another way of being"	Thoughtful, aggrieved. Moving between hopeless and defeated, to hopeful and resourceful.	Processing through telling her story-wanting to understand and be understood.
Beth	Escape and enlightenment.	"these things [the Hearing Voices Network charter] are very much about trying to expand what we understand it is to be a human"	Thoughtful, protesting, challenging, questioning.	Advocating for change through sharing personal experiences.
Peter	Enlightenment	"It [attending a HVG] made me think about my voices, what they actually were"	Matter of fact.	A storyteller.
Jackie	Escape	"you're not this person over here that they want you to be which is like nothing"	Thoughtful, protesting, challenging, angry and aggrieved.	Advocating for change through sharing personal experiences.

Bea	Escape and Endeavor	“I feel a lot of the 20 years I’ve been using services I haven’t been listened to”	Thoughtful, wistful, protesting, challenging, aggrieved.	Processing and exploring through sharing her story.
Felicity	Endeavor	“because I think life is about learning”	Wise, cautionary, concerned, protesting.	Sharing wisdom.
Dominic	Escape, Endeavour and Enlightenment	“It becomes an upward spiral, instead of a downward one”	Aggrieved, educating, hopeful.	Educating and advocating for change through sharing personal experiences.

Experience Centred and Culturally Oriented Analysis

The presence of dominant cultural narratives, turning points and community narratives in participant stories were considered. Analysis was open to the possibility of novel narratives, which enabled the identification of depictions of the books as being helpful (beyond being identified as a turning point) and depictions of limitations and barriers to engagement with the books.

Presence of Dominant Cultural Narratives

Dominant narratives of VHs, or more broadly of people who have received a diagnosis of a “psychotic illness”, were present in all narratives except for Peter’s (example quotes are provided in Table 10). These tended to be towards the beginning of each narrative’s chronology and formed part of the main tension to be overcome, with participant narratives forming counter-narratives to the dominant cultural narrative of VHs. The exception to this was Anna for whom the dominant narrative was present in her description of her life now, although she did speak about ‘Living with Voices’ as providing a challenge to this. Participants described being told they were crazy and disordered, with voices being viewed as symptoms of a mental illness and/ or a problem that needed to be eradicated. Seven participants described the limited expectations about their futures that were held for them after telling people about their voices or receiving a psychiatric diagnosis. Finally, three narratives contained beliefs that VHs are bad or dangerous, and three contained cultural and spiritually informed views that the presence of voices is a sign an individual is evil or possessed.

Table 10

Example Quotes Demonstrating the Presence of Dominant Cultural Narratives

Example quote	Participant
[…] and just being told that, 'no you're crazy' and, um, and, you know, 'you have a problem. […] [the voices are] a disorder and they're not helpful in any way', and the objective should be to get rid of them […]	Em
It comes with a prognosis and that is… people with schizophrenia don't work, they don't get married, they don't have children, it's a crippling illness, it's a disabling illness, and you have to be looked after by other people.	Lottie
[…] there were times where I thought that, you know like, I had been possessed by the devil and he was telling me things	Beth

Participants described how dominant cultural narratives were conveyed (Table 11) including via wider cultural discourse (Lottie), from MH professionals (seven participants), and through religious communities (Em, Beth).

Table 11

Example Quotes Demonstrating Participants' Perceptions of the Means Through Which Dominant Cultural Narratives Were Conveyed

Example Quote	Participant
[…] we've got this idea in the culture that there's something… weird or wrong about hearing voices that makes you kind of scary or dangerous, there was that. And I think as well, a lot of it did come from the mental health team. They were very much like 'this is a problem, it's a scary weird problem, and it's difficult to talk about, but the prognosis is not good'.	Lottie
I was in a very conservative religious community at the time, um, the approach of trying to cast out my demons […]	Em

Participants protested this stigmatising narrative of voice hearing, describing how it impacted their wellbeing, functioning, and opportunities (Table 12). Em and Jackie experienced the negative view of voices held by professionals and attempts to eradicate the voices as making their VHEs more distressing, with the relationship between VH and voices becoming more antagonistic. Beth described how contact with psychiatric services caused her to lose trust in her own perception, which disrupted her ability to make sense of her experiences. Six participants described medication negatively affecting their ability to function, including preventing them from developing ways of managing distress and working with their voices. In contrast, Bea’s voices had been successfully treated with medication, for which she was grateful, however she spoke about how the purely medical way her voices were understood meant she missed out on opportunities to explore and address the contextual factors underlying her voices and be supported with the impact of derogatory voices. Three participants described how internalising stigmatised views of VHs led to them having negative perceptions of themselves, and finally, six participants described how the limited expectations held for them impacted their opportunities in life, either due to internalising messages and not believing they had the capability to access employment, education or volunteering opportunities, or because of stigmatising beliefs held by others who prevented them from doing so.

Table 12

Example Quotes Demonstrating Perceived Impacts of Dominant Cultural Narratives

Example quote	Participant
I was kind of being told that they [voices] shouldn't be there so I didn't want them there, and they didn't respond well to that.	Em
I… thought that I was distressed for a reason, um, and at that point, once I started really interacting with psychiatry, um… really I started to doubt that because everything that everyone said was that… I, you know, I couldn't trust what I thought, I couldn't trust what I heard, I couldn't trust what I believed, I couldn't trust my experiences.	Beth
And honestly not the greatest medication to be taking as an undergrad [laughs] because you sleep for 18 hours a day and you drool and you eat everything, and it actually didn't do anything for the voices either […]	Lottie
[Friend] "But previously you'd be so befuddled by drugs that…" [Jackie] "There's no way to think your way out of it. They think that just by… it never stops anything, it just makes you unable to think what to do."	Jackie and friend
I would have liked there to be some dialogue of like, you know, it's not like nothing's happened, I have been in hospital for three months hearing these voices saying these things to me and I know they're gone now but there's a conversation to be had, even if it's just about like my relationship with my grandparents.	Bea
I just feel like the biggest piece of sleaze in the world […] capable of nothing, dark, I infect everything, I infect everyone…	Em
We [Jeremy and his wife] were given quite a negative impression as to what life might look like going forwards so, you know, we were told, um, that this would be a life-long debilitating experience, that it will get progressively worse as time goes on, um […] so essentially you know, from [date] to [date] I was, um,	Jeremy

just attending this day centre, um, with very little aspiration and very, yeah, yeah very limited ambition. […] they just didn't believe that I had a future really that I um, I went, there was this social work assistant and she took me down the job centre to apply for benefits and they asked me 'did I have any GCSEs' […] and she just sort of cut in and said 'no she won't be going back to work'.	Bea

Presence of Turning Points

Turning Points Leading to the Modification of Dominant Cultural Narratives. Each of the nine narratives containing dominant cultural narratives of voice hearing and psychosis described turning points that resulted in modifications to the dominant narrative. Participants described different turning points, which can be divided into two categories: 'engaging with different perspectives about voice hearing'; and 'having opportunities to see oneself differently'.

ENGAGING WITH ALTERNATIVE NARRATIVES OF VOICE HEARING

Accessing Books. Five participants described coming across and reading books as their main introduction to alternative narratives of voice hearing. Participants described significant impacts of coming across alternative narratives (Table 13), including having renewed hope, having negative stereotypes about VHs counteracted, and being encouraged to explore the meaning of their VHEs.

Table 13

Example Quotes Demonstrating the Turning Point of Engaging with Alternative Narratives of Voice Hearing Through Reading

Example Quote	Participant
[…] it had given us [Jeremy and his wife] hope that that negative message could be overcome and we'd started to experience that in terms of… you know, feeling more hopeful about the future, feeling that, you know, seeing that recovery is possible.	Jeremy
[…] and they kind of had even like, an emotional softness towards the people who were hearing voices rather than like, 'they're the scourge of society'.	Anna
[…] I've just gone 'oh I have this illness that made me hear voices and when I was being treated for it the antipsychotics worked, the voices went […] But the thing is, like, there was actually, like he says in the book, a lot of meaning in the voices for me, because it was basically like my family's reaction for when I dropped out of [diploma].	Bea

Example of Others. Two participants described how contact with VHs who held different perspectives about voice hearing, and who embodied the idea that VHs can have lives beyond those that are expected for them, provided a turning point (Table 14). Felicity described a chance encounter with a HVG facilitator who invited her to join a group, signposted her to resources and events about voice hearing, and counteracted her expectations of what VHs should be like. Beth described seeing Eleanor Longden speak at her university, which helped validate her prior understanding of her voices that had been eroded through contact with psychiatric services.

Table 14

Example Quotes Demonstrating the Turning Point of the Example of Others

Example Quote	Participant
[…] she told me how her life is that, you know, hearing voices every day and, and she was ok and she was making friends and all her, her experience and so, I said 'wow, wow', you know 'she looks so composed'".	Felicity
I think really what it gave me more than anything was the affirmation that how I had understood myself and my experiences […] was validated now by another person […] Um, and that gave me a lot of desire to actually start exploring what my experiences meant and to start shaping the relationship with my voices.	Beth

Accessing Therapy. Em described how their therapist, who was not connected with the HVM, introduced a new way of thinking about voices and helped them to start building a relationship with their voices. Once their relationship with their voices improved, they started regaining function that had been lost through treatment (medication and electroconvulsive therapy), returned to university and eventually started a career in mental health (Table 15).

Table 15

Example Quotes Demonstrating the Turning Point of the Accessing Therapy

Example Quote	Participant
And, I ended up with a therapist who… was like… 'what if you just learned to get along with them? And, um, not have to get rid of them and not have to, you know, they're part of you, they brought you through a lot of hard times, they're there for a reason'	Em
Um, but once I started kind of building that internal world and that internal relationship, um, I don't know, um, I started reading again, um, and […] I realised, if I can read again, then that means that I can probably go back to school […] I ended up, you know, getting back into school […] and, ended up acing all of my classes again and just, um, um, things, you know, I had my brain back.	Em

HAVING OPPORTUNITIES TO SEE ONESELF DIFFERENTLY

Jeremy and Bea described how accessing and succeeding in training and education helped challenge the limited expectations for them held by MH professionals (Table 16). For Bea this occurred before encountering alternative narratives of voice hearing and was facilitated by a tutor who encouraged and motivated her to keep going when she was thinking of dropping out of college. She went on to access education and take up multiple voluntary positions. For Jeremy this occurred after encountering alternative narratives of voice hearing, and he went on to have an academic career.

Table 16

Example Quotes Demonstrating the Turning Point of Having Opportunities to See Oneself Differently

Example Quote	Participant
[…] but yeah it was the training course that really gave the, OK I could have a job and, you know, I could be able to do this if it’s flex-time and, you know, with reasonable adjustments and all of that sort of thing, um, yeah.	Jeremy
[…] I had a tutor there who just, um, really encouraged me […] and just that, you know, completely changed everything so that’s how I got a place um at [University] doing the degree I wanted to do so.	Bea

Turning Points Leading to a Change in Relationship with Voices. Nine narratives included turning points that led to a change in relationship with voices (Table 17) including changes in perception of voices and changes in the dynamic between VH and voices. Peter described being invited to attend a HVG, through which he developed a new understanding of his voices as coming “from me” as opposed to being externally generated. Five participants described how the books helped them make sense of their VHEs by introducing them to different understandings of voice hearing, including the idea that voices can be connected to life experiences. For Lottie this occurred years after reading the books when she started having flashbacks to trauma she had experienced as a child, and she was able to draw on the ideas she had first encountered through reading to make connections between her voices and memories of trauma. Six participants learned new ways of responding to voices from reading the books, leading to the development of more positive relationships. For Dominic this was facilitated by developing insight (from reading the books) into a medication side-effect he was experiencing, which resulted in his medication being tweaked, spending less time asleep as a result, and so having more time to voice dialogue (which he had also learnt about through reading). Em and Beth also learned strategies from accessing wider resources including reading academic papers and watching training videos and, as discussed above, Em developed new ways of responding to their voices through therapy.

