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Title: Voice hearing: A secondary analysis of talk by people who hear voices

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Voice hearing: A secondary analysis of talk by people who hear voices

ABSTRACT

Unitary explanations of mental illness symptoms appear to be inadequate when faced with everyday experiences of living with these conditions. In particular the experience of voice hearing is not sufficiently accounted for by bio-medical explanations. This paper revisits data collected from a sample of voice hearers to perform a secondary analysis with the aim of examining the explanatory devices deployed by individuals in their accounts of voice hearing. Secondary analysis is the use of existing data, collected for a previous study, in order to explore a research question distinct from the original inquiry. In this study we subjected these data to a thematic analysis. Voice hearers make use of standard psychiatric explanations about the experience in their accounts. However the accounts paint a more complex picture and show that people also impute personal meaning to the experience. This in turn implicates both personal and social identity; that is how the person is known to themselves and to others. We suggest that this knowledge can inform a more thoughtful engagement with the experiences of voice hearing by mental health nurses.

INTRODUCTION

The landscape of mental health care is inhabited by competing paradigms and understandings of what constitutes mental health and illness. Psychiatric discourse implies an established biological aetiology. Despite limited evidence regarding the biological causation of many mental illnesses, the absence of any biological marker, pathognomonic test or specific anatomical lesion, biological psychiatry is presented as the most authoritative and legitimate paradigm (Bentall, 2009). The application of unitary explanations of mental illness it would seem are inadequate when answering complex questions regarding the human condition (Gallop & O'Brien, 2003).

Crowe et al (2008) contend that contemporary mental health care is populated by co-existing multiple paradigms; biological, cognitive, interpersonal and psychodynamic. Acceptance of this heterogeneity can help mental health nurses to collaborate and work in partnership with the person experiencing mental distress. An overly rigid alliance with a particular approach to mental ill health may discourage people using services and limit therapeutic partnerships.

Mental health nurses are ideally placed to assist people who hear voices given the shared value placed upon strong working alliances (Adam et al 2003). Helping people cope with their voice-hearing experiences however remains a challenge for the profession with some nurses lacking a developed knowledge of the subject and unsure what to do when confronted with the experience.

BACKGROUND

Mental health nursing is promoted as being an inter-personal, person-centred process (Hagerty & Patusky, 2003). However evidence suggests that the interactional work of mental health nurses is being afforded less priority than non-interactive activities and that institutional custom rather than person-centred care governs practice (Middleton & Uys, 2009).

Bio-medicine responds to mental symptoms as pathological and a rational, linear approach to problem-solving is adopted. Diagnosis and the associated cure and/or control of symptoms are given total priority. Technocratic approaches however may deprive the individual of intimacy with the experience, transferring ownership from the person to science (Jonsdottir et al, 2004). This can lead to practice becoming prescriptive and nurses being pulled away from

the person's side both figuratively and literally. Voice-hearers may find that nurses look no further than the diagnostic label, selecting details from their experiences that merely conform to preconceived constructs. A more critical approach to practice however allows an analytical attitude towards established certainties and the opportunity to revise approaches in the light of new evidence.

Bentall (2003) has claimed that the most common form of hallucination consists of hearing voices. Voice-hearing refers to a subdivision of auditory hallucinations representing the linguistic, dialogical characteristics of 'hearing' and responding to inter-subjective voice events (Rojcewicz & Rojcewicz, 1997). Slade and Bentall (1988) suggest that between 10-15% of the general population have heard voices at least once whilst Posey and Losch (1983) put the total at 71%. The prevalence of auditory hallucinations amongst people diagnosed with schizophrenia is between 53% and 60% (Haddock and Slade, 1996) or as high as 74% (Wing et al, 1974). Voices are also reported by people with other mental health problems and those with no diagnosis at all suggesting that they have no diagnostic specificity (Asaad & Shapiro, 1986). The experience is pathognomonic of no one mental condition (Lakeman, 2001). Within mental health services however voice hearing is considered to be the most pathognomonic of symptoms. Epidemiologic research spanning a century illustrates that voice-hearing is experienced by a large number of people within the general population. Research conducted in both the 1890s by Sidgewick et al, (1894) and 1990s by Tien (1991) has shown a lifetime prevalence of between 8-15% and an annual incidence of 4-5%.

