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EXPLORING THE JOURNEY OF VOICE HEARING.

Section A: A Systematic Review and Thematic Synthesis of Qualitative Literature on Personal Recovery and Voice Hearing.
Word Count: 7,986

Section B: A Grounded Theory Study Exploring Change Processes Following Cognitive Behavioural Therapy for Distressing Voices.
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A thesis submitted in partial fulfilment of the requirements of
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Acknowledgements

I would like to say a huge thank you to the participants who shared their story with me, without which this study would not have been possible.

Thank you to Rachel for sharing your knowledge and for your unwavering support, and to Mark, for your time and helping me discover my passion for working with people who hear voices. Thank you to my fellow trainees for the support along our shared journey. To my family and friends, thank you for the time away from the world of psychology.

Lastly, Claire, thank you. You kept me going when it didn’t seem possible.

Statement re the impact of COVID-19

The recruitment of this study was limited due to the impact of the COVID-19 pandemic. Initially this caused delays with recruitment due to the study not being approved at the beginning of the pandemic, meaning potential participants were no longer eligible. It also limited the number of clients moving through the service where participants were recruited from. Theoretical sampling was intended to occur, however, this was not possible with the limited number of potential participants.

Summary of the Major Research Project

Section A: Presented is a systematic literature review on the recovery journey of voice hearers. A thematic synthesis approach was used to synthesis 12 qualitative papers and quality assessment was guided by the CASP. Three superordinate themes emerged: ‘Recovery Phases’, ‘Recovery Facilitators’ and ‘Barriers to Recovery’. Voice hearers navigated initially finding voices distressing yet moving towards accepting voices. Searching for meaning and seeking distance from voices were divergent recovery pathways. A proposed model encompasses enabling and disrupting recovery experiences. The implications for clinical practice and future research are discussed.

Section B: Presented is an empirical paper describing the development of a grounded theory of change and change maintenance following CBT for distressing voice hearing (CBTv). Three categories emerged as facilitative of therapeutic change within CBTv: ‘New Ways of Managing’, ‘Overcoming Challenges’ and ‘Gaining New Perspectives’. The maintenance and furthering of positive change after CBTv was captured across five categories: ‘Having a Sense of Control’, ‘Standing on My Own Two Feet’, ‘Voices Are Just Part of My Life’, ‘Investing in Sustaining Relationships’, and ‘Rediscovering and Developing Identity’. Challenging circumstances were also faced by participants and are incorporated into a 3-phase model for maintaining change following CBTv. Clinical, theoretical and research implications are discussed.

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Section A: Literature Review

A Systematic Review and Thematic Synthesis of Qualitative Literature on Personal Recovery and Voice Hearing.

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Section A: Literature Review

Abstract

Background**:** Recovery literature has been influential in the conceptualisation of emotional distress and service provision. While personal recovery in psychosis has been well-studied, voice hearing literature has not been reviewed to elucidate recovery processes.

Method**:** Four databases were searched to identify relevant qualitative literature. 12 eligible studies were included in this review and the CASP appraisal tool was applied to assess quality.

Results**:** Three superordinate themes were found relating to 'Recovery Phases', 'Recovery Facilitators' and 'Barriers to Recovery'. Papers included descriptions of finding voices distressing initially yet moving toward integrating and accepting voices. Searching for meaning versus seeking distance from voices were pivotal processes to recovery pathways. Enabling and disrupting recovery experiences are discussed within a proposed model.

Conclusions**:** Recovery in voice hearing is an individual and potentially ongoing process. Future research should seek to examine recovery factors in voice hearing longitudinally and add further evidence to the supportive role services can play in recovery and voice hearing.

Introduction

Hearing voices

Voice hearing, or auditory verbal hallucinations, is an incident of hearing a voice in the absence of an observable source, experienced as real for the hearer (Beavan, 2011). Voice hearing is commonly associated with a mental health diagnosis such as schizophrenia or borderline personality disorder (APA, 2013; Larøi et al., 2012). However, estimates suggest five percent of the general population hear voices, with only a quarter meeting the criteria for a psychiatric diagnosis[1] (Van Os et al., 2009; Johns et al., 2004).

Voice hearers who use psychiatric services are more likely to be distressed by voices, hear voices more frequently, struggle to cope and seek distance from the voices (Beavan & Read, 2010; Romme et al., 1992; Krakvik et al, 2015). However, research also suggests that hearing voices can be a beneficial experience for the hearer, further enriching their lives with positive content and companionship (Romme & Escher, 1989; Beavan & Read, 2010). As such, the experience of voice hearing has been conceptualised on a continuum of severity across the wider population (Johns & Van Os, 2001), with those whose experiences are at the more severe end of this continuum more likely to be highly distressed by voices, experience depression and at an increased risk of suicide (Birchwood & Chadwick, 1997; Birchwood et al., 2004; Kjelby et al., 2015).

Several factors have been indicated in the aetiology of voice hearing. Adverse experiences or acute stressors, such as trauma or bereavement, disproportionately occur within voice hearing populations and can be antecedents to voice onset (Corstens & Longden, 2013; Longden et al., 2012). Psychological explanations suggest voice hearing to be a misattribution of internal cognitive intrusions as external. Interpretations of such intrusions, and subsequent behavioural

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[1] Such diagnoses are contested in mental health, with many questioning their validity (Cooke, 2017). Despite this, medical language is still dominant in describing the experiences which will be discussed in this review. As such, terms such as ‘psychosis’ will be used to group experiences, but the intention is not to suggest the presence of illness.

and affective responses, can create distress-maintaining patterns for voice hearers (Morrison et al., 1995). Prominent medical model hypotheses suggest voices are caused by neurochemical imbalances, abnormal neuroanatomy, or genetics (Kumar et al., 2009), while others connect voice hearing to spirituality (McCarthy-Jones et al., 2013).

The mental health recovery movement

Traditionally within mental health, recovery has been defined within the medical model and the goal for mental health practitioners has been an absence of symptoms (‘Clinical Recovery’; Law & Morrison, 2014). However, hearing voices can be an enduring experience and a cessation of voices contrasts with the aims of many voice hearers (Corstens et al., 2014). Instead, ‘Recovery’ or ‘Personal Recovery’ has been conceptualised as an idiosyncratic process based on hope, rebuilding self and living a meaningful life (Pitt et al., 2007). More specifically, Recovery has been described as ‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles… a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness’ (Anthony, 1993).

Gaining prominence through the service user movement, the values of person-centred, holistic and subjectivity underpinning Recovery have influenced mental health treatment and research (Slade, 2009). Examples of innovation led by the values of Recovery include the proliferation of over 70 recovery colleges in the UK and the evaluation of specific recovery-orientated interventions in mental health services (Perkins et al., 2018; Bird et al., 2014). Recovery principles have also been incorporated into mental health policy in the UK, with the coalition government making a commitment to ‘test the key features of organisational practice to support the recovery of those using mental health services’ (HM Government, 2011: p.22). People being able to manage mental health difficulties and move toward ‘individualised recovery’ remains a key priority in National Health Service’s (NHS) community mental health team framework (NHS England, 2019, p.4). While it is contested whether recovery ideas have been fully adopted in the UK (Slade et al., 2014), it is important to consider what defines Recovery and how it occurs.