Table 17

Example Quotes Demonstrating Turning Points Leading to a Change in Relationship with Voices

Example Quote	Participant
A Hearing Voices Group was started in my area, and I went to that. It made me think about voices, what they actually were.	Peter
I think that changed the way I saw my voices, because I thought, ‘oh I understand what it is they’re trying to tell me now, I understand where they’ve come from and what the echo is’	Lottie
[…] the books led to me to try voice dialoguing […] Something as complex as voice dialoguing would not have been possible for me without substantial guidance, that was found in the books […] Although there have been setbacks, […] the voices have become markedly more cooperative, less loud and less frequent.	Dominic
And, I ended up with a therapist who… was like… ‘what if you just learned to get along with them?’ […] so I ended up […] checking in with them, um, every night before I got to sleep I, you know, we kind of hold a community meeting,	Em

Turning Points Relating to Mental Health Treatment and Support. Changes in treatment acted as a turning point for three participants, after which they were able to start making more autonomous choices and construct more positive futures for themselves. Beth spoke about learning what to say in order to be discharged from hospital and facilitate a move “away from anyone who knew what had gone on, so that I could like, kind of start over”. From there she started “regaining a sort of sense of self” which included stopping all medication and attending university where she encountered alternative narratives of voice hearing. Jackie described a 23-year long journey of trying to persuade MH professionals to agree to her stopping medication, and eventually coming off all medication three years before her research interview. Following this, she described trying to find “a way back to you” from a “sick role”, a process supported by reading books associated with the HVM . Lottie described attending a Wellness Recovery Action Plan group at her local Mind centre after being told her community mental health team could not offer any further treatments. Attending this group helped her “commit to being alive in the long term” and start the process of “rebuilding things and becoming stable”. This occurred after encountering alternative narratives of voice hearing through reading.

Presence of Community Narratives

As discussed above, the HVM is broad and welcomes a diversity of perspectives, however it us underpinned by a set of values that could be said to constitute a community narrative (Corstens et al., 2014). This community narrative was present in all narratives apart from Anna’s (example quotes displayed in Table 18).

Table 18

Example Quotes Demonstrating the Presence of the HVM Community Narrative in Participant Stories

HVM Value	Participant	Example Quote
Voice hearing is believed to be a natural part of the human experience, and all people are believed to have the potential to hear voices. Voice hearing is therefore not understood to be an abnormal or pathological experience.	Beth	I think for me that’s, well all of these things are very much about trying to expand what we understand it is to be a human and, to validate the very very broad and vast experiences that we have.

Different beliefs and explanations for voice hearing are accepted and valued.	Lottie	As a voice hearer you kind of have a sort of agreement that reality is quite individual to people, and my reality might actually be different from yours […] I think as a voice hearer, and having kind of, read books like this, you're like, 'fine! If that's how the world is for you then fair enough'.
People are encouraged to develop their own understandings of their VHEs.	Beth	Um, and that gave me a lot of desire to actually start exploring what my experiences meant and to start shaping the relationship with my voices.
It is believed that most VHEs can be understood within the context of an individual's life experiences.	Jeremy	I guess another thing that I could see through this whole process, that, this illness model was just really, uh, deficient, um, and that, um, a kind of trauma model made much more sense to me that, actually these were, these experiences were kind of, projections of, um, past trauma
Working towards an acceptance of voices is viewed as being more helpful than attempting to suppress or eliminate them.	Dominic	Let me say though that the idea that one can obliterate voices with medication or really any method is flawed. What voice dialoguing allows you to do is not destroy the voices, *but to change your relationship with the voices*. [emphasis participant's own]

Depictions of the Books as Helpful Beyond Turning Points

Participant narratives also contained depictions of how accessing books had been helpful beyond the turning points discussed above. Jeremy, Bea and Jackie’s friend spoke about how the books were useful for sharing ideas with family members and helping them to gain insight into VHEs (Table 19). Jeremy’s wife read the books alongside him and supported him to implement strategies, and Bea’s sister read the book to her, which started a conversation about her VHEs for the first time. Jackie’s friend spoke from the perspective of a family member, talking about how she and her husband found reading the books helpful for understanding their son's VHEs.

Table 19

Example Quotes Describing How the Books Were Helpful for Sharing Ideas with Others

Example Quote	Participant
Yeah, um, so [my wife] read the books, yeah, yep, so it wasn’t just having an impact on me, it was having an impact on us as a family […]	Jeremy
[…] my sister’s been reading aloud the book, and for the first time, I mean this is 20 years ago this happened, she was like “what were your voices, who were they?”	Bea
[…] in our family it was almost more useful for us to read them to gain some sort of insight and to see, ‘oh that’s what somebody has’ because we’re trying to feel our way towards his experience and what he’s going through.	Jackie’s friend

Dominic, Em and Lottie spoke about using the books to share ideas with other VHs, with Dominic using them in a HVG he helped to set up, and Em and Lottie using them in peer work (Table 20).

Table 20

Example Quotes Describing the use of Books in a HVG and Peer Support Work

Example Quote	Participant
The group met up once a week for an hour or two and we slowly read through the 50 stories […]	Dominic
[…] when I've been doing peer work it's been nice to be able to recommend books to people or at least say 'these ideas are out there for you if you want them, when you're ready, there is a whole world of people that think differently about what you're experiencing and, and you could access that world if you wanted to'.	Lottie

Five participants spoke about how having the ideas written down (in the books and more broadly in academic literature) helped legitimise them – either corroborating ideas they had already been exploring or having a body of literature that could be shared with treatment providers and colleagues in mental health (Table 21).

Table 21

Example Quotes Describing How the Books Helped to Legitimise Alternative Narratives

Example Quote	Participant
I mean research gives you I think, or gave me the validation that in the research world people were saying “oh yeah trauma and voices like, that’s that, we know that, that’s a thing”	Beth
So it helps to have… this knowledge written down, like it made me feel more OK with, you know, sharing that with other people in my work too, because I realise that, OK, this isn’t just, this isn’t just me this is, this is something that has helped a lot of people, and this is something that has been researched.	Em
[…] when Romme and Escher’s next book came out, Living with Voices, um, that just seemed to underscore, um, everything, so further evidence of the model […] and, I’ve been trying to get professionals to see that, um, and to kind of buy into it ever since really.	Jeremy

Participants also spoke about the books being an emotional support (Table 22). Six participants found comfort in being able to relate to the stories, learning they were not alone with their experiences, and gaining hope for the future. Beth spoke about how reading first person narratives at times of distress helped her to sit with and move through her pain.

Table 22

Example Quotes Describing Reading Being a Source of Comfort/ Emotional Support

Example Quote	Participant
Um it was quite a revelation [….] made me feel kind of normal, um, I could recognise myself in some of the stories […]	Anna
And, I think it can be really helpful to see it… written very truthfully from another person, and like, I think that it also sort of contains it in a way where it's like […] I can step into this and acknowledge sort of the depth of what I'm feeling right now, without it being quite as overwhelming.	Beth

Both Lottie and Beth spoke about the benefits of having the ideas available in written form (Table 23). Lottie valued having control over how and when she could engage with the ideas she encountered through reading, in comparison to coming across the ideas in a group or on YouTube. Beth spoke about how having resources available (books, first person narratives, research and training videos) enabled her to make sense of her VHEs and develop ways of working with her voices independently when she would have found it difficult to do so in a group.

Table 23

Example Quotes Describing the Benefits of Having Access to the Ideas in Written Form

Example quote	Participant
I think the things is about a book is you can, you can open it and close it whenever you want to… and it's an experience between you and that book, and nobody mediates that, and nobody controls or witnesses it, and you can do what you like with that book […] whereas you probably couldn't do that in a support group, or even with YouTube […]	Lottie
I liked talking about how I figured things out and what I thought about things [in a HVG] but actually being like "I really have no idea what I think" at that point was still a bit too vulnerable, so a lot of it I did just sort of, thinking, like, sitting on my bed and thinking [laughs].	Beth

Barriers and Limitations of the Books

Some stories included depictions of less helpful aspects of the books, including barriers to engagement and limitations of the books (Table 24). Anna described how her voices "got in the way" when she tried to talk to her psychiatrist about '50 Stories of Recovery', which stopped her from finishing it. She also criticised the books' lengths and suggested having short summaries would make them more accessible. Beth spoke about how important it was for her to find stories written by people she could identify with (in terms of gender, nationality, and experiences of sexual trauma), which led to her talking about the difficulty in finding first person narratives of voice hearing written by people of colour. Finally, there was a sense that the books, and the HVM more widely, may be less helpful for some or sometimes a little too one sided. Jeremy found the ideas in the books extremely helpful for managing his VHEs but struggled to find support for other experiences that came with the voices (being able to see the voices, and tactile and somatic experiences). This led to him talking about the importance of a truly bio-psycho-social model, and how psychiatry, psychology and the HVM can all tend to neglect different aspects of this. Lottie had found the HVM approach to voice hearing extremely helpful but wondered about those for whom the approach hadn't been entirely successful, suggesting that the way the ideas are presented in the books might be a little one sided.

Table 24

Example Quotes Describing Barriers to Engaging With the Books and Limitations

Example Quote	Participant
I didn't, like what I do with all books I didn't finish reading it, as I said I think the voices got involved […]	Anna
[…] the book's just so, they're great but all of them are really long.	Anna
In terms of published narratives I think there certainly are fewer […] that are written by people of colour which is hugely problematic.	Beth
I'd not… met others who could see, you know their, their voices, or who had had these kind of, the more tactile sort of somatic experiences, um, uh, and so it was quite, it was hard to find… help and support for that side of things […]	Jeremy
[…] so the biomedical model you end up with bio-reductionism, I guess my concern with the hearing voices network is you end up with psycho-reductionism, um, and that you, you know, and both of those reductionisms you end up losing the, the social, the political, the economic, um, so you lose sight of all of that context as well, um, and that actually we need a model that is bio-psycho-social, that takes all of this, all of this together.	Jeremy
And maybe that is a, a shortcoming of the Accepting Voices book […] I think in the voice hearing movement sometimes there's that, kind of simplistic, if you can make meaning out of it and understand it and learn to, like, roll with it and be zen about it then it will be fine, but I'm aware that that's not how it works out for everybody.	Lottie

Discussion

The discussion will include a summary of findings outlined in relation to the research questions and existing empirical and theoretical literature, limitations of the current study, and implications for research and clinical practice.

What Stories Do Participants Tell About Reading Books Associated With the HVM and How Does This Reading Feature in Their Stories?

Literary analysis demonstrated that most participants told stories containing elements of protest, challenge and questioning towards MMHS. This is in keeping with many first-person accounts of voice hearing (Coleman, 1999; Romme et al., 2009) and fits with evidence suggesting stigma towards people living with a diagnosis of mental illness among healthcare professionals is prevalent (Henderson et al., 2014; Rao et al., 2009) and can negatively impact quality of care and expectations of recovery (Jones et al., 2008; Leonhardt et al., 2020; Mitchell et al., 2009). As discussed, the political nature of stories may have been influenced by the context in which they were told (as well as being a product of participant experiences), and indeed a number of participants stated or implied they were taking part in the project in order to advocate for change or contribute to the widening evidence base for the efficacy of the HVM approach. This may also reflect the fact that all participants had engaged with the HVM in various ways (at a minimum, all had read books associated with the HVM), which emphasises the importance of advocacy in order to promote the rights of VHs (Corstens et al., 2014).