Voices can be anonymous but frequently they equate to people who are significant to voice-hearers. Socially aligned voices typically sound like individuals who are known to the person (Leudar & Thomas, 2000). An approach that does not explore the meanings of the voice-

hearing experience and dismisses people's accounts as mere hallucinations is another form of objectification, an overt denial of the subjective experience of the person. This can result in incongruence between practitioner and person in relation to understanding the experience. People who experience the phenomenon have expressed a desire for mental health nurses to know how to assist them in managing their voices. They demand commonsense feedback and collaboration in the management of voice-hearing events (Baker et al, 1997).

METHODS

The study reported here set out to explore what people said about their voice-hearing experiences in terms of the commonly available discourses about the experience. The research question was, 'what explanatory resources are deployed in the talk of voice-hearers when discussing their experiences'? The aim was to examine the resources drawn upon and used in talk about voice hearing by those experiencing it to facilitate a better understanding of meaning making.

We employed a thematic analysis to examine a secondary data corpus consisting of transcripts of interviews with people (n=20) experiencing the phenomenon of voice-hearing. The transcripts amounted to over 300 pages of transcribed talk consisting of more than 93,000 words in total. These interviews formed part of an original inquiry (Coffey et al, 2004) and the current study set-out to conduct a secondary analysis of these data. In the current study the team consisted of the original researcher plus a new researcher who conducted much of the secondary analysis.

SECONDARY ANALYSIS

Traditionally research findings have been derived from primary data sources often generated by interview and observation. These rich forms of text have seldom been acknowledged as a

data source beyond the original research (Thorne, 1998). Secondary analysis involves the use of existing data, collected for a previous study, in order to explore a research question distinct from the original inquiry (Szabo & Strang, 1997). It provides a mechanism for extending the contexts in which qualitative research data are used and interpreted (Popay et al, 1998). Secondary analysis involves the use of single or multiple data sets and may be employed by the original researcher in a re-use of their own data or by a new analyst using established data sets (Heaton, 1998).

The benefits of secondary analysis of existing data sets include; generating new knowledge, new hypotheses or supporting existing theories; reducing respondent burden and permiting broader use of data from rare and inaccessible respondents (Hinds et al, 1997; Sandelowski, 1986; Szabo &Strang, 1997; Thorne, 1994). Maximising the use of data to answer subsequent research questions is an efficient method of research (Bernard et al, 1986).

Ethical issues

Among a range of ethical issues researchers are required to consider the nature of harm that could accrue to respondents if their identity is disclosed (Corti et al, 2000). The onus to maintain anonymity rests with the secondary researcher who must adhere to the same privacy and confidentiality restrictions as the primary analysts (Procter, 1993). In this study all transcripts were fully anonymised by the primary researcher and the secondary analyst had no access to participant names. Local Research Ethics Committee approval was gained for the collection and analysis of these data. As the original researcher was involved in this secondary analysis we were able to make a defensible judgment that the current analysis was within the scope of the original consent.

Original study

The original study (Coffey et al, 2004) used a mix of quantitative and qualitative methods gained through face-to-face research interviews of voice-hearers (n=20) who were receiving care from community mental health nurses. Quantitative information was used to assist in the description of the sample and assess the quality of the voices using a standardised measure. Qualitative responses were sought to contextualise and add depth to these responses through the use of follow-up prompts and open questions.