To incorporate ideas of Recovery more successfully, it is important to consider in depth the meaning of Recovery in a mental health context. Leamy et al.'s (2011) synthesis of mental health Recovery literature found 13 characteristics of Recovery and five processes by which Recovery can occur. Leamy & colleagues' resulting framework is known as the CHIME model, denoting 'Connectedness', 'Hope' and 'Optimism', 'Identity', 'Meaning' and 'Empowerment' as key components of Recovery (see Figure 1). The structure of the CHIME model has largely been supported in the literature and continues to be a prevalent means to conceptualise Recovery (Bird et al., 2014; Stuart et al., 2017). Whereas this model provides an overarching framework for Recovery and mental health, Recovery processes have also been investigated within specific sets of experiences and difficulties.

Figure 1

CHIME recovery model (reported in Ballesteros-Urpi et al., 2019)

Recovery and psychosis

Psychosis has been defined as losing touch with the objective reality and is an expression often used to refer to psychiatric diagnoses such as schizophrenia and bipolar affective disorder (Morrison et al., 2008). Recovery has garnered much qualitative investigation in populations who have experienced psychosis (Leamy et al., 2011), perhaps due to the idiosyncratic nature of Recovery. A review of published experiential accounts suggested individuals viewed the process as recovery from the consequences of psychosis, as opposed to a 'cure' (Andresen et al., 2002). Key processes identified in this study were that of finding hope, re-establishing identity, finding meaning in life and taking responsibility for recovery. For those experiencing a first episode of psychosis, a reduction or absence of psychosis symptoms has been perceived as contributing to Recovery, alongside improvements in social relationships, autonomy and self-reliance (Eisenstadt et al., 2012). Within individuals who experience schizophrenia specifically, building one's identity and sense of self has been implicated as crucial Recovery processes (Shea, 2010), with societal stigma being a barrier (Lam et al., 2011; de Wet et al., 2015).

More recently qualitative research on service-user perspectives on Recovery in psychosis has been synthesised, covering the recovery journey, facilitators and barriers (Wood & Alsawy, 2018). Stages of Recovery identified from previous literature moved from the person before psychosis, experiencing an episode, integrating and making sense of psychotic episodes and, lastly, rebuilding self and life. Social support, spirituality, agency, positive environment and holistic care from services were all implemented as facilitators to this journey. Corroborating previous findings, stigma was also seen as damaging to the process of Recovery, alongside social deprivation, substance misuse and negative experiences of mental health services and medication. While these studies contain important experiences of Recovery and psychosis, it has been argued that hearing voices is a meaningful experience which should not always be viewed as a symptom of psychosis or mental illness (Slade & Longden, 2015). Therefore, as a unique experience, related Recovery processes for people who hear voices may differ.

The hearing voices movement

From the recovery movement, collaboration between voice-hearers, clinicians and researchers gave rise to a new way of understanding voices, termed the 'Hearing Voices Movement' (Romme et al., 2009). This paradigm shift has since culminated in the international Hearing Voices Network (HVN) which aims to normalise voice hearing and make sense of the experience, connect voice-hearers with one another and facilitate peer-support through HVN groups. This work started with the seminal research by Romme & Escher (1989), which sought to learn more about voice hearers' experiences. Contrary to dominant ways of thinking at the time, many respondents who heard voices were not psychiatric patients, were able to cope with their experiences and had positive relationships with their voices. Those who reported difficulties coping with voices were more likely to see voices as hostile, aggressive, not part of themselves and employed less adaptive strategies. Romme & Escher (1989) collated responses and proposed a three-phase model of the experiences of coping with voice hearing.

Respondents reacted to initial voice hearing with fright and confusion, constituting the 'Startling Phase'. Next, the 'Organisation Phase' is characterised by selecting and trialling different ways of coping and efforts to communicate with the voices. Lastly, once ongoing methods to manage the voices are established, individuals are thought to be in the 'Stabilisation phase'. In this final stage, the respondents were considered to have integrated the voices as part of the self and life and had choice in their relationship with voices. While these findings are supported by qualitative responses, the authors do not outline the process, methods or analysis of arriving at these phases. Romme & Escher's model has been highly influential in understanding recovery processes in voice hearers and research has sought to validate these stages and further elucidate Recovery processes for voice hearers using more rigorous design and qualitative methods (Milligan et al., 2013; Bogen-Johnson et al., 2019). To date, no review has synthesised this literature. Given voice hearing can be a distressing experience impacting on functioning and leading some to seek support from mental health services (Beavan & Read, 2010), investigating Recovery processes could inform the support available.

Rationale and aims

Advocates of the hearing voices movement support the ideas of Recovery in voice hearers and hope to integrate them within mental health services (Intervoice, 2021). However, research on voice hearers is less represented in Recovery literature. There are perhaps two reasons for this, a) voice hearing is often clustered as a symptom of psychosis rather than a separate experience, and b) voice hearing may not always be an experience to 'recover' from. This is because many are not distressed by hearing voices; it is experienced by non-clinical populations and Recovery implies a state that requires improvement (Romme & Escher, 1989). For the purposes of this review, the term 'Recovery' will still be used, despite these issues, to refer to individuals leading a personally meaningful life of their choosing (HVN, 2021). As such, studies that include both clinical and non-clinical samples will be included within this review. Due to the idiosyncratic nature of Recovery processes previously outlined in the literature, qualitative data will be privileged (Corstens et al., 2014). This review thus seeks to synthesise existing qualitative research on recovery processes in voice hearing to:

I. Review the research on recovery and voice hearing

II. Explore recovery processes in voice hearing

III. Identify core components (barriers and facilitators) in voice hearers' recovery

Methods

Eligibility criteria

As per the aims of this review, papers were identified which explored aspects of Recovery from voice hearers' perspective (see Table 1 for eligibility criteria).

Table 1

Inclusion and exclusion criteria.

Inclusion criteria:
- Studies which sought to explore personal recovery in voice hearing from the perspective of the voice hearer. Studies were also included if they did not set out to investigate recovery processes but did relate results to recovery or voice hearers' recovery journey over time.
- Papers which included qualitative data from voice hearers on their perceptions of recovery.
- Studies investigating voice hearing in adolescents and adults (14+ years old)[2].
- Studies where participants were all voice hearers.
- Studies published in English, peer reviewed and reporting primary data.

Exclusion criteria:
- Studies focused solely on symptom reduction (clinical recovery) as an outcome.
- Studies referring to psychosis or diagnostic labels more broadly, and not specifically discussing voice hearing.
- Research evaluating a specific type of intervention for voice hearers where voice hearers do not relate the outcome to their personal recovery.
- Studies which examined voice hearing experiences in the context of organic disease, post-partum or immediately following illicit drug use[3].

Search strategy

A systemic search was conducted on 27th September 2020 for relevant articles published since the inception of four databases; Applied Social Science Index and Abstracts (ASSIA),

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[2] Voice hearing in young children is more often transient and less distressing, whereas voice hearing in adolescence shares features with adult voice hearing and adolescence is a common period when adult voice hearers report onset (Pearson et al., 2008; de Leede-Smith & Barkus, 2013).