Most participants told stories of hope and progress, describing improvements with VHEs, improvements with mental health, “escape” from harmful MMHS, and living lives that were fuller than they had been led to expect. The books were depicted as turning points (discussed further below), in which stigmatised dominant cultural narratives of voice hearing were challenged and a change in relationship between participants and their voices facilitated.

The exception to this was Anna, who described continuing to struggle with negative VHEs, and whose narrative suggested stigmatising dominant cultural narratives were continuing to inform her sense of self. The reason for this is likely to be multifaceted and a full understanding is beyond the scope of this research, however it is interesting to note a few key features of her story in relation to the books. Firstly, Anna described her voices acting as saboteurs, something that has been highlighted as a barrier to change in previous research examining therapeutic interventions for distressing VHEs (e.g. Hazell et al., 2017). This suggests having support to persevere with the books or to counteract voices' negative perceptions may be helpful, and Anna did feel encouraged to re-read 'Living with Voices' after her research interview. Secondly, Anna was the only participant who spoke about continuing to have spiritually informed beliefs about her voices. Although the HVM welcomes all understandings of voice hearing, 'Living with Voices' has a particular focus on understanding voices within the context of difficult life experiences, which she may have found less relevant. Anna actually highlighted this as a difficulty when talking about a course of cognitive behavioural therapy for psychosis she had recently completed, saying she did not understand how it could help with the presence of evil spirits.

Participants also depicted the books as being helpful beyond providing turning points. This included depictions of the books as resources that legitimised the HVM approach, that could be shared with others, as sources of emotional support, and as ways of gaining access to ideas in which one has control over engagement (in comparison to accessing information in a group or via YouTube). Stories also depicted limitations of the books and barriers to engagement, including a lack of first-person narratives written by people of colour, a lack of representation of experiences that can occur alongside voices (e.g. being able to see voices, and somatic experiences), the books presenting a one-sided picture of recovery, and the length of the books. This is in keeping with emerging research identifying both helpful and harmful outcomes of reading recovery narratives (Rennick-Eggelstone et al., 2019b).

Do dominant cultural narratives and community narratives feature in these stories and if so, how?

Stigmatising dominant cultural narratives of voice hearing featured in all narratives apart from that of Peter and tended to feature in stories as an obstacle that was eventually overcome (with the exception of Anna as discussed above). Participants described how stigmatised narratives were communicated through mental health services, religious communities and wider culture discourse, and were either internalised and incorporated into personal life stories or resisted but imposed by others. The impact of stigmatising narratives included reduced expectations for the future (held by the participant and/ or others) leading to reduced opportunities, reduced hope for recovery, a worsening of VHEs, and a disrupted capacity to make sense of experiences. Some participants also spoke about enforced treatment which resulted in a worsening of VHEs, and medication side-effects that were more debilitating than the voices. This is in keeping with Rappaport's (2000) proposal that the incorporation of stigmatised dominant cultural narratives into one's personal story can become a "self-fulfilling prophecy" - e.g. Jeremy, who stopped his MPhil and had little ambition for the future for four years after being told by MH professionals that he would not be able to have an academic career- as well as the impact of stigma towards VHs held by others as discussed above.

Community narratives based around the values underpinning the HVM were present in all narratives apart from Anna's, and featured in the ways participants understood themselves, their VHEs and reality in terms of an acceptance of difference. Most participants depicted this as a positive change compared with the beginning stages of their narrative, where their identity and beliefs about voices had been informed by stigmatised dominant cultural narratives, except for Jackie who described having always resisted her stigmatised identity. The incorporation of the community narrative into participants' personal stories suggests encountering the ideas of the HVM can be a powerful way of challenging stigmatising dominant cultural narratives of voice hearing, re-storying experiences and facilitating the construction of more empowered personal stories.

Are there any turning points depicted in participant's narratives and if so, what changes are described?

The following turning points were depicted in participant narratives: turning points leading to the modification of dominant cultural narratives (accessing books, accessing therapy, encountering other VHs with different perspectives about voice hearing, having opportunities to see oneself differently); turning points leading to a change in relationship with voices (attending HVGs, reading books, accessing therapy); and turning points related to mental health treatment and support (including "escape" from psychiatric services and access to a Wellness Recovery Action Plan group), which enabled participants to make new choices about their futures. Turning points in participant stories tended to focus on a shift from an identity defined by a "sickness role" towards one that emphasised agency, competence and wellbeing, in keeping with recovery literature (Davidson & Strauss, 1992; Mancini, 2007; Roe 2001).

Implications for Clinical Practice

Participant narratives suggest that encountering alternative narratives of voice hearing through reading books associated with the HVM can provide turning points that facilitate a change in relationship with voices and enable the construction of more positive and empowered personal identities, as well as providing other benefits including helping others to understand VHEs. This suggests facilitating access to such books may be beneficial for some VHs and the people in their lives. However, depictions of limitations of the books and the HVM suggest books should be recommended with some caution, for example it would be helpful to first explore with individuals what they may or may not find helpful, and provide ongoing support with exploring the ideas in the books and implementing strategies if desired. Participants also highlighted the importance of representation (in terms of diversity of narrators, experiences, and understanding of VHEs) therefore seeking out or supporting the creation and dissemination of more diverse stories would be helpful.

Participant stories highlighted the beneficial impact of engaging with the HVM approach to voices, contributing to the growing evidence base suggesting this can be a helpful approach to take when supporting people with distressing VHEs (Middleton, 2021). More broadly, participants highlighted the beneficial impact of changing relationships with voices, and pointed to the processes of normalising and reframing (e.g. coming to understand voices as being connected to life experiences rather than viewing them as being externally generated or the result of a biological illness) and approach (e.g. voice dialoguing) rather than avoidance or attempted suppression of voices as being important. This suggests these processes may be beneficially for alleviating distress when working clinically with VHs.

Finally, participant stories highlighted the negative impact of stigma towards VHs held by MH professionals (although this may have been unintended, the assumed poor prognosis without justification was stigmatising), demonstrating the importance of practitioners taking a person-centred approach; not making assumptions about people based on their experiences or diagnosis; and being open to listening to the views, goals and values of the people they are working with.

Limitations and Recommendations for Future Research

A key limitation of the study was a lack of diversity of participants. Firstly, all participants defined their identity as white, meaning the study did not explore the experience of VHs of colour who have engaged with the books. This is a particular shortcoming given the importance of representation and lack of narratives written by VHs of colour highlighted by Beth. Secondly, all participants spoke about having positive attitudes towards the books, therefore the study has not been able to capture and explore the experience of VHs who have had more negative experiences. One possible reason for this could be the recruitment strategy, whereby all participants were recruited through the HVM or service user/ psychiatric survivor movements whose values compliment that of the HVM, which may have led to the recruitment of a biased sample. Finally, the majority of participants (with the exception of Anna and Felicity) described at least starting undergraduate degrees, with five completing their undergraduate degrees, one completing a master's degree, and two going on to do PhDs. Although it is not necessary to have an academic background in order to access such books, it is interesting that an overwhelming majority of participants had such a high level of education. That the ideas are contained in literature may be a barrier to access for people who find engaging with books more challenging, something which this study has not been able to explore fully.

Following from this, it would be helpful to conduct similar research with a more diverse group of participants, including VHs of colour and VHs who have not been recruited through psychiatric survivor movements (e.g. recruiting through NHS services). A second important area for future research concerns the impact of stigma held by MH practitioners towards VHs, highlighted in participant stories as discussed above. Previous research has shown that education interventions to counteract myths and stereotypes associated with mental illness can be effective for reducing stigma (Reddyhough et al., 2021), which suggests a possible way of reducing stigma held by practitioners towards VHs could be to introduce them to literature associated with the HVM or first-person accounts of VHs. Further research would be beneficial to explore this further.

Final Conclusions

The current study aimed to explore VHs' experiences of reading books written by people associated with the HVM and to see how such reading featured in their personal stories. Participant stories suggested encountering a HVM community narrative about voice hearing (including through reading) can act as a turning point where stigmatising dominant cultural narratives of voice hearing are challenged, helping to open the way for more positive identities to be constructed. Further research is needed to explore the experience of reading books associated with the HVM for VHs of colour, as well as VHs who are not associated with service user or psychiatric survivor movements.

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Section C: Appendices

Appendix A: Excerpt taken from Hornstein et al. (2021, p. 7) demonstrating identification of findings relevant to the current review

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Appendix B: Critical Appraisal Skills Programme (CASP) for qualitative research

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Appendix C: Summary of Critical Appraisals Skills Programme (CASP) evaluation

Study	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Bogen-Johnston, deVisser, Strauss & Hayward (2019)	Yes	Yes	Yes: appropriate and justified.	Partially: Purposive sampling from Early Intervention in Psychosis Services was used therefore all participants had engaged with treatment which was not reflected in the research question; inclusion but not exclusion criteria are outlined; recruitment process is outlined in detail and no further discussion around recruitment is included.	Partially: setting not outlined; data collection method and process clear and justified; form of data is clear; analysis did not reach the point of saturation.	Yes: possible impact of personal biases and assumptions and how they were mitigated is discussed.	Yes: Ethical approval obtained; consideration given to ethical issues (e.g. consent).	Yes: in-depth description of analysis process; clear how themes were derived; sufficient data are presented however selection process is not described; different perspectives are included; indication that researcher has examined their own potential	Yes: Findings are explicit; evidence for researcher arguments is discussed and arguments against are discussed in terms of limitations of the study; more than one analysist and respondent validation is used; findings are discussed in relation to original research question.	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; clinical implications are outlined.

								biases, however the potential influence of this over selection of data for presentation is not discussed.		
Clements, Coniglio & Mackenzie (2019)	Yes	Yes	Yes: appropriate and justified.	Partially: Convenience sampling from one HVG was used which limits generalisability; inclusion but not exclusion criteria are outlined, and inclusion criteria are justified; recruitment process is outlined but there is no discussion around why people may or may not have chosen to take part.	Partially: setting not outlined; data collection method and process clear and justified; form of data is clear; saturation not discussed	Yes: possible impact of personal biases and assumptions and how they were mitigated is discussed.	Yes: Ethical approval obtained; consideration given and safeguards put in place re potential emotional impact of taking part in the study.	Yes: in-depth description of analysis process; clear how themes were derived; sufficient data are presented however selection process is not described; different perspectives are included; indication that researcher has examined their own potential biases, however the potential	Yes: Findings are explicit; evidence against arguments is discussed in terms of limitations of the study; more than one analysist is used however there is no mention of respondent validation; findings are discussed in relation to original research question.	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; clinical implications are outlined.

								influence of this over selection of data for presentation is not discussed.		
de Jager et al. (2016)	Yes	Yes	Yes: appropriate and justified.	Yes: recruitment strategy outlined; inclusion and exclusion criteria outlined and justified; discussion of why one potential participant chose not to take part included.	Yes: setting justified; data collection method and process clear and justified; form of data is clear; saturation not discussed.	Yes: possible impact of personal biases and assumptions and how this was mitigated is discussed.	Yes: Ethical approval obtained; consideration given and safeguards put in place re potential emotional impact of taking part in the study.	Yes: in-depth description of analysis process; sufficient data are presented, however selection process is not described; different perspectives are included however there is no mention of contradictory data; discussion of potential bias and influence during analysis but not selection of data for presentation.	Yes: Findings are explicit; evidence against is discussed in terms of limitations of the study; credibility is discussed (feedback from expert panel, respondent validation); findings are discussed in relation to original research question	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; clinical implications are discussed.
Dos Santos & Beavan (2015)	Yes	Yes	Yes: appropriate	Yes: recruitment strategy outlined;	Partially: Setting not	Yes: possible	Yes: ethical approval	Partially: adequate	Yes: findings are explicit;	Valuable: discussion of

	and justified.	inclusion and exclusion criteria outlined and justified; no discussion around recruitment (e.g. why participants may or may not have chosen to take part).	outlined or justified; data collection method and process clear and justified; form of data is clear; data saturation not discussed	impact of personal biases and assumptions and how this was mitigated is discussed.	obtained; consideration given as to informed consent, confidentiality and potential concerns regarding the impact of participating in the study on participants' relationships with the hearing voices movement.	description of analysis process (although not in depth); clear how themes were derived; sufficient data are presented, however selection process is not described; contradictory data are not discussed however it is implied that where there are differences of opinion they are included in the themes; discussion of potential bias and influence during analysis but not selection of data for presentation.	evidence against is discussed in terms of limitations of the study; more than one analyst is used but the study had been unable to obtain respondent validation; findings are discussed in relation to the original research question.	contribution the study makes to existing knowledge/ understanding; further areas for research are identified; clinical implications are discussed.