Secondary study design

This study involved a secondary thematic analysis of qualitative interview transcripts from the original study for the purposes of examining a new research question. Ideally both the audio-tapes and transcripts should be available in order to re-examine the data from a different perspective. The recordings were however no longer available as they had been erased according to the terms of our ethics approval. We used our interest in how subjectivity and experience are constructed in talk to inform our approach.

Data collection

Data collection was already complete with no generation of new informant data. The original data set was generated via exploratory interviews from a purposive sample of voice hearers (*n* = 20) in one region of the UK. Interviews consisted of both forced-choice and open questions based upon the literature on voice-hearing . These research interviews provided the opportunity for the person to give accounts of their experiences and these data were appropriate for conducting further analysis of talk.

Data analysis

We used the outline guide to the phases of thematic analysis suggested by Braun and Clark (2006) while being cognisant that analysis is more a recursive than a linear process. Analysis commenced with reading transcripts naively to aid familiarisation before what might be termed, immersion. Immersion involved repeated active reading of the data to search for patterns and meanings. Field-notes were made on each of the original interviews taking the form of a summary of each participants account, reflective notes and memos related to ongoing analysis and issues of analytical interest. Data were then coded manually by inserting notes into the transcripts.

Following the initial coding and collation of the data set codes were sorted into potential themes. In essence; the codes were analysed to determine how different codes may combine to form a theme (Campbell & Schram, 1995). In organising the data into themes we adhered to Kissling's (1996) advice and let the data itself suggest names for the themes.
At this stage candidate themes and sub-themes included: *medical language, expert, prejudice, good and bad voices, alone, diagnosis, engagement with voices, reality, medication, us and them , being different or otherness, groups, identity, stress, typical responses, meaning, religion, control, label, normalness, lack of control, hope, doctor knows best, trust and relationships.*

Themes were reviewed collapsed and refined as our analysis led us to question our interpretation of the supporting data. Finally we examined the data across all categories and in the proposed themes in relation to our research question and analytical interest. The aim was to ensure that there was a meaningful coherence with the data within themes and a clear and identifiable distinction between themes. The themes and sub-themes were then defined and named as follows:

Bio-medical responses

Personal meanings

Self and identity

The individual themes were analysed in-depth and a detailed analysis written with accompanying extracts.

FINDINGS and DISCUSSION

The interview transcripts used for the secondary analysis contained data from twenty voice hearers (n = 20). There was an even split in gender (female n=10 and male n =10). Respondents ranged in age from 22 to 68 years (mean 43.2 years. sd 13 years). The respondents had lived with voice-hearing for a considerable amount of time, ranging from 18 months to 48 years (mean 12.8 years. sd 12.1 years). Fifty per cent of the sample had experienced voice-hearing for over 10 years. The majority of the sample reported that their diagnosis was schizophrenia (n = 15), two reported their illness as psychosis, one gave a diagnosis of bi-polar and two were unable to give a diagnosis (see Table 1 for a demographic summary).

TABLE 1 HERE

Bio-medical responses

This theme included talk which supported or disputed bio-medical explanations. Mental health services tend to adopt a reductive approach to voice hearing so that these experiences are shaped to fit particular bio-medical constructs. This can result in incongruity between practitioner and patient perspectives of the voice-hearing experience. Explanations offered by voice hearers in this study unsurprisingly include bio-medical descriptions while also signalling perceived limitations with these labels. These explanations resemble attempts to

adapt and find accommodations with the voice hearing experiences through the use of bio-medical explanations.

In response to a question about the relationship between voices and diagnosis Iris who had heard voices for 24 years attributed the experience to schizophrenia:

> *That the meaning of the voice suggests to me or confirms that I have schizophrenia that I have to be looked after*
>
> (Iris: Interview 9)

Paula, who had heard voices for 13 years, displayed an understanding which directly linked her experience and diagnosis:

> *Well voices are schizophrenic I think you know. People who hear voices are schizophrenic*
>
> (Paula: Interview 16)

Iris and Paula made use of the bio-medical label 'schizophrenia' to describe the meaning of hearing voices for them. For Iris this was an explicit warrant that she must 'be looked after'. Illness designations can in effect provide permissions to be exempt from specific social activities or as Iris asserted they can also be seen as providing access to care. This is perhaps not surprising given that this sample of voice hearers were all receiving treatment from community mental health teams at the time of the study and there are few alternative everyday understandings in western societies. A bio-medical frame of reference can relieve the person of feelings of guilt and self-blame and create a self-protective narrative (Peters et al, 1998).