[3] Voice hearing experiences in the context of organic disease, post-partum or following illicit drug use were excluded due to these being understood and experienced differently, often as temporary experiences (Davison, 1983; Klompenhouwer et al., 1995; Wearne & Cornish, 2018).

CINAHL, MEDLINE and PsycINFO. Limits returned only peer-reviewed, English language journals. Titles and abstracts were searched based on the strategy in Table 2.

Table 2

Final search strategy.

Recover* OR wellbeing OR improve* OR symptom reduc* OR outcome OR change OR rehabilitation
AND
Voice hearing OR voice hear* OR AVH OR hallucinat* OR unusual experience* OR distressing voice* OR hearing voices OR hear voices
AND
Qualitative OR interview OR focus group OR subjective experience OR experience OR phenomenol* OR meaning OR grounded theory OR thematic OR themes OR narrative OR stories

Search terms were decided upon following a recursive process. Firstly, key terms and synonyms relevant to the question were considered. Key terms were also taken from initial papers investigating Recovery in voice hearing found through Google Scholar searches and screening previous reviews relevant to Recovery (Leamy et al., 2011; Wood & Alsawy, 2018). Research supervisors consulted on and reviewed the final search strategy. The final search strategy consisted of three parts, which reflected the key areas of this review: hearing voices, Recovery and the voice-hearer’s perspective. A broad range of terms related to Recovery were used to capture literature that did not specifically use the term Recovery but discussed processes relating to Recovery ideas. Reference lists of identified papers were also searched to further identify relevant literature (see Figure 2 for the process of paper selection).

Data extraction

Search results were exported to the Refworks software and duplicates were removed. The author then conducted the initial screenings of titles and abstracts against the inclusion and exclusion criteria. Eligibility of included papers after full paper reading was decided separately by the author and second supervisor. Disagreements were discussed with supervisors before a decision was made as to whether a paper was eligible. Table 3 displays a summary of included studies.

Figure 2.

PRISMA diagram showing the process of study selection

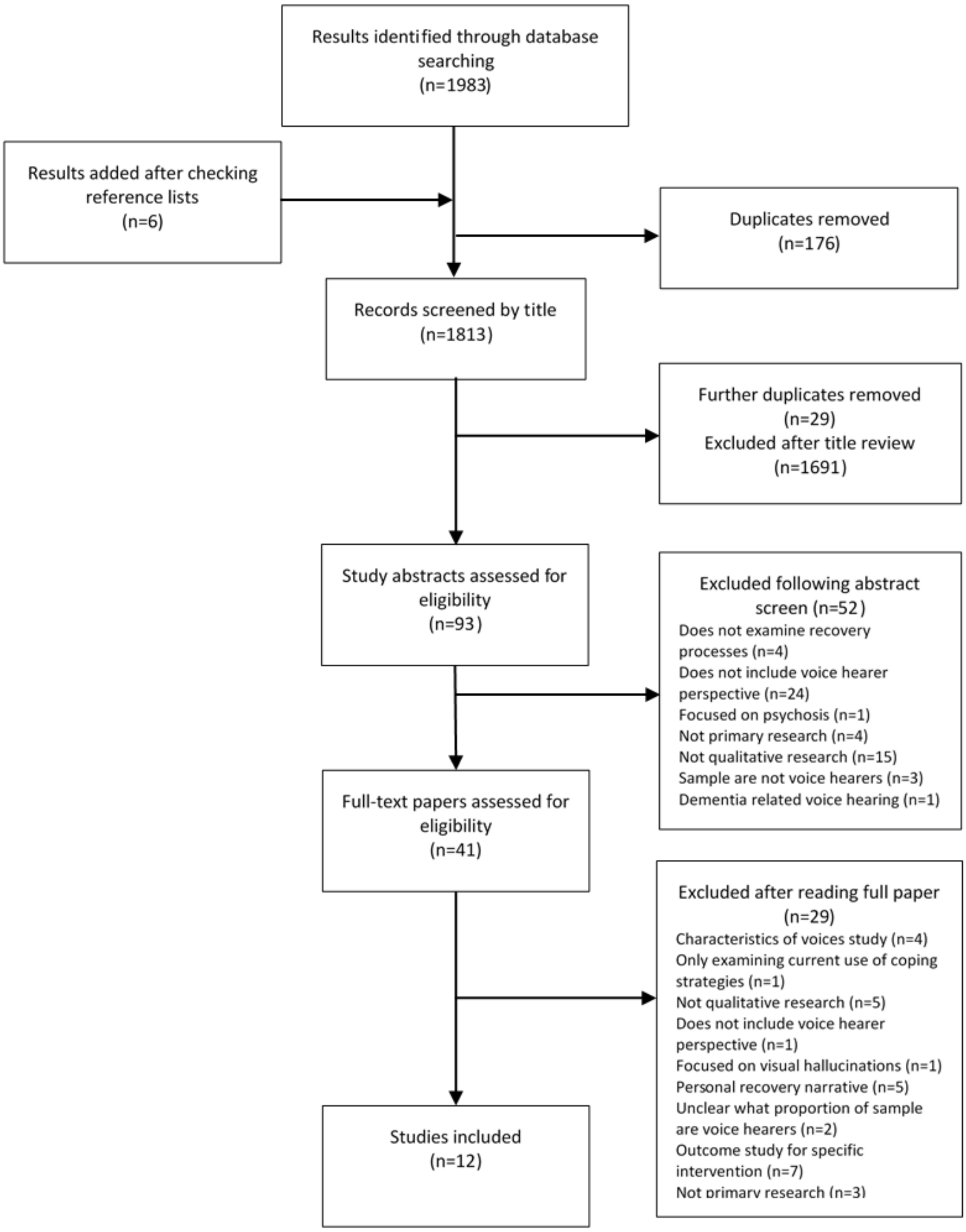


Table 3

Summary of included studies.

Study	Author (year)	Participants	Demographics	Context	Design and analysis	Main findings related to recovery
1	Dos Santos & Beavan (2016)	Voice hearers, N = 4	Male = 2, Female = 2, Age early 30s to late 50s, Ethnicity NS, 3/4 schizophrenia, 1/4 bipolar, hearing voices 16 months – 40+ years.	Recruited from 3 New South Wales HVN groups.	Semi-structured interviews. Interpretive Phenomenological Analysis.	Group attendance linked to themes of sharing with others, self-esteem, relating to voices and agency beyond the group.
2	De Jager et al. (2016)	Voice hearers, N = 11	Male = 4, Female = 7, Age 23-63, 10/11 White, 1/11 Asian, 4/11 schizophrenia, 4/11 schizoaffective, 3/11 psychosis NOS, 5/11 employed, 1/11 student, 3/11 retired, 2/11 disability support pension, 3/11 married, 1/11 divorced, 7/11 single.	Recruited from New South Wales HVN and the Australian Schizophrenia Research Bank.	Semi-structured interviews. Narrative Inquiry.	Turning away vs turning toward recovery typologies. Turning away related to distance from voices via medication or distraction. Turning toward linked to personal growth, voice-specific skill and integration.
3	Racz et al. (2017)	Voice hearers, N = 6	Male = 4, Female = 7, Age 31-57, Ethnicity NS.	Recruited from Semmelweis University’s community psychiatric self-help group for voice hearers in Budapest.	Semi-structured interviews. Interpretive Phenomenological Analysis.	Four main themes: understanding and accepting voices, improving relationships with voices, peer support from self-help group, the role of the hearing voices method. Hearing voices method linked to communicating with voices, an active role and relationships.
4	Clements et al. (2020)	Voice hearers, N = 5	Male =4, Female = 1, Age 30-62, Ethnicity NS, 3/5 schizophrenia, 1/5 schizoaffective, 1/5 undifferentiated schizophrenia.	Recruited from attendees of a HVN group.	Semi-structured interviews. Interpretive Phenomenological Analysis.	Overarching theme related to tension and recalibration, which permeated five themes: beliefs about voices, relationship with voices, learning to live with voices, rediscovering myself and influences to understanding voices.