Goodliffe, Hayward, Brown, Turton & Dannahy (2010)	Yes	Yes	Yes: appropriate and justified.	Partially: recruitment strategy outlined; inclusion and exclusion criteria outlined but not justified; no discussion around recruitment (e.g. why participants may or may not have chosen to take part).	Yes: setting not justified but use of independent facilitator for focus groups is highlighted; data collection method and process clear and justified; form of data is clear; data saturation discussed.	Yes: possible impact of personal biases and assumptions and how this was mitigated is discussed.	Can’t tell: Insufficient information about potential ethical issues raised by study (e.g. potential distress); no mention of ethical approval.	Yes: in-depth description of analysis process; sufficient data are presented, however selection process is not described; different perspectives are included however there is no mention of contradictory data; discussion of potential bias and influence during analysis but not selection of data for presentation.	Partially: findings are explicit; evidence against is discussed in terms of limitations of the study, and unexpected findings are discussed; respondent validation is not used and it is not clear whether more than one analyst was used however the author highlights that criteria for quality grounded theory studies (including credibility) have been followed; findings are discussed in relation to the original research question.	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; clinical implications are discussed.
Hayward, Bogen-	Yes	Yes	Yes: appropriate	Can’t tell: recruitment strategy is not	Partially: setting outlined but	No: No discussion of	Partially: ethical approval	Yes: adequate description	Partially: findings are explicit;	Valuable: discussion of contribution the

Johnston, Deamer (2018)			and justified.	outlined; inclusion and exclusion criteria outlined but not justified; no discussion around recruitment (e.g. why participants may or may not have chosen to take part).	not justified, but use of independent interview is highlighted; data collection method and process clear and justified; form of data is clear; no discussion of data saturation.	relationship between researcher and participants.	obtained; no further consideration of ethical issues discussed.	of analysis process; clear how themes were derived sufficient data are presented, however selection process is not described; different perspectives are included however there is no mention of contradictory data; discussion of potential influence of researcher bias on analysis and selection of data for presentation.	evidence for findings is discussed but not evidence against; more than one analysist was used but not respondent validation; findings are discussed in relation to the original research question	study makes to existing knowledge/ understanding; further areas for research are identified; clinical implications are discussed.
Hayward & Fuller (2010)	Yes	Yes	Yes: appropriate and justified	Can’t tell: Participants were recruited from a therapy pilot- this is appropriate for the research but the paper does not outline how participants were	Partially: setting not discussed; data collection method and process clear and justified;	No: No discussion of relationship between researcher and participants.	Can’t tell: Insufficient information about potential ethical issues raised by study (e.g. potential distress); no	Yes: in-depth description of analysis process; clear how themes were derived; sufficient	Yes: findings are explicit; evidence for researcher arguments is discussed, evidence against is discussed in	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are

				recruited in the original study, or have any further discussion around recruitment.	form of data is clear; saturation not discussed.		mention of ethical approval.	data are presented and selection process is described; different perspectives are included and contradictory data discussed; no discussion of potential influence of researcher bias on analysis and selection of data for presentation.	terms of limitations; in depth discussion of credibility of findings although respondent validation was not used; findings are discussed in relation to original research question.	identified; clinical implications are discussed.
Hornstein, Branitsky & Robinson Putnam (2021)	Yes	Yes	Yes: appropriate and justified.	Can’t tell: The current paper presents further analysis from a data set that was originally analysed and discussed in a previous paper- this is appropriate for the research but the current paper does not outline the recruitment strategy. However it does	Partially: setting for follow up interviews not discussed; data collection method and process clear and justified; form of data is clear; saturation	No: No discussion of relationship between researcher and participants.	Partially: ethical approval obtained; no discussion of ethical issues.	Partially: adequate description of analysis process; clear how themes were derived; insufficient data presented to illustrate themes but sufficient data presented to illustrate	Yes: findings are explicit; evidence for and against researcher arguments is discussed including limitations of the study; more than one analysis was used but not respondent validation; findings are discussed in	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; implications are discussed.

				outline how 15 participants were chosen for participation in follow-up interviews.	not discussed.			case examples and selection process is described; different perspectives are included; no discussion of potential influence of researcher bias on analysis and selection of data for presentation.	relation to original research question.	
Hornstein, Robinson Putnam & Branitsky (2020)	Yes	Yes	Yes: appropriate and justified.	Yes: recruitment strategy outlined; inclusion and exclusion criteria outlined and justified; further discussion of recruitment included (e.g. ethical issues around recruitment, measures taken to make signing up for the study more accessible.	Partially: setting for follow up interviews not outlined but not discussed; data collection method and process clear and justified; form of data is clear; saturation not discussed.	No: No discussion of relationship between researchers and participants.	Yes: ethical approval obtained, further discussion of ethical issues included (e.g. confidentiality, consent, measures taken to ensure participants did not feel pressured to take part).	Partially: in depth description of analysis; insufficient data presented to illustrate model; model allows for different perspectives however contradictory data are not discussed; no discussion of potential	Yes: findings are explicit; evidence for researcher arguments is included, arguments against are included in terms of study limitations; more than one analysis was used but not respondent validation; findings are discussed in relation to original	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; implications are discussed including implications for other research teams.

								influence of researcher bias on analysis and selection of data for presentation.	research question.	
Milligan, McCarthy-Jones, Winthrop & Dudley (2012)	Yes	Yes	Yes: appropriate and justified.	Partially: recruitment strategy outlined but not justified, and recruiting all participants from an Early Intervention in Psychosis Service means some perspectives may not have been included (e.g. people whose voices are not distressing, people who are not seeking treatment etc.) ; inclusion and exclusion criteria outlined and justified; no further discussion around recruitment included. .	Yes: setting for interviews outlined and appropriate; data collection method and process clear and justified; form of data is clear; saturation is discussed but highlighted as a limitation-sample size was based on a pre-determined figure, rather than being informed by thematic saturation.	Yes: discussion of possible impact of personal biases and assumptions and how these were mitigated is included.	Yes: ethical approval obtained and paper demonstrates consideration of ethical issues (e.g. confidentiality, wellbeing of participants).	Yes: adequate description of analysis; clear how themes were derived; sufficient data presented to illustrate themes; different perspectives included; discussion of potential influence of researcher bias on analysis but not data selected for presentation.	Yes: findings are explicit; evidence for and against research arguments is included (including limitations); more than one analysist was used but not respondent validation; findings are discussed in relation to original research question.	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; broad clinical implications are discussed.

Moore, Williams, Bell & Thomas (2020)	Yes	Yes	Yes: appropriate and justified.	Partially: recruitment strategy outlined; inclusion and exclusion criteria outlined but not justified; some further discussion of recruitment included (why some potential participants had been unable to take part).	Partially: setting for interviews outlined but not justified; use of interviewer who had not been involved in the intervention highlighted; data collection method and process clear and justified; form of data is clear; saturation not discussed.	Yes: discussion of possible impact of personal biases and assumptions and how these were mitigated is included.	Yes: ethical approval obtained and paper demonstrates consideration of ethical issues (e.g. informed consent, participants received a voucher as a recognition for their time and contribution).	Partially: in depth description of analysis; clear how themes were derived; sufficient data presented to illustrate themes; different perspectives included and contradictory data discussed; discussion of potential influence of researcher bias on analysis but not data selected for presentation in included.	Yes: findings are explicit; evidence for and against research arguments is included (including limitations); more than one analysist was used but not respondent validation; findings are discussed in relation to original research question.	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; no further areas for research are identified however limitations of current study are highlighted, therefore areas for future research are implied; clinical implications are discussed including use of intervention with wider clinical populations.
Ng, Chun & Tsun (2012)	Yes	Yes	Yes: appropriate and justified.	Partially: recruitment strategy outlined and justified; inclusion and exclusion criteria outlined but not justified; no further discussion of	Yes: setting for interviews outlined but not discussed; data collection method and process clear and	No: No discussion of relationship between researchers and participants.	Yes: ethical approval obtained and paper demonstrates consideration of ethical issues (e.g. consent, consideration of participant	Partially: adequate description of analysis; sufficient data presented to illustrate themes; clear how themes were	Partially: findings are explicit; evidence against findings is discussed in terms of limitations, evidence for findings (in terms of	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are not explicitly identified but

				recruitment included.	justified; form of data clear; saturation not discussed.		comfort during interviews).	derived; different perspectives included; no discussion of potential influence of researcher bias on analysis and data selected for presentation in included.	discussing findings in the context of theories and research) is not presented; it is not clear whether more than one analysist was used and respondent validation is not mentioned; findings are discussed in relation to original research question.	can be inferred from the discussion; broad implications are discussed.
Payne, Allen & Lavender (2017)	Yes	Yes	Yes: appropriate and justified.	Partially: sampling strategy is outlined but it is not clear how participants were recruited; inclusion and exclusion criteria outlined and justified; no further discussion of recruitment included.	Yes: setting for interviews outlined but not discussed; data collection method and process clear and justified; form of data clear; saturation not discussed.	No: No discussion of relationship between researchers and participants.	Partially: ethical approval obtained; no further discussion of ethical considerations.	Partially: adequate description of analysis; sufficient data presented to illustrate themes; clear how themes were derived; different perspectives included; no discussion of potential influence of researcher	Partially: findings are explicit; evidence for researcher findings is discussed, evidence against is discussed in terms of limitations; more than one analyst and respondent validation were used; findings are discussed in relation to	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; further areas for research are identified; clinical implications are discussed.