Hall (1996) alludes to the power of psychiatric diagnosis to devastate the identity of individuals designated ill and impose enduring limitations through prophetic labelling. The diagnostic label has currency in social settings effectively determining present and future life expectations (Hayne, 2003). Nevertheless labels were deployed by some voice hearers in

their talk as ready explanatory resources for these experiences. Psychiatric labels are identity-rich descriptors that have social implications for individuals. There was however a sense in which participants utilised bio-medical tags for the purposes of explaining current treatments or circumstances while distancing themselves from the more profound social consequences of these labels. In part this was achieved by talk that showed resistance to the assertions of the bio-medical version of voice-hearing.

For instance Ben who had been hearing voices for over 30 years accepted some benefit but highlighted the incomplete response of medication to his voices,

> *I'm still hearing voices despite medication but they're not so strong they are they're suppressed a bit.*
> *Researcher: So that you feel the medication has taken the edge off the voice?*
> *Yes, yes.*
>
> (Ben: Interview 2)

Heidi's account of the help she received after complaining of an increase in voices constructed the response from services as limited,

> *I think she would just increase the dosage of my medication.*
> *Researcher: Anything else she might do?*
> *No she will probably tell the psychiatrist*
> *Researcher: Anything else?*
> *No, as I said my CPN is good with the medication and I can tell her things that have happened in the week and I see my psychiatrist once every three months um……I think that's all*
>
> (Heidi: Interview 8)

The accounts of voice-hearers also referred to the negative effects of the labelling process intrinsic to the categorisation of subjective experiences. Nia who had heard voices for two years indicated her understanding that labelling has a negative effect:

> *What is schizophrenia? Schizophrenia is a wide diagnosis these days. I would say that yeah* […] […] […] *but I don't think labelling should be used you know. I think it's wrong to label people with schizophrenia because we are all human beings you know what I mean*
>
> (Nia: Interview 14)

Nia, who like Ben was ready to accept some aspects of the bio-medical response, made use of an alternative discourse of deviance to throw into doubt any absolutist claims that might otherwise be advanced to support a biological stance. She implied that the labelling process led to people being seen as other than human and made available alternative less satisfactory categories. Many participants in this study showed awareness of multiple explanations for voice hearing symptoms in their accounts while displaying uncertainty about bio-medical responses. A history of psychiatry as a field of contention in which civil rights, anti-psychiatry and survivor movements have challenged the prevailing hegemony may form part of the available repertoire that speakers draw upon in their accounts (Crossley 2006). Despite this psychiatry retains its influence and engagement with it in the accounts of voice-hearers should not be unexpected. Ruth who had experienced voice-hearing for ten years acknowledged that the assignation of a label can be both a negative and positive experience:

> *I think labels are a good thing people say labels are bad but to actually have a label put on you that you're suffering from a certain kind of illness I think that's a good thing because then you own that illness in the way that is what you are, you can identify with that and you're not running around looking for something*
> (Ruth: Interview 18)

Ruth appeared to adhere to a particular normalising ideology in which the views of the professions are held as an important explanatory framework while showing awareness of competing versions. Ideologies are made-up of the background expectancies and ideas of certain social groups (Waitzkin, 1991) with the implication that those ideas endorsed by particular professions are focused on normalising deviance through efforts at adjustment and adaptation (Gray, 2001). There is evidence to suggest that some people believe that not having a label is an issue and attest to the problems encountered in dealing with the unknown (Peters et al, 1998). Diagnosis appears fundamental to some as it facilitates the naming and classification of unusual experiences. As an explanation it serves to bring a sense of order to

experiences and has the potential to empower people to reconstruct their lives (McIntosh, 1996).