5	Romme & Morris (2013)	Voice hearers, N = 50	Gender NS, Age NS, Ethnicity NS. 47/50 had received psychiatric care, 26/50 schizophrenia, 5/50 depression, 4/50 dissociative identity disorder, 3/50 borderline disorder, 2/50 manic depression, 7/50 did not clearly report, 3/50 no diagnosis.	Recruited through contacts in HVN across 23 countries (mostly European).	Written narrative accounts or semi-structured interviews. Analysis method unspecified.	3 phases of voice hearing recovery discussed: startling = developing hope and control; organisational = understanding voices and taking back power from voices; stabilisation = relationships with voices and others, voice emotional expression.
6	Hayward et al. (2015)	Voice hearers, N = 12	Male = 8, Female = 4, Age 20-69, Ethnicity NS, hearing voices for 2-45 years.	Recruited via the English and Australian HVN and the British charity MIND.	Semi-structured interviews. Thematic Analysis.	4 main themes identified in voice-voice hearer relationship over time. These were stress, changing experience of voices, valuing conversations (with the voices and others) and different ways of being with the voices.
7	Milligan et al. (2013)	Voice hearers, N = 6	Male = 5, Female = 1, Age 17-30, Ethnicity NS, hearing voices for 9-252 months.	Recruited from an EIP service in the North of England.	Semi-structured interviews. Interpretive Phenomenological Analysis.	6 main themes covered participants' voice heaing journey: negative trigger, rejection, crisis-induced change, adjusting and trying to cope, and new understandings.
8	Oakland & Berry (2015)	Voice hearers, N = 11	Gender NS, Age 30-60, Ethnicity NS, duration of group attendance 9 months – 6 years.	Attendees and facilitators from 3 HVN groups in the UK.	Semi-structed interviews. Thematic Analysis.	Themes relating to recovery included acceptance, hope and benefits from the group (including talking, learning from others personal experience and coping beyond the group).
9	Payne et al. (2017)	Voice hearers, N = 8	Male = 4, Female = 4, Age 26-60, 3/8 White British, 1/8 Black British, 1/8 White British Jewish, 2/8 British, 1/8 European, group attendance 2 months – 5 years.	Attendees from 2 HVN groups in the UK.	Semi-structured interviews. Interpretive Phenomenological Analysis.	Themes identified through group attendance were "healing: connecting with humanity"; "group as an emotional container"; "making sense of the voices and me"; and "freedom to be myself and grow".

10	Ng et al. (2012)	Voice hearers, N = 20	Male = 12, Female = 8, Age 22-55, Ethnicity NS, 20/20 schizophrenia, 20/20 living in half-way houses, 10/20 employed, 10/20 unemployed.	Recruited through NGOs providing mental health treatment to people in Hong Kong.	Semi-structured interviews. Thematic Analysis.	Results indicated variation in ways of coping, including “changing social contacts”, “manipulating the voices”, and “changing perception and meaning towards the voices”.
11	Bogen-Johnson et al. (2019)	Voice hearers, N=20 (N=12 after sample attrition)	Male = 12, Female = 8, Age 19-35, 17/20 White British, 2/20 White Other, 1/20 Mixed Race, 9/20 employed, 1/20 volunteering, 1/ 20 student, 9/20 unemployed, hearing voices for <1 year-21 years.	Recruited from EIP services in England.	Semi-structed interviews. Thematic Analysis.	“Common Pathway” (antecedents, onset, chaos, responses and change through help) describes shared pathway for voice hearers. While 3 other themes describe divergent pathways: “Voices Stop”, “Voices Continue but Beliefs Change”, “Voices Continue but Beliefs Do Not Change”. Belief change suggested as important in recovery journey.
12	Holt & Tickle (2015)	Voices hearers, N=8	Gender NS, Age 25-63, 8/8 White British, 5/8 unemployed, 2/8 volunteering, 1/8 not currently working, age at voice onset 3-43, Years receiving services 4-22.	Recruited within 2 mental health NHS trusts in the UK. No other details provided.	Semi-structured interviews. Grounded Theory.	Descriptive categories of sense-making were: “Search for Meaning”, “View of Self”, “Framework for Understanding Voices”. Participants search for meaning of voice hearing, but success of this process is related to perceptions of agency, stigma and hope(lessness).

Analysis

Analysis was guided by the process of Thematic Synthesis described by Thomas and Harden (2008). Thematic Synthesis collates qualitative research by analysing the results of published papers which are coded to determine themes in the data, similar to thematic analysis. For this review, full results sections were coded which included participant quotes and authors' explanations. An inductive approach was adopted by being led by the data rather than pre-existing research or frameworks.

Initially, a level of familiarity was attained with included studies. Results sections from the papers were then exported into NVivo for line-by-line coding. Following this, themes and sub-themes were arrived at through the grouping of initial codes based on likeness (see Appendix A). Frequency and relevance were considered when deciding on analytic themes.

Results

Overview of studies

The literature screening process produced 12 eligible papers. Three papers explicitly aimed to investigate recovery processes for voice hearing (de Jager et al., 2015; Romme & Morris, 2013; Payne et al., 2017), whereas the other studies intended to examine experiences in which recovery-related data emerged. Of these, five studies described longitudinal processes or 'a journey' linked to changing experiences or perceptions for voice hearers (Clements et al., 2020; Hayward et al., 2015; Milligan et al., 2013; Bogen-Johnson et al., 2019; Holt & Tickle, 2015). Three papers reported or updated models on voice hearing (Romme & Morris, 2013; Milligan et al., 2013; Bogen-Johnson et al., 2019) which suggested phases voice hearers might navigate.

Quality assessment

Quality assessment will be discussed prior to results to provide a context for interpretation in relation to study rigour. The Critical Appraisal Skills Programme (CASP) checklist for qualitative research was used (Appendix B). Studies were rated by the author and an independent researcher, with high concordance. Disagreements were discussed until a rating was agreed upon. Results of the 10-item tool are displayed in Appendix C. All studies were of adequate quality for inclusion.