								bias on analysis and data selected for presentation in included.	original research question.	
Racz, Kalo, Kassai, Kiss & Pinter (2017)	Yes	Yes	Yes: appropriate and justified.	Partially: recruitment strategy outlined; inclusion and exclusion criteria outlined but not justified; no further discussion of recruitment included.	Partially: setting for interviews outlined but not discussed; data collection method and process clear and justified; form of data clear; saturation not discussed.	No: No discussion of relationship between researchers and participants.	Partially: ethical approval obtained; no further discussion of ethical considerations.	Partially: in depth description of analysis; sufficient data presented to illustrate themes; clear how themes were derived; different perspectives and experiences included; no discussion of potential influence of researcher bias on analysis and data selected for presentation in included.	Partially: findings are explicit; evidence for researcher findings is discussed, evidence against is discussed in terms of limitations; more than one analyst used but not respondent validation; findings are discussed in relation to original research question.	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; no further areas for research are identified however limitations of current study are highlighted, therefore areas for future research are implied; clinical implications are discussed.
Ruddle (2017)	Yes	Yes	Yes: appropriate and justified.	Yes: recruitment strategy outlined; inclusion and exclusion criteria outlined and justified; no	Partially: setting for interviews not outlined or discussed;	Yes: discussion of possible impact of personal biases and	Yes: ethical approval obtained; consideration of ethical issues	Partially: in depth description of analysis; sufficient data	Yes: findings are explicit; evidence for researcher findings is discussed and	Valuable: discussion of contribution the study makes to existing knowledge/

				further discussion of recruitment included.	data collection method and process clear and justified; form of data clear; saturation not discussed.	assumptions and how these were mitigated is included.	demonstrated (e.g. confidentiality and consent).	presented to illustrate themes; clear how themes were derived; different perspectives and experiences included; discussion of potential influence of researcher bias on analysis but not data selected for presentation in included.	discussion of limitations is included; more than one analyst is used but not respondent validation; findings are discussed in relation to original research question.	understanding; clinical and research implications are discussed.
Schnackenberg, Fleming & Martin (2018)	Yes	Yes	Yes: appropriate and justified.	Yes: recruitment strategy outlined; inclusion and exclusion criteria outlined but not justified; some further discussion of recruitment included.	Yes: setting for interviews outlined and justified; data collection method and process clear and justified; form of data clear; saturation discussed.	Partially: impact of potential researcher bias discussed in limitations, but was not included in discussion of research design and methods.	Yes: ethical approval obtained; consideration of ethical issues demonstrated (e.g. written consent, potential for participant distress).	Partially: in depth description of analysis; sufficient data presented to illustrate themes; clear how themes were derived; different perspectives and experiences included; discussion of	Yes: findings are explicit; evidence for researcher findings is discussed and discussion of limitations is included; it is not clear whether more than one analyst is used; respondent validation was not used however interviews	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; clinical and research implications are discussed.

								potential influence of researcher bias on analysis but not data selected for presentation is included in discussion of limitations.	provided a summary at the end of each interview and participant were given an opportunity to correct this summary.	
Steel et al. (2020)	Yes	Yes	Yes: appropriate and justified.	Partially: recruitment strategy outlined; inclusion and exclusion criteria outlined but not justified; further discussion of recruitment included (e.g. discussion of why some participants withdrew).	Partially: setting for interviews not discussed; data collection method and process clear and justified; form of data clear; saturation not discussed.	No: No discussion of relationship between researchers and participants.	Partially: ethical approval obtained; no further consideration of ethical issues discussed.	Partially: adequate description of how data are presented; some questions are illustrated with adequate data, others are not; different perspectives and experiences included; no discussion of potential influence of researcher bias on analysis and data selected for presentation.	Yes: findings are explicit; evidence for and against researcher findings is discussed and discussion of limitations is included; more than one analyst is used but not respondent validation.	Valuable: discussion of contribution the study makes to existing knowledge/ understanding; clinical implications are discussed; research implications are implied through discussion of limitations.

Appendix D: Mixed Methods Appraisal Tool (MMAT): Mixed Methods Checklist

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Appendix E: Summary of Mixed Methods Appraisal Tool (MMAT): Mixed Methods Checklist evaluation

Papers	Is there adequate rationale for using a mixed methods design to address the research question?	Are the different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Hazell et al. (2020)	Yes: use of mixed methods design is appropriate, rational is clearly explained.	Partially: different components are integrated during the discussion to answer the research question, however limited information is given about the quantitative component (i.e. not all changes are listed) therefore it is not possible to tell whether all information has been integrated and discussed.	Yes: meta-inference adequately answers research question.	No: one inconsistency (negative change highlighted in quantitative component) is not discussed.	Qualitative: 1.1: Yes 1.2: Yes 1.3: Yes 1.4: Yes 1.5: Yes Quantitative: 4.1: Yes 4.2: Partially- clear description of sample; no discussion of why potential participants may not have participated or recruitment strategy. Sample is limited in terms of ethnicity (all participants are White British or White Other). 4.3: Yes 4.4: No- not all participants of the original RCT took part in exit interviews. This

					limitation is highlighted and discussed in the paper. 4.5: Yes
Mourgues et al. (2020)	Partially: use of mixed measures design is appropriate however the rationale is not clearly explained.	Yes: Different components are well integrated in results and discussion sections.	Yes: meta-inference adequately answers research question.	Yes	Qualitative: 1.1: Yes 1.2: Yes 1.3: Yes 1.4: Yes 1.5: Yes Quantitative: 3.1: No- researchers recruited ‘treatment seeking’ and ‘non treatment seeking’ voice hearers from relatively narrow groups (members of HVGs and psychic mediums respectively) meaning some perspectives may not have been included (e.g. people receiving treatment from mental health services, people with religious understandings of voices). 3.2: Yes 3:3: Yes 3:4: Yes 3.5: Yes
Rosen et al. (2015)	Yes: use of mixed methods design is appropriate, rational explained.	Yes: Different components are well integrated in results and discussion sections.	Yes: meta-inference adequately answers research question.	Yes	Qualitative: 1.1: Yes 1.2: Yes 1.3: Yes

1.4: Yes
1.5: Yes

Quantitative:

4.1: Not possible to tell as limited information is given about sampling strategy.
4.2: No- All participants were receiving psychiatric support and taking medication- this means participants not seeking treatment (e.g. people with positive experiences of voice hearing) were not included in the study, which is not reflected in the research question.
4.3: Yes
4.4: Not possible to tell- no discussion of eligible participants who chose not to take part.
3.5: Yes

Appendix F: Mixed Methods Appraisal Tool (MMAT): Qualitative Studies Checklist

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Appendix G: Summary of Mixed Methods Appraisal Tool (MMAT): Qualitative Checklist evaluation

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Appendix H: Themes, codes, and example quotes from papers

Superordinate Themes	**Subthemes**	**Codes**	**Example Quotes**
Coming to see voices as less threatening	Origin of voices	Change in understanding of origin	By fostering an environment of mutual curiosity and exploration, the group enabled her to identify the starting point of her voices: childhood trauma. Understanding their origin and protective function has served as a catalyst for Tina to change her relationship with the voices. She has learned to appreciate their adaptive features while also setting appropriate boundaries; the voice that was once hostile and threatening now provides valuable insight into her emotional world." (Hornstein et al., 2021, p. 7)
		Shift from external to internal understandings	Steven's voices and visions started in childhood, but only became aggressive and frightening when he was a teenager… He was terrified of being "taken over by spirits and made to do bad things against my will" and was diagnosed with chronic paranoid schizophrenia. After 30 years of medication, Steven, now 58, came to the HVG in search of new ways of making sense of his experiences, especially those linked to his spiritual upbringing... He now considers his voices to be part of him and strives to treat them with compassion. (Hornstein et al., 2021, p.6).
		Understanding voices within the	This co-occurrence cemented for the client the association between her voice and the childhood fears around her mum's illness. Keeping this link in mind enabled the client to find the courage and wisdom to bring a

		context of life experiences	compassionate response. Instead of resisting, ignoring, avoiding the voice (her "old strategies"), she instead started to "soothe" the voice, saying "thank you for warning me about the thing I am most afraid of. I understand that you're holding a space for my fear…" (Heriot-Maitland & Levey, 2021, p. 1830).
		Shift in understanding enabling a sense of agency.	For some, making connections facilitated a sense of being able to affect change themselves, as it provided a situation which could more actively be affected (resolution of trauma) instead of a more passive way of making sense (biological illness). Ben's MHP: *…he..no longer feels so …threatened. Instead, it is clear to him now, why the voices are there. …they do now have a cause* [related to abuse]. *…he knows …it is not his fault. And in this way he is much more self-confident and more courageous…* (Schnackenberg et al. 2018, p. 1003)
	Perception of voices	Change in understanding of meaning/ purpose/ intention of voices	Quite a lot got achieved, realised that feelings about things I hadn't been able to cope with in the past had been projected onto the voices, and that the voice was looking after them. Realised that the voice wasn't against me, but was trying to protect me and helping me cope with feelings. (Steel et al., 2020, p. 111)
		Recognising voices can be helpful	Participants described developing mutually beneficial relationships with voices founded on trust and respect, as participants discovered how voices could provide help and fulfil their needs. For example, Cooper explained

			"if I didn't hear the voices, I probably wouldn't have kept my job". Useful encouragements led to Cooper interacting with the voices for other purposes, such as asking for advice: Sometimes I can't always do things straight off the top of my head and I will refer to the voices to see if they have any better ideas. (Clements et al., 2019, p. 201).
	Change in beliefs about omnipotence of voices	Challenging voices	Using techniques to challenge the voices developed group members' feelings of being able to control their voices […] (Goodliffe et al., 2010, p. 455).
		Examining evidence	"Erm, but eh I think I've overall found it easier to not erm totally listen to them because, erm I had some evidence that they're not entirely true. That the things they are saying are not entirely true." (Hazell et al., 2020, p. 7).
		Learning from past experiences	However, after reflecting upon their past experiences, the participants believed that it was something they would be able to overcome ("I feel stronger than the voice now. So I feel like I can tell him to like go away. Like 'leave me alone'!"- Eva). (Borgen-Johnston et al., 2019, p. 314).
		Testing voices	The belief about compliance was tested rigorously. The method used was that a command be chosen and D repeat it up to 100 times and wait to see if disaster ensued. This was done sequentially with commands demanding enormous increases in the cost of bus fares, the cost of mil, the inflation rate, the interest rates, and the level of personal taxation. In all these the beliefs were refuted. (Chadwick & Birchwood, 1994, p 198).

		Change in beliefs about veracity of voices	Luke reported: ‘They [the voices] were saying that there was going to be three cars driving in the car park and it’s going to be all the kids from [a rough area near to his home] then you get out the car, and they’re going to massacre everyone that’s here. But it never happened, I was just sitting there waiting for it.’ Luke went on to describe how because of the unreliability of his voices, his perception of them changed from a source of truth and facts, to a source that tells good stories or lies. (Milligan et al., 2012, p. 113).
		Change in beliefs about power/ influence of voices	The first challenge of power was for ‘the man’ to exert such power over the psychologist by making the psychologist experience similar sensations that Alan believed would be clearly noticeable (i.e. the psychologist would not be able to pretend that he had not experienced such sensations). Once it was evident that such power was not influenced, Allen challenged ‘the man’ to punish him in the session; no such punishment was evidenced. From a belief of power at 100% conviction in initial sessions, the voice power was reduced to 0% conviction in these final sessions. (Barrowcliff, 2008, p. 241)
		Challenging the power of voices through	During the ATT practice he noticed that he now masters his attention to a level where he can easily switch from the voices to other sounds. As he stated, *“I’m in control, not the voices.”* (Valmaggia et al., 2007, p. 131).

		implementing new strategies	
		Examining evidence enabling VH to disregard voices	I am just kind of thinking, ‘where is the evidence?’ In terms of what they are saying […] that clarity isn’t, doesn’t happen every time I hear the voices. But knowing that it can is actually quite empowering. Knowing that I do, I can kind of not control them but control my investment in them, there is a difference. (Moore et al., 2020, p. 6).
Developing new ways of responding to voices	Attending to voices	Acknowledging voices	Knowing how to listen, interact and acknowledge voices allowed participants to mediate their own needs with those of their voices and assert boundaries: If a voice comes to me at an inopportune moment… I’ll say “I acknowledge you, I understand you’re there, please give me two hours and we’ll speak again in two hours’ time”. (Clements et al., 2019, p. 201).
		Listening to voices	[…] instead of ignoring it, or brushing it off, or changing my immediate focus to make it go away, I embraced it and said “Alright. Let’s stick around and let’s see’. You know, basically “what the hell are you trying to tell me? What do you want?”. And the more you open yourself up, the more it happens.” (Mourgues et al., 2020, p. 6).
		Learning from voices	On a couple of occasions, the voices have given me knowledge concerning what I’ve been experiencing. When listening, with open-minded compassion, I can occasionally benefit by gaining more understanding about the voices. (Heriot-Maitland & Levey, 2021, p. 1833).