Divergent constructs may not be treated by participants as mutually exclusive. A person may accept the label of schizophrenia or another mental illness because it facilitates access to interventions and still reject bio-medical explanations for the causes of their problems. This explanation may provide an illusory certainty however as bio-medical interventions may prove to be ineffective while the social implications of diagnostic labels themselves carry much cultural weight.

Personal meanings

The articulation of feelings through accounts is an important way people construct and express meaning (Mishler, 1986). People aim to create order and meaning through the imposition of a narrative structure on diverse experiences. Even if explanations are not consciously pursued by the person the surrounding culture may impose meanings on behaviour identified as 'madness'. Meanings which are privileged in a given culture will reflect the dominant interests of powerful groups. Many people experiencing voice-hearing do not explain this phenomenon with reference to mental illness. Frequently people arrive at explanations grounded in their own life experiences and knowledge base; with the last resort being the explanation of psychiatric disorder (Davidson, 2003). Mark who had been hearing voices for 17 years continually made use of religious explanations and the presence of good and evil to explain his experiences but also included the likelihood of childhood trauma as an explanation.

> *well I believe it was like an evil spirit you know, but then also it could be, it could be eh, like anything happening in childhood or something, a disturbing thing or something it could spark it off, anything could spark it off but how they come in I don't know, it's a mystery to me.*
>
> (Mark: interview 13)

It was not uncommon for people to have experienced an extended period of distress prior to receiving a psychiatric explanation for their experiences. Jane who had experienced voice-hearing for 20 years made sense of these experiences by relating them to the distress of terminating a pregnancy:

> *Well I had an abortion .. .. .. I was so guilty about the termination I thought that this was the soul of the little boy called .. .. .. I terminated*
>
> (Jane: Interview 10)

These meaning making accounts are in line with evidence that life events particularly traumatic ones can represent a contributory factor in the formation of voice beliefs (Andrew et al, 2008; Morrison 2001). Mark and Jane located the origin of their voice hearing outside of a psychiatric description drawing on a range of explanatory sources.

Len offered a vivid description of his meaning making in relation to his experiences:

> *I have gone through everything that is not real is imaginary or people believe to be true, you know you have got demons, God, clairvoyance, telepathy. I have gone through them all and you are trying to fit something in to explain it, to make it make sense. You take the most irrational reasons, oh it, it does not take much to end up getting stuck on one of them* [..] [..] *because if you do not have a good sense of what is real it is very easy to just pick one and end up sticking with it because it explains everything it puts everything into place. I like everything in place*
>
> (Len: Interview 12)

Len constructed meaning making as a process of selecting from competing versions or explanations within the host culture. These choices include spiritual and supernatural explanations. He indicated that in doing so one may become 'stuck' on explanations which are 'irrational'. Len's account suggested meaning making was a process or journey on the way towards achieving an understanding that allows adaptation and accommodation with the experience. Len stated explicitly, 'I like everything in place' showing that meaning making in whatever form is a quest by voice hearers to arrive at explanations that are congruent with their understandings of themselves and their place within the social world.

Jane like a number of other participants drew on religion as an explanatory resource and in particular the dualism of a 'good' versus 'evil' understanding.