Research aims and design

Qualitative methodologies were appropriately selected for all studies. Various approaches were used across the studies, including interpretive phenomenological analysis (Dos Santos & Beavan, 2015; Racz et al., 2017; Clements et al., 2020; Milligan et al., 2013; Payne et al., 2017), thematic analysis (Hayward et al., 2015; Oakland & Berry, 2015; Ng et al., 2012; Bogen-Johnson et al., 2019), narrative analysis (de Jager et al., 2016) and social constructionist grounded theory (Holt & Tickle, 2015). One study did not report how they analysed data (Romme & Morris, 2013), meaning the procedure by which the authors arrived at their conclusions is unclear and casts doubt on the rigour of this research.

Recruitment

Participants were recruited from HVN groups (Dos Santos & Beavan, 2016; Racz et al., 2017; Clements et al., 2020; Oakland & Berry, 2015; Payne et al., 2017), Early Intervention in Psychosis (EIP) services (Milligan et al., 2013; Bogen-Johnson et al., 2019), charities (Ng et al., 2012), research networks (Romme & Morris, 2013) and a mixture of these sources (de Jager et al., 2015; Hayward et al., 2015). Some studies required participants to have currently heard voices (Dos Santos & Beavan, 2015, Bogen-Johnson et al., 2019), which could have impacted on the results, whereas the remainder did not stipulate or allowed for historic voice hearing. Equally, two papers (Racz et al., 2017; Ng et al., 2012) specified that participants must have a mental health diagnosis. Considering arguments that voice hearing exists outside of a psychiatric model of distress (Van Os et al., 2009), participants in this study may not reflect the heterogeneity seen in voice hearing populations. Two papers reported how either clinicians (Clements et al., 2020) or contacts within the same research field (Romme & Morris, 2013) identified participants, and no studies reported reasons for non-participation, potentially introducing bias into the research. It is possible voice hearers with varied or more distressing experiences of recovery were less likely to take part.

Several studies did not report certain demographic information such as gender (Romme & Morris, 2013; Oakland & Berry, 2015; Holt & Tickle, 2015) and ethnicity (Dos Santos & Beavan, 2015; Racz et al., 2017; Clements et al., 2020; Romme & Morris, 2013; Hayward et al., 2015; Milligan et al., 2013; Oakland & Berry, 2015; Ng et al., 2012). While many qualitative results do not intend to be generalisable, it does influence the conclusions which can be drawn and socio-cultural influences. Of the studies that reported on ethnicity, samples were predominantly of White ethnicity suggesting results may be limited given the diverse experiences of Recovery and varying pressures facing people from different ethnic backgrounds (Morgan et al., 2017).

Data collection

While several studies provided adequate descriptions of interview questions (Romme & Morris, 2013; Hayward et al., 2015, Oakland & Berry, 2015; Ng et al., 2012), the remaining studies provided either only some examples of questions or no indication of the interview schedule used. This limits the transparency of the research and makes it hard to determine whether bias influenced data collection. Studies discussing data saturation (Hayward et al., 2015; Oakland & Berry, 2015; Bogen-Johnson et al., 2019) or sufficiency (Milligan et al., 2013) are in the minority, suggesting it is unclear to what extent results from other papers are adequately defined and capture the experiences of voice hearers.

Data analysis and findings

In terms of data analysis, all bar three studies included detailed descriptions of the analytic procedure (Racz et al., 2017; Romme & Morris, 2013; Ng et al., 2012), and of these, only Racz and colleagues discussed how themes were derived from the data. The analytic rigour applied to these studies is therefore unclear. For six papers, the researcher's role and potential bias within qualitative analysis was thoroughly considered, however in the remaining papers this could have been expanded upon (Oakland & Berry, 2015; Payne et al., 2017; Racz et al., 2017; Romme & Morris, 2013; Ng et al., 2012; Holt & Tickle, 2015). Cross-checking analysis between researchers featured in all but three papers (Romme & Morris, 2013; Ng et al., 2012; Holt & Tickle, 2015). Respondent validation was uncommon, only featuring in four papers (De Jager et al., 2016; Hayward et al., 2015; Payne et al., 2017; Bogen-Johnson et al., 2019). These quality assurance measures are a means for researchers to check interpretations are valid and true to participants' experiences. Study findings that do not include these should therefore be interpreted with caution.

Thematic synthesis

Thematic synthesis resulted in the generation of 3 superordinate themes: 'Recovery Phases', 'Recovery Facilitators' and 'Barriers to Recovery' (see Table 4 for summary). The theme 'Recovery Phases' captured the reported experiences voice hearers navigated along the journey toward Recovery. 'Recovery Facilitators' and 'Barriers to Recovery' highlight the factors which respectively help or hinder Recovery processes. Results will be described with verbatim quotes, of which, the most pertinent were selected for inclusion.

Table 4

A summary of Recovery themes

Recovery phases	N	Recovery facilitators	N	Barriers to recovery	N
Adverse Experiences and Stress	6	Supportive Mental Health Services and Engaging With HVN	12	Mental Health Services as Disempowering and Unhelpful	9
Voice Onset: Fear, Bewilderment and Shame	10	Making Sense of Experiences	12	Negative Impact of Voices	5
Overwhelmed by Voices	9	Changing Beliefs and Relationship with Voices	11	Social Isolation	6
Attempting to Cope and Reaching Out	10	Connection with Others and The Outside World	11	Stigmatised Identity	12
Differing Responses to Change	11	Empowerment	11		
Integration of Voices & (re)Developing Self	11				

Recovery Phases

This superordinate theme was found across all studies (n=12). The characteristics of voice hearers' Recovery was described as being a personal process. The Recovery journey was also thought of as iterative, non-linear and ongoing. Six subthemes were identified which related to Recovery phases of voice hearing.

Adverse Experiences and Stress

Six studies discussed challenges participants faced earlier in their lives or more recent stressors (De Jager et al., 2016; Romme & Morris, 2013; Hayward et al., 2015; Milligan et al., 2013; Bogen-Johnson et al., 2019; Holt & Tickle, 2015). The below captures some of the common adversities reported:

> *"18 voice-hearers related their voices to their sexual abuse; 11 related them to their emotional abuse; 6 to intense adolescent problems; 4 to high levels of stress; 2 to being bullied; 2 to their physical abuse"* (Author; Romme & Morris, 2013; p.264)

Acute stressors were also discussed, and participants spoke of these as antecedents to voice hearing.

> *"I had a very difficult night having the panic attacks and it was dark, and I think that probably, was the beginning of the tipping point into voice hearing."* (Participant; Hayward et al., 2015; p.100)

Voice Onset: Fear, Bewilderment and Shame

This subtheme captured the beginning of voice hearing and the reaction it provoked in participants, discussed in 10 papers (Dos Santos & Beavan, 2015; De Jager et al., 2016; Racz et al., 2017; Clements et al., 2020; Hayward et al., 2015; Milligan et al., 2013; Oakland & Berry, 2015; Payne et al., 2017; Ng et al., 2012; Bogen-Johnson et al., 2019). This reaction was often characterised by fear of voices initially:

> *"I was scared…It was new to me, the whole idea of hearing voices, and I was a little bit petrified that I was going mad"* (Participant; Clements et al., 2020; p.200)

Some studies spoke of participants not knowing anyone else who had heard voices, and so this was a completely new experience for them. At this stage, general feelings of bewilderment and a deep sense of shame were discussed across several studies, which often lead to a secrecy around voice hearing.