		Voices wanting to be heard.	"I've just learned they didn't really want anything. They just wanted to be heard." (Rosen et al., 2015, p. 6).
	Quality of interaction	Compassion towards voices	Previously, my voices would've been angry, threatening, and controlling, with brittle and nasty tones. However, I applied compassionate well-being for myself by grounding myself, then self-soothing, and finally using imaging. I also soothed the voice. During this practice from therapy, I felt a little calmer and also experienced strong compassion towards myself, the voices, and others. The voices response was to soften their tone and then become quiet. (Heriot-Maitland & Levey, 2021, p. 1832).
		Being respectful towards voices	And P16 spoke of the value of giving the voice more of an identity, and how this aided the process of being respectful when responding assertively: … you give it a single entity when you converse but when [therapist] was doing it she gave it a face as well. So it was much easier to you know "well hang on! I've got to be gentle here. I've gotta be realistic" [I: yeah] and erm, you answer the best I can [I: okay] without being con-confrontational [I: Yeah!] Erm, but being certain of my place but not in a point where I'm aggressive. (Hayward, Bogen-Johnston, Deamer, 2018, pp. 135-136).
	Negotiating and setting boundaries	Negotiating	With the group's encouragement, they may try out new ways of responding to voices or learn to negotiate with them, rather than feeling powerless to affect their intensity, tone, frequency or content. (Hornstein, Robinson Putnam & Branitsky, 2020, p. 6).

		Setting boundaries	I also set boundaries with the voice so that the voice identities only giggled to themselves instead of speaking to me… I consider my active reaction to the voices was the most effective way to deal with them. (Ng, Chun & Tsun, 2012 p. 5).
		Developing mutually beneficial relationships	Participants described developing mutually beneficial relationships with voices founded on trust and respect, as participants discovered how voices could provide help and fulfil their needs. (Clements et al., 2020, p. 201).
Becoming more accepting and less fearful of voices	Developing acceptance	Shift from wanting to eradicate voices to learning to live with voices	With the therapy I've come to the conclusion that I might not be able to get rid of him. But I can control him, and I don't have to be depressed by him (Hayward & Fuller, 2010, p. 369).
		Acceptance of voices	All participants identified needing to accept their voices to begin to get along with them. Some participants accepted that the voices weren't "going away", making it necessary to "learn to relate to them a bit better" (Clements et al. 2020, p. 201).
	Change in emotional response	Change in attitude towards voices	Other participants described ways in which they had learned to have some control over their voices, either by developing a different attitude or behavioural response towards the comments of voices: "But yeah, just seems the voice couldn't deal with it, he had no power over me anymore. It's like telling him that I actually don't care about his stupid jibes, and eh telling me he's gonna make me fatter and everything, it's kind of made me

			enjoy eating a bit more really. Just changing my way of thinking about it." (p3). (Hazell et al., 2020, p. 6).
		Reduction in anxiety about voices	If the method helps the person to challenge the voices and begin communicating, the anxiety often declines, and the relationship between the self and the voice will change. (Racz et al, 2017, p. 310).
		Reduction in distress	At her post-therapy assessment, Sally gave feedback on her experience of CBRT. She reported finding it helpful to discuss her voices with someone who understood her experiences. She reported continuing to engage with her voices and finding them less intrusive and distressing." (Paulik et al., 2013, p. 629).
		Knowing it's possible for voices to stop reduces distress	Reasons given for a reduction in voice-related distress were… knowing that one can get rid of voices (P3). (Steel et al., 2020, p. 110).
		Reduction in fear	T3 referred to a *'powerful week'* where the genogram was used to consider the links between a past abusive relationship and the current voice relationship. C6 agreed that this connection *'became clearer through the therapy'* and described the impact on her relationship with the voice: *'I'm much less afraid than I was before. I have more understanding of what's occurring and hearing that gives me more power against him [the voice]'.* (Hayward & Fuller, 2010, p. 367).

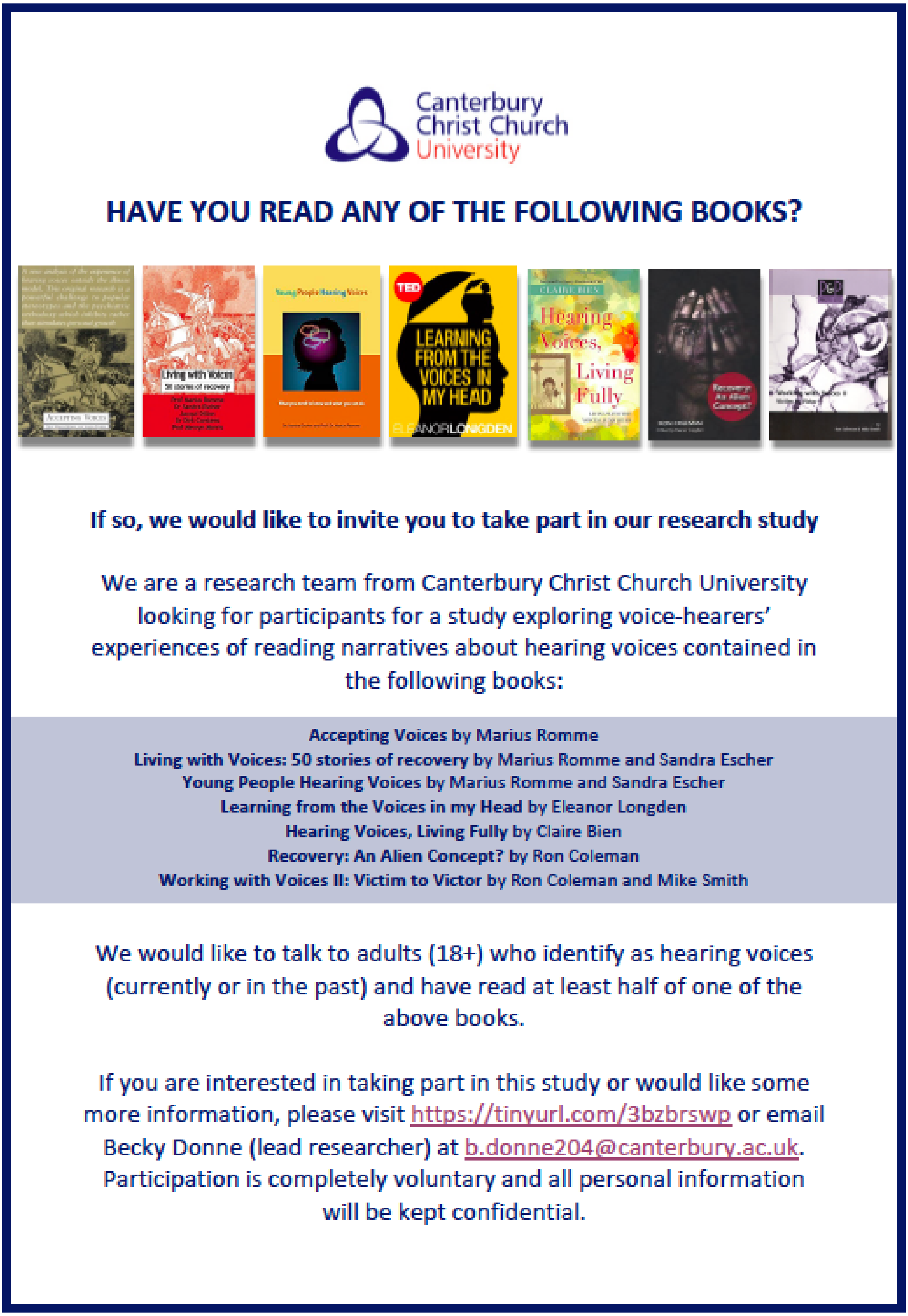
		Normalising voices reduces distress	Discovering common experiences with others had a powerful normalising effect on the members of the group. Although several participants said that they had been informed that there were other people living in the community who had similar experiences, they had not believed this until they actually met the other group members. Hearing the experiences of others was perceived as reducing group members' sense of fear and as influential in reducing the behaviours that they engaged in as a reaction to the voices. (Goodliffe, Hayward, Brown, Turton & Dannahy, 2010, p. 453).
Beyond voices		Managing anxiety	Across typologies, participants emphasized the importance of learning about how to nourish general mental health. For example many participants commented that the voices amplified existing anxieties or vulnerabilities: "The voices always played on what was your vulnerable point". Learning how to manage anxiety meant that when voices attempted to amplify concerns they had less traction or believability and participants were less distracted by their comments" (de Jager et al., 2016, p. 1416)
		Improved self-image	For years I had felt that I wasn't really a human being… I became human in relation to the other members in the group, and then carried that into my relationships with my voices and with other people in my life. (Hornstein et al. 2021, p. 7).

		Developing self-acceptance	I really adored the fourth session where it all switched for me. I was able to gain power over my voices and accept myself as I am. (Dellazizzo et al., 2018, p. 217).
Facilitators	Engagement in Therapy	Therapy	AT helped me explore more confident ways to relate with The Devil. Since I was no longer overwhelmed by my paralyzing fear, I was able to stand up to my menacing voices. Instead of avoiding contact and suffering from The Devil's intrusions, I learned how to confront him. As this occurred, I began to perceive The Devil as less powerful (Dellazizzo et al., 2018, p. 217).
		Bringing the voice into the room	At his 3-month follow-up, self-depreciation was absent. This can be attributed to the planned change in the avatar's relationship to the patient, altering from continual denigration to a pleasant supportive role.... As the avatar ceased her punitive verbal attacks and expressed admiration of his good qualities, which he had never before experienced, the persecutory voices became much less frequent and rarely critical". (Leff et al., 2014, p. 170).
	Influence of others	Drawing on experiences of relating to others	The genogram was also used to explore when and how clients had achieved more positive relating within other relationships (T3). Both these diagrams facilitated the process of identifying ideas for change, and the possible impact of change, in the relationship with the voices (Hayward & Fuller, 2010, p. 368)

		Using others to challenge voices	A list of qualities provided by my close friends was included into the dialogue. These qualities served as support to prove my worth to The Devil and to myself. For the first time, I was able to confront The Devil and say “no”. I realised that my friends did not see me as bad as The Devil described me to be. I then began to see through The Devil’s manipulations and lies as I valued my friend’s thoughts more. (Dellazizzo et al., 2018, p. 216).
		Others help to normalise voices	That’s one of the main things that the group has helped me with, not fearing, I wasn’t exactly scared of the voices, but not fearing the conditions, […] since going to the group and reading all the books and learning all the theory […] I’m not at all scared that I hear voices anymore, and they don’t worry me in the slightest (Dos Santos & Beavan, 2015, p. 33).
		Others inspire acceptance of VHEs	Sue inspired Catherine to start accepting the voices, rather than battling: “Well I can see that by accepting, she was able to find herself again and to have a job and be part of her family” (Ruddle, 2017, p. 33).
		Prioritising opinion of others over voices	By listening to other group members and making their opinions a priority, authority was shifted away from the voices. Therefore, for most group members, actually being in the group environment had a beneficial effect of decreasing the power of the voices. (Goodliffe, et al., 2010, p. 455).