> *I went to Westminster Abbey; I thought that was because there was a conflict between evil and good. I went to Westminster Abbey; I thought I was possessed by an evil voice*
>
> (Jane: Interview 10)

People make meaning of their experiences in order to cope with them. Experiences that can be placed within the context of their past or current lives may be easier to come to terms with. Dave and Edward, who had heard voices for 20 years and 4 years respectively, located their voices in relation to past experiences with family members:

> *I hear things like about my parents arguing but they are dead now, I hear them arguing and ugh talking about me not talking to me talking about me*
>
> (Dave: Interview 4)

> *I have heard a voice that has been like my father from the past* [..] [..] *shouting at me and that sort of thing*
>
> (Edward: Interview 5)

It is not uncommon for voices to be individuated and aligned to people in the voice-hearer's social world (Nayani and David, 1996). These voices often reflect the relationship that existed between the individuals prior to the experience of voice hearing; thus directly influencing the response to that voice. Mental health practitioners need to be cognizant of the reciprocal relationship that exists between voice and voice-hearer in order to account for the reflexive nature of the experience (Davies et al, 1999).

Self and identity

Dennett (1991) uses metaphor to offer a philosophical view of self as being the centre of narrative gravity. Self cannot be isolated or touched but is central to the construction of

people's memories and the stories people tell about themselves. During life people acquire increasingly elaborate descriptions of the self, some of which are received from significant others, some of which are self-informed as people reflect on experiences and others which result from interaction in social settings. It has been suggested that these descriptions coupled with an accommodation of memories of life-events provide a reservoir of knowledge about the self that is the bedrock from which all other aspects of self are derived (Bentall, 2003).

The social identities of people in mental distress are often re-formulated in the context of illness (Goffman, 1968). Psychiatric illness has been described as a disease of the 'self' (Estroff, 1989). The person not only experiences psychological and emotional symptoms, social consequences and stigma but may also be socialized into assuming the role and identity of a 'mental patient'. The overt and at times covert communication of a pessimistic outlook and poor prognosis exacerbates the loss of self inflicted by aspects of the illness (Davidson & Strauss, 1995). This is compounded by a mental health system that reinforces compliance and passivity, fosters dependency and has at best been wary of signs of self-determination and autonomy. Participant's accounts of voice hearing in this study appear to illustrate difficulties in separating descriptions of the self from bio-medical labels.

Paula reduced the description of her problems to an 'I am' status:

> *So what I am trying to say there is a root to everything and I think it's been going on so many years up there that I am mentally schizophrenically ill*
>
> (Paula: Interview 16)

Paula indicated her contention that there is 'a root to everything' that had been going on for many years and was fundamental to her identity. The implication was that her notions of self have always been tentative and subject to being moulded by the experience of voice hearing

and the medical explanations that have come with this. Paula's narrative was illustrative of Estroff's (1989) concept of schizophrenia as an 'I am' illness. This depicts mental illness as more than a condition that one has, it is something a person is or may become. Schizophrenia with its potential for chronicity is an example of the different ways people relate to ownership of chronic diseases as either me/not me (Estroff, 1989). The expression 'I am schizophrenic' suggests how receiving a diagnosis of schizophrenia becomes central to one's identity.

People when asked to give an understanding of their problems often responded with 'I have' statements as seen in Iris's response when asked to give an understanding of her illness:

> *I understand I have schizophrenia*
>
> (Iris: Interview 9)

The use of personal pronouns in the way individuals represent themselves in speech can indicate how they remain apart from or join with their illness. *'I am'* descriptions impute identity affiliations and suggest that the experiences of voice hearing coupled with biomedical explanations are significant in how people come to know themselves. It is worth noting however that this sample of voice hearers as current users of services did not overtly reject medical explanations but instead incorporated these into their own understandings of voice hearing and explanations centred on the self.

Participants showed awareness of the potential 'othering' consequences of constructions of self as schizophrenic or mentally ill. An example of this can be seen in Jane's account.

> *I would not do anything to anybody. I mean people are always afraid when somebody has had a mental illness that they are going to do something unpredictable, going to go charging around with an axe or attack somebody*
>
> (Jane: Interview 10)

For Olivia who had heard voices for 3 years, and her partner there was a sense of keeping hidden those identity-relevant aspects of her experiences that may work to isolate and separate her from her own support systems.