> *"…when I first started hearing the voices, I felt, I didn't feel I could really tell people. I felt quite ashamed and, as if there was something wrong with me."* (Participant; Payne et al., 2017; p.211)

Overwhelmed by Voices

Papers that contributed to this subtheme discussed how voices became overwhelming and overpowering for participants, worsening since initial onset (De Jager et al., 2016; Racz et al., 2017; Clements et al., 2020; Romme & Morris, 2013; Hayward et al., 2015; Milligan et al., 2013; Ng et al., 2012; Bogen-Johnson et al., 2019; Holt & Tickle, 2015). Voices were often seen as separate, external to participants and able to exert control over them.

> *"When voices were dominating, participants felt "plagued" (Alex) or "overwhelmed" (Ella)"* (Author; Clements et al., 2020; p.201)

Papers described how these experiences reduced participants' sense of control, increased distress and lead to feelings of hopelessness and fatigue.

> *"Subsequent experiences had a sense of "chaos" as voices increased in frequency and confusion and distress escalated"* (Author; Bogen-Johnson et al., 2019; p.312)

Attempting to Cope and Reaching Out

This phase captures how voice hearers responded to increasing distress levels across all except two studies (Racz et al., 2017; Holt & Tickle, 2015). Coping strategies were beginning to be experimented with, however, these could be ineffective or unhelpful ways of managing, or could not be consistently relied on.

> *"Participants described trying everything they could think of to improve their situation, to no avail."* (Author; de Jager et al., 2016; p.1413)

Several papers mentioned participants' disclosure of voice hearing to others, which could be professionals, family members or fellow voice hearers. For two papers (Milligan et al., 2013; Bogen-Johnson et al., 2019), this communication was an outcome of participants' voices and wellbeing reaching a crisis point which necessitated additional support. Following disclosure, family members or professionals could encourage access to other potentially beneficial resources, such as mental health services or HVN groups.

> *"…all informants finding the group through another person, either a loved one or via their current mental health professionals"* (Author; Dos Santos & Beavan, 2015; p.30)

Differing Responses to Change

All except one study (Oakland & Berry, 2015) referred to the ways in which participants responded to voice hearing following overwhelming experiences, crises or disclosure. Two main responses were identified: search for meaning of voices or seeking distance. Searching for meaning related to participants who strived to understand their voices. This response involved acknowledgement and a belief there was an underlying meaning or purpose to their experience.

> *"I prayed . . . deeply as to what was my purpose, what was the point of having a mental illness?* (Participant; de Jager et al., 2016; p.1413)"

Alternatively, most papers reported on a different response, one that sought distance from voices. Attempting to block out voices or fighting with them were examples of how this was attempted.

> *"I do scream at the voices, I quite often in the morning when they're having a go at me."* (Participant; Hayward et al., 2015; p.103)

As opposed to searching for meaning, seeking distance was associated with a fixed understanding of voice hearing and could result in continued distress. This occurred for participants believing voice hearing to be a meaningless experience, having little interest in understanding them or continuing to see voices as an illness either because of the benefits of the medical model or because they were told this by professionals.

> *"An explanation of the voices was not seen by all participants as being valuable, which could in itself be a potential blocking factor."* (Author; Holt & Tickle, 2015; p.259)

Integration of Voices & (re)Developing Self

Integration of voices described the phase whereby voices came to be less distressing or disruptive. For participants who continued to hear voices, seeing voices as part of oneself or one’s life and having ways of effectively managing were associated with this phase, as opposed to aiming for voices to go away.

> *“With the new meaning towards the voices, they might consider the voices as a part of themselves and of their lives and could feel more in control of the voices.”* (Author; Ng et al., 2012; p.5)

For participants whose voices had stopped there was a sense of relief but concern remained about voices returning. Voices stopping was attributed to medication and professional support and could lead to further consideration on the significance of the experience.

> *“They discussed their fears of voices returning as well as thoughts (which were mixed) on how the experience had changed them”* (Author; Bogen-Johnson et al, 2019; p.313)

Most papers that contributed to this subtheme described participants building upon their sense of self once distress had reduced. Several papers (Clements et al., 2020; Payne et al., 2017; Bogen-Johnson et al., 2019) discussed how personal growth was attributed to the experience of voice hearing at this stage, which seemed possible to occur whether voices continued or not.

> *“The experience has very much helped to understand myself and find my voice”* (Participant; Clements et al., 2020; p.201)

Improvements in self-esteem, being able to live a more meaningful life, recognising and accepting emotions and oneself and developing identity were all experiences that occurred during this phase, contributing to the process of recovery.

Recovery Facilitators

‘Recovery Facilitators’ were factors that supported Recovery journeys, featuring in all papers.

Supportive Mental Health Services and Engaging with HVN

All papers described how accessing supportive mental health services or engaging with HVN groups facilitated recovery. Mental health services, when holistic and attuned to voice hearers, provided participants with a general sense of being supported, which some described as being quite novel following disclosure of voices. Professionals who listened to individuals and supported them to find ways of coping with voices were appreciated, as were psychological interventions.

> *“Some participants indicated that therapy, either through psychological interventions or the support of EIP team members, bettered their ability to cope with their voices or helped their self-confidence.”* (Author; Milligan et al., 2013, p.114)

Starting medication could also be helpful to participants recovery, leading to increased confidence in daily life and improved functioning.

> *“I can function better and I can think better and I’ve been able to pass my courses.”* (Participant; de Jager et al., 2016; p.1414)

HVN groups were another source of support for participants. The various benefits of attending the group included feeling supported by group members, having a sense of connection, learning coping strategies from others, and sharing life stories.

> *“Learning to tell my story [a different] way shifted…so much for me…So I’m not telling an illness story. I’m telling a story of opportunity or learning.”* (Participant; Clements et al., 2020; p.202)

Studies described how these groups perhaps offered something different to mental health services, which fostered experiences of personal growth, did not adopt an illness model of voice hearing and actively promoted the possibility of Recovery.

> *“Observing others’ abilities to deal with their experiences helped group participants*

> *to believe that recovery was possible."* (Author; Oakland & Berry, 2015; p.124)

Making Sense of Experiences

Making sense of experiences was the process whereby meaning was beginning to or had been attributed to voice hearing. This was described in all papers and further facilitated Recovery. Studies discussed how sense-making lead to participants' changing understanding of voices, making links to previous adversity and conceptualising their voices under different explanatory frameworks, such as relating to spirituality. This could occur through self-reflection, psychological therapy or HVN groups.

> *"I have an understanding of what my voices are and where they come from and as I've been able to cope with them better, and as I've got better in myself and they've reduced then that's made life a lot better"* (Participant; Payne et al., 2017; p.211)

This facilitator served the function of normalising voices within the context of individuals' lives and reduced distressed. There was also some mention of individuals having a greater insight into the experience, finding voices more familiar and predictable.

> *"...participants became acutely aware that their voices were likely to become problematic during times of heightened anxiety and vice versa, thus becoming a "litmus test" for psychological well-being"* (Author; de Jager et al., 2016; p.1415)

Changing Beliefs and Relationship with the Voices

Bar one study (Payne et al., 2017), all papers included results related to changes in beliefs or relationships with voices. Changing beliefs about voices, most commonly beliefs about voice truthfulness, power and control, appeared linked to Recovery. Perceptions of voices having less power were associated with participants having a greater sense of control. Reappraisal of voice power could occur within psychological therapy, or some participants shared their intuitive attempts to challenge voices.