		Learning strategies from others	I really started getting some real traction in managing the voices… [the group] taught me how to interact with my voices, how to make time for them to come at a different time (Paper 4: Clements et al., 2020, p. 203).
		Group as a place to learn new ways of relating to oneself and others.	The group becomes a laboratory for exploring new and more authentic forms of relating to oneself and to other people. As a result, the voice-hearing experiences itself undergoes change. Voices may stop or become more contextualised, or quieter, or clearer, or a person's relationships with them may start to shift (e.g. become less oppositional or less controlling; empathy, rather than fear, may emerge more strongly). (Hornstein et al., 2020, p. 6).

Appendix I: Research Advert



Canterbury
Christ Church
University

HAVE YOU READ ANY OF THE FOLLOWING BOOKS?

If so, we would like to invite you to take part in our research study

We are a research team from Canterbury Christ Church University looking for participants for a study exploring voice-hearers' experiences of reading narratives about hearing voices contained in the following books:

Accepting Voices by Marius Romme
Living with Voices: 50 stories of recovery by Marius Romme and Sandra Escher
Young People Hearing Voices by Marius Romme and Sandra Escher
Learning from the Voices in my Head by Eleanor Longden
Hearing Voices, Living Fully by Claire Bien
Recovery: An Alien Concept? by Ron Coleman
Working with Voices II: Victim to Victor by Ron Coleman and Mike Smith

We would like to talk to adults (18+) who identify as hearing voices (currently or in the past) and have read at least half of one of the above books.

If you are interested in taking part in this study or would like some more information, please visit https://tinyurl.com/3bzbrswp or email Becky Donne (lead researcher) at b.donne204@canterbury.ac.uk. Participation is completely voluntary and all personal information will be kept confidential.

Appendix J: Ethical Approval

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Appendix K: End of Study Report

Monday 11th July 2022

Dear Salomon's Ethics Committee

Re Project: How Voice Hearers Change Their Relationships with Their Voices and the Role of Encountering Books Aligned with the Hearing Voices Movement.

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

The study's abstract is as follows:

Introduction: Dominant cultural narratives portray voice hearers (VHs) as having a disabling illness from which they are unlikely to recover, and as violent and criminal. The incorporation of such views into VH life stories can lead to negative voice hearing experiences and reduced hope for the future. This study explored the experiences of VHs who have encountered alternative narratives of voice hearing through reading books associated with the Hearing Voices Movement.

Methods: Narrative interviews were used to elicit stories from ten VH participants. Narratives were analysed using literary and experience centred and culturally-oriented narrative analysis.

Results: Stigmatising dominant narratives of voice hearing were present in nine narratives and an alternative community narrative, associated with the HVM, was present in nine participant narratives. Turning points were identified.

Discussion: Encountering alternative narratives about voice hearing, including through reading, can act as a turning point where stigmatising narratives of voice hearing are challenged and more positive identities constructed.

I plan to share of summary of findings to all participants who requested ongoing communication about the study via email. We also hope to publish the findings in the peer reviewed journal 'Psychosis'.

Kind regards,
Becky

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Appendix L: Information Sheet

Participant Information Sheet

Research Title: Exploring voice hearers' experiences of reading books associated with the Hearing Voices Movement

We would like to invite you to take part in our research study. Before you decide, it is important that you understand the purpose of our study and what you would be doing if you choose to take part. We would like you to read the following information. It is important that you read this sheet carefully and note any questions you have, if any. It may be helpful to talk to others who know you as this might help you decide whether it is a good idea to take part. Please ask us if there is anything that is unclear or if you have any further questions.

My name is Becky Donne and I am a Trainee Clinical Psychologist at Salomon's Institute for Applied Psychology, Canterbury Christ Church University. This research project forms part of my doctoral thesis and is supervised by Dr Sue Holttum (Senior Lecturer in Research) and Dr Anna Turek (Highly Specialised Counselling Psychologist).

Part 1 tells you the purpose of this study and what will happen if you choose to take part.

Part 2 gives you more detailed information about the study. Please ask us if anything is unclear or if you have any further questions.

Part 1

What is the purpose of the study?

We are interested in talking to people who hear voices (currently or in the past) about their experiences of reading narratives about voice hearing contained in certain books. This will help us to understand the possible impact reading about these narratives may have for people who hear voices, which may help to inform services and treatment.

Who can take part?

We are inviting people to take part if they identify as hearing voices (currently or in the past), are over 18 and have read at least half of any of the following books:

- Living With Voices: 50 Stories of Recovery by Romme, Escher, Dillon, Corstens and Morris.
- Accepting Voices by Romme and Escher
- Young People Hearing Voices by Escher and Romme
- Learning from the Voices in my Head by Eleanor Longden
- Hearing Voices, Living Fully by Claire Bien

- Recovery: An Alien Concept? by Ron Coleman
- Working with Voices II: Victim to Victor by Ron Coleman and Mike Smith

Do I have to take part?

You do not have to take part. It is important that you read this information and consider whether you wish to share your story and experience about reading one or more of the above books. This is your decision. You may wish to talk with people who know you before deciding. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

If you decide that you would like to share your story and experiences with me (Becky), we will first ask you to complete a short online questionnaire. This will include questions about demographic information (e.g. age and gender), your experience of hearing voices, and whether you have ever accessed treatment for mental health. As part of this you will also be asked if you consent to take part in the study. Following this, we will arrange a time that suits you to talk. We will either meet via an online video platform or telephone call, or at a place that is convenient to you where we can follow physical distancing guidelines if this is feasible at the time. We will go through the research information again and you can ask me questions.

What will I be asked to do?

I will ask you to tell your story, and especially, how one or more of the books feature in your story, in whatever way that might be. I will ask a few questions about your story as you are telling it. The interview will take as long as you need to tell your story. This can take up to an hour, and occasionally may take longer than this. You can take breaks whenever you need to and can end the interview at any time.

Once I have finished interviewing all participants, I will be going through all of the interviews to develop an understanding of what people have said. While I am doing this it would be helpful if I could contact some participants to check that my understanding of their story is correct. If you choose to take part in the study, I will ask you at the interview whether you would be interested in doing this. You do not have to say yes to this, and you can still take part in the interview if you don’t want to be contacted afterwards.

If you are interested in hearing about what I have found out, we can speak on the phone at a later time. I can also send you a summary to read.

Will I be paid?

We will reimburse your time with a £10 voucher that can be used in a wide range of shops.

Is there anyone who should NOT take part?

Unfortunately, we cannot invite you to participate if you cannot take part in an interview or give informed consent in English, or if you have not read at least half of one of the books listed above. If you are currently acutely distressed or think you may find it particularly distressing to talk about this topic, we would advise that this may not be the best time to take part in this study.

What are the possible disadvantages and risks of taking part?

It is possible that discussing your experiences of reading these books may raise uncomfortable emotions or remind you of a difficult time. It is important that you consider this before agreeing to take part. The interview will go at your pace and you can ask for a pause or to stop entirely at any time without having to give a reason. The interviewer (Becky) will also ask to pause the interview if it appears to be causing distress for you. You do not have to answer any questions or speak about any experience if you do not want to. There will be time for you to ask questions about the research both before and after the interview. We hope that you would find the interview enjoyable, but because it might touch on areas of distress, we will ask you for a contact number of someone who supports you and will ask you if we can contact this person on your behalf should it be necessary.

What are the possible benefits of taking part?

We cannot promise that the study will help you but the information we get from this study may help us to improve our understanding of the impact reading recovery particular narratives about hearing voices has for other people who hear voices. This may help us to improve treatments.

What do I do now?

If you have any questions or would like to take part in the study, you can contact me via email on b.donne204@canterbury.ac.uk. I will contact you to answer any questions you might have and to ask whether you would like to take part. If you would like, I can also speak with someone who knows you well to answer any questions. If you say yes, I will send you a link to the online questionnaire. If you say no I will not contact you again.

Part 2

What will happen to my story?

I (Becky) will take an audio recording of your story whilst you tell it. This recording will then be kept on an encrypted and password protected memory stick. Any information from your interview will be anonymised before it is used in the research. We will follow ethical guidelines and keep ALL your information securely by separating your contact details from your interview.

The audio-recording will be stored after the study has finished on a password protected CD along with an anonymous written record of the interview. This will be kept in a locked filing cabinet in a specified office in Canterbury Christ Church University. This will be kept for 10 years and then destroyed.

Regulatory authorities from Canterbury Christ Church University may audit the demographic information we have about you (e.g. age, gender etc.). This information will be kept separate from your name and the other information from your interview (your story) to protect your anonymity.

Confidentiality

Your story and information will remain anonymous and confidential unless you tell me something during your interview that suggests that you or another person is currently at risk of serious harm. I would need to pass this on to my supervisor. I would try to discuss this with you first if possible.

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

If you decide to withdraw from any part of the study, we will ask you if we can still use your anonymous interview material. If you say no, we will delete all records of the data you have given us. It is your choice to take part or not to take part. We would ask that if you want to withdraw your data, you let us know within two weeks after your interview.

What if there is a problem?

If you have a concern about any aspect of the study, you should ask to speak to me in the first instance, and I will do my best to address the issue to your satisfaction.

If you would like to make a complaint or discuss your concerns with someone independent of the study, you can do this by contacting Dr Fergal Jones (Research Director, Salomons Institute for Applied Psychology): fergaljones@canterbury.ac.uk.

What will happen to the results of the study?

The results will be used to form part of a doctoral thesis for a doctorate in Clinical Psychology at Canterbury Christ Church University. A report about the study will also be submitted to a journal that publishes research into mental health. All data will be anonymised and identifiable information changed or removed to protect your anonymity.

Who is sponsoring the Research?

The study is being organized and funded as part of a doctorate at Canterbury Christ Church University. The study is independent of the authors of the books or their publishers and no funding has been sought from them or provided by them. There is no commercial interest.