> ….the family help and [CPN] helps
> Researcher: so you use your family as a support to help?
> Yeah
> Researcher: and what do other people make of it in the family [..]?
> Yeah, well we don't talk about that much really
> Researcher: no?
> Partner: they treat her as normal
>
> (Olivia: Interview 15)

Constructing the self as mentally ill may allow certain absences (from work or familial duties), it may afford certain permissions (to treatment or welfare benefits) but it also carries weighty cultural implications including the possibility of sanctions such as limits to liberty. Jane, Olivia and her partner among other participants show that the implications of labels associated with voice hearing are such that they don't raise it in social situations and may have to work to appear 'normal'. Moving beyond mental illness affiliations may be another step in the process for many voice hearers especially given the limited efficacy of the psychiatric responses and their attendant consequences. For participants in this study their sense of self while aligned with illness designations remained mutable.

CONCLUSION

This analysis demonstrates that multiple explanatory resources are deployed by voice hearers when talking about their experiences. These explanations invoke standard psychiatric descriptions but also make clear that these alone are insufficient. Alternative and parallel explanations embedded in personal meanings were evident in interview responses. Both bio-medical and personal understandings however implicate core notions of the self. The person's identity is transformed in the eyes of others and internally within the person. The individual's role is progressively constricted by loss. Loss of family and friends, loss of

valued social roles and the loss of the acceptable identities that are derived from these roles culminates in a reformulation placing them in a new category of mental illness.

Rather than contributing to this process and seeking to match people to supposedly incontrovertible identities the challenge for mental health nurses is to practice in a manner that is creative and acknowledges the strengths of the individual. Our analysis suggests new understandings that can inform recognition of the potential for recovery and lead to a change in approach from mental health nurses.

Explanations have significant force in everyday interactions as they secure access to resources and allowances to participate or be absented from social obligations. They have rhetorical power, achieve social action and are important resources deployed by voice hearers. The explanations themselves presented here are perhaps limited by the nature of the relationship participants had with mental health services as current users. This study too is limited by the same issues raised in the original study. Prominent among these is that forced-choice questions limited opportunities to provide accounts and to develop stories which prioritised participant's meanings. Nevertheless this study has important relevance for mental health nurses who need to develop awareness about the heterogeneity of voice-hearing explanations in order to develop congruent responses. This may be aided by further studies that consider how people's narratives can be used to inform skilled practice and provide interventions aimed at realising the individual's potential, maximising strengths and developing coping skills (Romme et al, 2009). Engagement with the person based on making a connection with that individual's experiences can help. The skill required is for the practitioner to focus on the literal account of the narrative and to pay attention to its contextual significance to achieve a connection (Crowe & Alavi, 1999). Nurses must be

careful not to marginalise voice hearers experience by privileging dominant explanations which have been shown to be deficient in responding to people's needs.

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Table 1

Interview Number	Pseudonym	Gender	Age	Diagnosis	Heard voices for: [years]
1	Anne	F	22	schizophrenia	4
2	Ben	M	68	schizophrenia	30
3	Chris	M	32	schizophrenia	10
4	Dave	M	58	bi-polar	20
5	Edward	M	35	schizophrenia	4
6	Frank	M	42	not known	2
7	Grant	M	58	schizophrenia	9
8	Heidi	F	52	not known	48
9	Iris	F	50	schizophrenia	24
10	Jane	F	64	schizophrenia	20
11	Kay	F	28	Psychosis	6
12	Len	M	30	Psychosis	1.6
13	Mark	M	45	schizophrenia	17
14	Nia	F	28	schizophrenia	2
15	Olivia	F	48	schizophrenia	3
16	Paula	F	53	schizophrenia	13
17	Quentin	M	39	schizophrenia	1.6
18	Ruth	F	33	schizophrenia	10
19	Susan	F	47	schizophrenia	10
20	Tom	M	33	schizophrenia	7