> *"I gave them the simple task to wash the dishes unaided. They were unable to achieve this, and so the seed of doubt as to their actual power was sown"* (Participant; Romme & Morris, 2013; p.264)

Accounts reflected a changing relationship with voices in line with changing beliefs, such as shifts in perceptions of relative power.

> *"I just feel like that my life is not controlled by my voice anymore. It's controlled by what I want to do and then the voice is secondary."* (Participant; Bogen-Johnson et al., 2019; p.314)

Participants also attempted to communicate and engage with voices in a different manner. This could be driven by a desire to better manage or to understand their intentions.

> *"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"* (Participant; Clements et al., 2020; p.201)

Some studies discussed participants accepting the voices and their existence, which seemed to reduce tension and stress of the individual. Although not possible for all, forming a more harmonious relationship could occur where voice hearers and voices could communicate with minimal conflict.

Connection with Others and the Outside World

Except Clements et al. (2020), all papers contributed to this subtheme which related to having a renewed sense of connection with other people and the world. This involved spending more time with loved ones, relating to fellow voice hearers, feeling accepted by others and being able to talk about their experiences of voice hearing and find benefit in this. HVN groups could be a safe space for connections between voice hearers to occur.

> *"I felt like I belonged somewhere so I could take my mask off and feel safe."* (Participant; Oakland & Berry, 2015; p.124)

Meaningful activity was a means for voice hearers to connect to the outside world and have purpose, which was often describe as an interpersonal process.

> *"Participants felt more valued by themselves and others when they were able to contribute to others: "It makes me feel as though I'm contributing to something."* (Participant; de Jager et al., 2016; p.1416)

Empowerment

Empowerment refers to descriptions of an empowered-self present for voice hearers, greater feelings of autonomy and an ability to face problems. This was described in all except one study (Milligan et al., 2013), and was associated with reduced fear of voices.

> *"It's changed my understanding of myself really because yes, I believe, it's one of those things, I believe I'm stronger than I was because of the experience I've been through."* (Participant; Bogen-Johnson et al., 2019; p.313)

Barriers to Recovery

The final theme, featured in all 12 papers, encompassed experiences that acted as barriers to Recovery for voice hearers. Whilst consisting of fewer subthemes and codes, experiences captured here were particularly poignant and could occur at any phase of Recovery.

Mental Health Services as Disempowering and Unhelpful

Featuring in nine studies (De Jager et al., 2016; Clements et al., 2020; Romme & Morris, 2013; Hayward et al., 2015; Milligan et al., 2013; Oakland & Berry, 2015; Ng et al., 2012; Bogen-Johnson et al., 2019; Holt & Tickle, 2015), mental health services could act as barriers to the recovery journey through interventions intending to support voice hearers being unhelpful or ineffective, leading to a sense of hopelessness.

> *"They gave me some medicine and told me it would get rid of it, but they only just kept getting worse and worse and worse"* (Participant; de Jager et al., 2016; p.1412)

Disclosure to professionals was a risk for voice hearers, which could result in them being placed in "*an asylum*". Alternatively, examples were captured whereby professionals refuted voice hearers' experience and the sense they made of it, invalidating and disempowering participants.

> *"participants described how pathological discourses of voice hearing from mental health clinicians invalidated their perspectives, gave them little hope for recovery and negatively influenced their identity"* (Author; Clements et al., 2020; p.202)

Negative Impacts of Voices

Voices in and of themselves constituted a barrier to recovery. Four studies (Milligan et al., 2013; Ng et al., 2012; Bogen-Johnson et al., 2019; Holt & Tickle, 2015) highlighted how voices tended to worsen again and becoming more distressing at times of heightened affect. This could prove to be a maintaining factor for distressing voices and mood difficulties, forming a vicious circle for some participants.

> *"I get paranoid and the voices contribute to the paranoia and the paranoia will get out of control and that's when the depression will set in from the paranoia."* (Participant; Milligan et al., 2013; p.111)

Fluctuating voice hearing activity and conflict in the voice-voice hearer relationship could also negatively impact on Recovery processes.

> *"What they do is wicked and it's horrible and I think making someone feel that vulnerable and that down, no I would never wanna have a relationship with someone like that"* (Participant; Hayward et al., 2015; p.101)

Social Isolation

Only six studies contributed to this subtheme (Dos Santos & Beavan, 2015; de Jager et al., 2016; Racz et al., 2017; Clements et al., 2020; Milligan et al., 2013; Payne et al., 2017) however, social isolation could form a significant barrier for individuals. Voices were regularly named as a cause of isolation and perpetuated feelings of disconnection from others for participants.

> *"I was so isolated because of the voices I think that I never really spoke to anyone"* (Participant; Dos Santos & Beavan, 2015; p.31)

Isolation permeated various relationships for voice hearers, including distance from their family, from fellow HVN group members and from the world generally.

> *"I had problems, and because of that I didn't have a harmonic relationship with the outside world"* (Participant; Racz et al., 2017; p.310)

Stigmatised Identity

Stigmatised identity was the most prominent Recovery barrier, coded in all papers. Data coded to this theme discussed the negative impact of stigma on the Recovery process, which included blatant prejudice, people having negative responses to voices or participants fearing judgement from others.

> *"Ella commented that it was often difficult to resist assuming the "societal…archetype of the crazy one. The insane person who is, by definition, defective and inferior"."* (Author/Participant; Clements et al., 2020; p.202)

When negative perceptions of voice hearing and emotional distress were internalised by participants in the studies, this could lead to diminished self-esteem and poor self-identity.