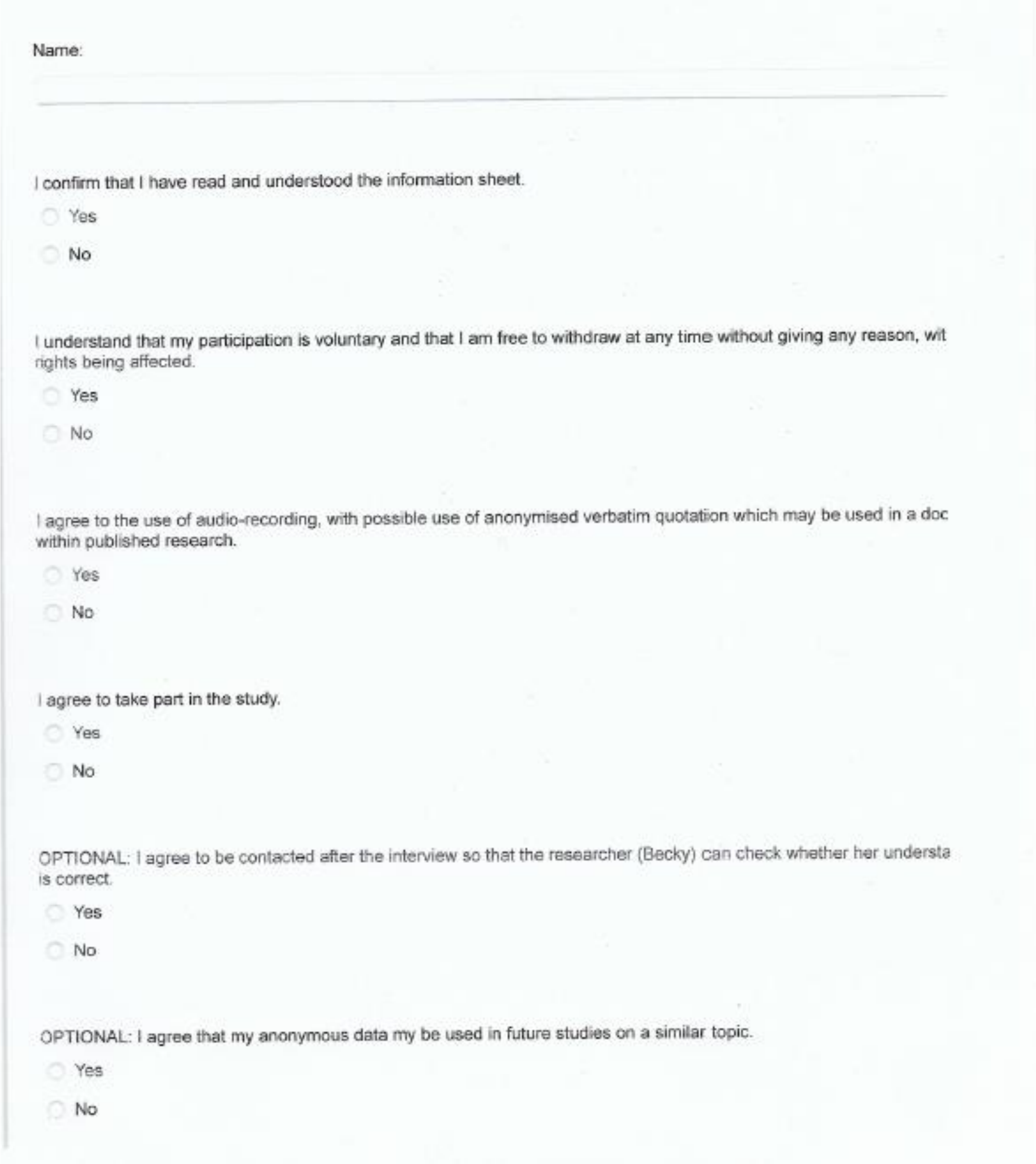
Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee to make sure that it is fair. Your project has been checked by the Salomons Ethics panel, Canterbury Christ Church university.

Next steps?

If you are interested in taking part in this study or have any further questions, you can contact me via email on b.donne204@canterbury.ac.uk. Please note, you are not committing to participating by doing this.

Appendix M: Online Consent Form



Name:

I confirm that I have read and understood the information sheet.

○ Yes

○ No

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, wit
rights being affected.

○ Yes

○ No

I agree to the use of audio-recording, with possible use of anonymised verbatim quotation which may be used in a doc
within published research.

○ Yes

○ No

I agree to take part in the study.

○ Yes

○ No

OPTIONAL: I agree to be contacted after the interview so that the researcher (Becky) can check whether her understa
is correct.

○ Yes

○ No

OPTIONAL: I agree that my anonymous data my be used in future studies on a similar topic.

○ Yes

○ No

Appendix N: Summary of Stories

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Appendix O: Extract from Lottie’s Interview

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Appendix P: Example Analysis (Lottie)

First Extract

3-6: Voices started in childhood. Very early influence of stigmatising dominant cultural narratives- even at this stage P was aware voices were “weird” and there was a risk inherent in telling people about the experience.

7-9: Even though at this point the voices weren’t particularly distressing- just happening in the background, not much of an impact.

10-12: Voices started to become more distressing in context of going to university, away from home for the first time- a big transition that can be frightening and stressful.

13-14: This is really interesting, I also studied theology and remember feeling quite overwhelmed by exploring these ideas. Interesting to hear how P understands this as contributing to change in voices.

15-16: Impact of stress, lack of sleep, drinking, contributing to change in VHEs.

17-21: Experiencing different unusual experiences, voices, prompting P to talk about her voices and unusual experiences for the first time. Interesting that she describes seeking help due to a belief that her experiences are not “normal” rather than due to distress.

23: Having to talk to lots of different practitioners rather than being able to develop a relationship with one.

25-26: Negative experience of medication- side effects, and didn’t help with VHEs.

27-30: Really determined to continue with life as planned despite VHEs.

32-33: Even though P says it was becoming more “unsustainable” to carry on with studies, she managed to finish first year- shows real drive and determination.

34-36: Presence of dominant narrative- voices as symptoms of an illness which needs to be treated with medication. Real pressure from doctor to give into this, despite negative impact of medication.

37-38: Presence of dominant narrative- negative “prognosis” of people living with a diagnosis of schizophrenia. A disabling illness.

39-40: Able to resist this narrative despite pressure from the doctor. Protective factor of being “ambitious”, “academic” and “interested in studies”?

41-43: However, “hallucinations” become more “wild” and P is taken home from university. Interesting that P had been telling her flatmates about her experiences at this point despite her early hesitation- I wonder why this was.

44-45: Real drive from CMHT to be able to put label on experiences. Pressure to try different medications- again, presence of dominant narrative that voices are connected to illness.

46-48: Has idea to look for books. There’s something in this story about agency, determination, wanting to push through and find solutions for herself despite difficult experiences and pressure from mental health services.

49-50: Impact of voices and medication together?

53: Turning point- book offering hope.

54-55: Impact of medical model- viewing voices as symptom rather than something that can be explored and understood.

56-58: Helpful to hear first person accounts that demonstrate diversity of experiences and beliefs about voices. Presence of community narrative? - Different beliefs and explanations for voice hearing are accepted and valued.

59-62: Benefit of encountering these ideas in a book as opposed to attending a group- group can be “frightening and depressing”.

67-68: Introduction to the idea of voices having a purpose- this was an important idea.

69: Dominant cultural narrative- something shameful about being a voice hearer (suggesting a “wrong-ness”)

71-72: Again, something important about hearing there are different understandings of voice hearing.

73-76: Negative prognosis vs hope found in the book.

77-78: Again, importance of hearing that different people having different beliefs and perspectives about their voices.

81-82: Dominant narrative coming from cultural discourse.

83-84: Dominant narrative also being directly communicated by mental health services.

85: No hope.

86-87: Impact of bio-medical approach- stops curiosity about experiences, shuts down exploration. Pushing of medication.

88-89: Negative impact of medication- actually becomes more of a problem than difficult VHEs.

90-91: Although P has been critical of the treatment she received through mainstream mental health services, the tone isn’t angry. Trying to understand the reason for unhelpful treatment- pressure on services. Suggestion that this pressure then leads to a shutting down of curiosity.

92: The book encouraged P to think about a more person-centred version of “stability”, unlike mental health services.

Second Extract

149: Challenge to dominant cultural narrative- that hearing voices means a person is “disordered” and “wrong”.

150: Presence of community narrative?- starting to think about whether voices are connected to life experiences. Also wanting to develop her own understanding of her VHEs.

150-155: Lack of power, difficult experiences, but ideas in book giving hope and strength. Importance of knowing diagnosis doesn’t have to define and shape life.

156-157: Again, starting to think about meaning of VHEs, although not yet being able to make that connection.

158- 160: How did we get from there to here?

162- 163: Withdrawal of treatment from CMHT. Psychiatrist described in a very positive way, doesn’t seem to be any anger towards services.

164: Again, real sense of drive, determination, agency- P knowing she wants more for herself and finding a way to make this happen.

165-170: Turning point: attending Recovery Action Plan Group- is there something here about being encouraged to look forward to the future, being person centred (what is helpful for YOU, what do YOU want your future to look like). Connecting with that sense of agency, drive, and personal strengths- “you probably know actually deep down inside what you need”.

171-172: “Breakdown” after a period of stability.

172-174: Trauma starts to re-surface- enables P to ‘join the dots’ and make sense of voices within the context of traumatic life experiences.

175: This new understanding has led to a different relationship with voices.

176- 177: Period of stability enabled trauma to resurface?

178: Having read ideas in the book supported P to make sense of her experiences. Presence of community narrative- voices understood within the context of life experiences.
183-186: VHEs quite bewildering, not easy to make sense of them.

187: Importance of safety and stability for memories to resurface.

188: Trauma memories enabled P to make sense of VHEs within context of life experiences.

189-193: Again, bio-medical model leading to shutting down of curiosity, no exploration of meaning of VHEs.

194: Meaning making facilitated by trauma informed therapy

196: Bio-medical model not allowing for individual experiences- when experiences don’t fit the recourse is to medication.

Appendix Q: Excerpt from research diary

05.01.2021: Have received ethical approval. This feels like an important step, but also a scary one because it means I need to start recruiting! Really noticing my lack of confidence with research- this is making me both want to avoid doing the work and avoid talking to my supervisor about any of it. I need to get over my fear of being judged for 'not knowing' so that I can actually ask questions and use supervision properly.

30.04.2021: Mixed feelings around recruitment. I've had some really interesting email exchanges with HVG facilitators and some potential participants but have also sent out many emails which haven't had any response, and have received some feedback that many HVGs aren't meeting due to Covid-19 so won't be able to share my advert. Becoming quite worried that I may not be able to recruit enough participants or that this will cause delays with the research.

03.06.2021: Really interesting email exchange with a potential participant who is very critical of the HVM and their approach to voice hearing. Had conversation with [supervisor] about this in an MRP meeting, leading to a discussion about our own personal biases towards the HVM (very pro!) and the importance of that not stopping us from attending to more critical stances. Really hoping this person will take part as it would be interesting to include his perspective.

27.08.21: Completed first interview. I was pretty nervous to start my interviews, and unfortunately it felt quite tricky. In particular the participant struggled to remember lots of his experiences, gave fairly short answers, and seemed to expect/ need lots of prompting- difficult to do this within a narrative approach (i.e. not having an interview schedule, purposefully leaving things open to allow participants to tell their story in their own way). Now worried about the rest of the interviews…

09.09.21:Had meeting with [supervisor] to discuss my first interview, really helpful to think through follow up questions I could be asking without introducing new information myself.

22.09.21: Third interview went well! Really interesting and full narrative. Very powerful listening to her story and I felt a real connection with her. I do need to make sure I don't slip into having a "conversation" though- it felt a bit like this when I was asking for clarification about the American mental health system.

13.02.22: Have been back in touch with some participants to ask follow up questions. One spoke about how much they had enjoyed the process of telling their story, and how powerful and validating it had been to receive a summary of their story written by another person. This has helped re-motivate me- I've really enjoyed talking to the participants and feel a real responsibility to do something with the stories they have shared with me.

07.03.22: Have applied for an extension due to impact of Covid-19 (difficulties with recruitment and emotional impact of Covid-19 outbreak on placement). Very pleased I did apply because I now have Covid-19 myself and am very fatigued. Horrible feeling- really want to be pushing through with the write up but physically can't, so frustrating!