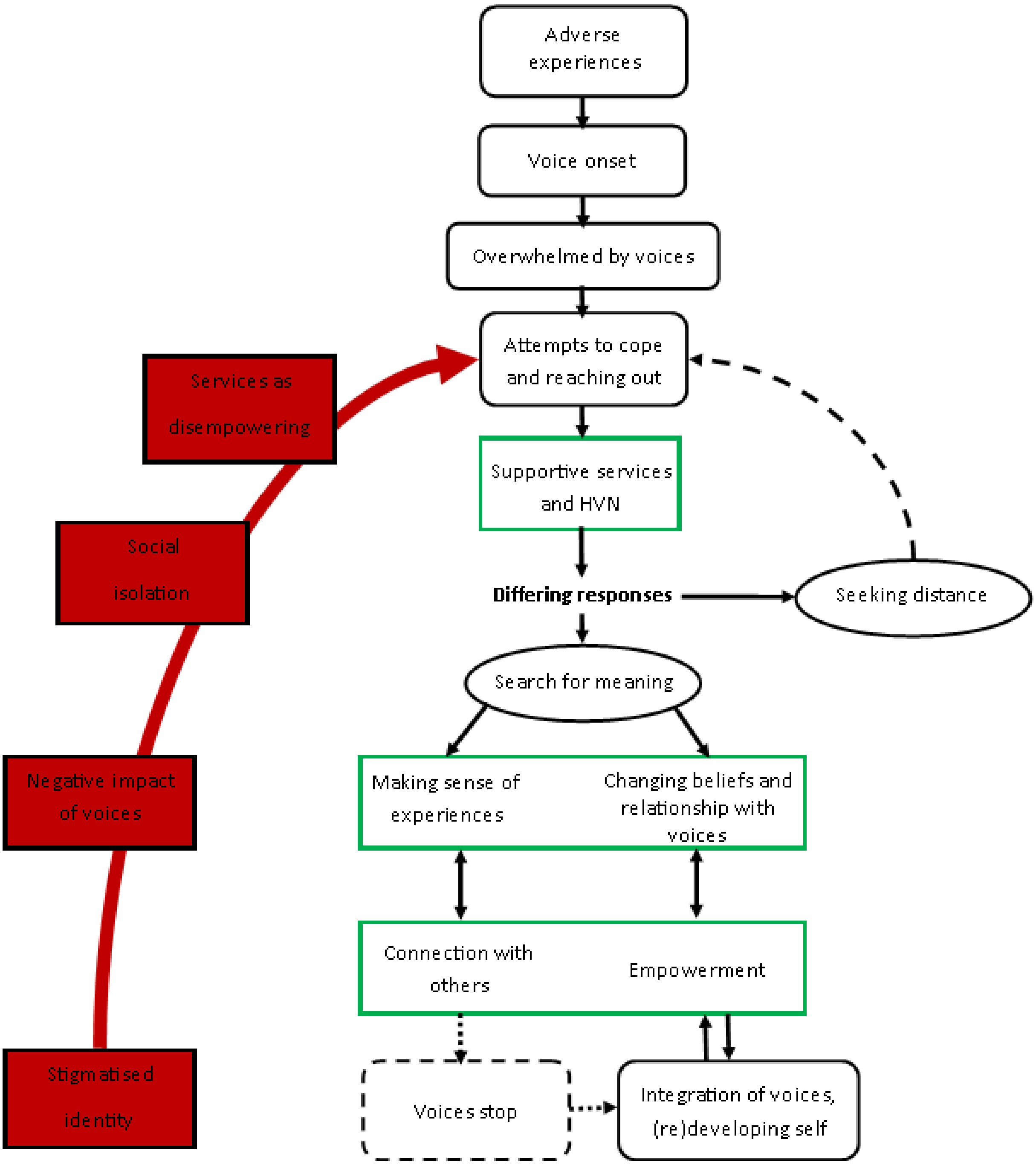
> *How could I contribute (to society) if I had this prognosis? I think my self-esteem and everything was the lowest it could be.* (Participant; de Jager et al., 2016; p.1413)

Synthesising a recovery model

Themes and subthemes emerging from the thematic synthesis have been integrated and are represented in Figure 3.

Figure 3.

Synthesis of themes and subthemes into a diagrammatic model of voice hearing Recovery.



Discussion

This review intended to systematically review and use thematic synthesis to integrate current literature on personal Recovery in voice hearing. The results suggest six phases voice hearers may experience along the journey of Recovery: ‘Adverse Experiences and Stress’, ‘Voice Onset’, ‘Overwhelmed by Voices’, ‘Attempts to Cope and Reaching Out’, ‘Differing Responses to Change’ and ‘Integration Of Voices & Developing Self’. Five facilitators and four barriers to Recovery phases were identified and are integrated within a proposed model of personal Recovery and voice hearing. Recovery was perceived to be ongoing and personal, and while phases are described, ways in which these were achieved and related outcomes were idiosyncratic for participants across studies.

Recovery phases and voice hearing

The findings that emerged within the theme ‘Recovery Phases’ largely map onto the initial model proposed by Romme & Escher (1989), and later expanded upon to combine the experiences of people who hear voices within clinical services (Milligan et al., 2013). The preceding adversity, onset of voices and attempts to cope support experiences described within the ‘Startling Phase’. Confusion and anxiety were feelings described at this time, but more poignant emotions of fear and shame associated with voice onset were also identified, which have previously been implicated in voice hearing (Carden et al., 2020) and is consistent with increased prevalence of traumatic events among this population (Corstens & Longden, 2013). While the ‘Organisation Phase’ perhaps depicts experiences as relatively simple compared to the findings of this review, there are similarities to the phases whereby some people who heard voices tried to uncover and attribute meaning to their experiences. Making sense of voices, through various personally meaningful explanations, was a facilitative process that was reported to reduce distress. This corroborates previous research and the value of sense making for voice hearers, which has been advocated for by members of HVN (Longden, 2010).

Processes of connecting with other voice hearers and regaining power from voices were also apparent in review findings. Lastly, 'Stabilisation' and the final phase of this model share some common features, namely accepting voices and improvements in relationships with voices. While a more balanced relationship with voices was indicative of the final phase of the outlined model, the process of changing relationships with voices was a facilitating factor and seemed to be important for integrating voices. The 'Stabilisation Phase' has been reproduced in several studies following Romme & Escher's original research (1989), however, this adds further definition to ideas that were proposed to be contained within stabilisation.

Understanding voices

Previous cognitive models of voice hearing have suggested schemata surrounding voices, the self and social standing predict appraisals, associated distress and responses (Morrison, 2001; Chadwick & Birchwood, 1994). Within cognitive theory and CBT for distressing voices, beliefs are thus of central importance. Belief change has been further indicated in Recovery and voice hearing and was reported as determining the Recovery pathway in one of the included studies (Bogen-Johnson et al., 2019). Whilst identified as supporting Recovery in this review, belief change was not found to be as significant as previously suggested. Instead, a pivotal process along the Recovery pathway featuring across previous literature was whether initial support-seeking resulted in a search for meaning or a desire for distance regarding voices, a parallel to the 'sealing over' and 'integration' psychosis recovery patterns (McGlashan et al., 1975). An explanation for this might be that this review synthesised results from studies including clinical populations (such as in Bogen-Johnson et al., 2019), and voice hearers attending HVN and third sector groups. Advocates from within the hearing voices movement have attested to the importance of understanding voices, making sense of experiences and the pertinence of this to personal Recovery (Corstens et al., 2014). This was apparent across the included literature, however, an alternative response of seeking distance was present. Distance-creating patterns of responding to voices, such as attempts to block out voices, are reportedly associated with experiencing distressing voice hearing (Sayer et al., 2000), and may have featured due to the inclusion of literature on clinical populations who tend to have higher levels of distress (Beavan & Read, 2010).

Interpersonal recovery processes

Within this review, several facilitators were found that related to study descriptions of interpersonal relationships. Literature focused on people with first episode psychosis has found there to be significant barriers to individuals seeking help (Anderson et al., 2013). The importance of loved ones initiating help-seeking processes was emphasised within this review, similar to Anderson and colleagues' (2013) findings. Psychosis research has also identified related Recovery themes regarding the role of others, with social support, isolation and stigma all previously being implicated in Recovery from psychosis (Wood & Alsawy, 2018). While this research is focused on psychosis populations and this review is relating to voice hearing specifically, there may be some shared Recovery processes across populations. Indeed, Leamy et al.'s (2011) work summarising Recovery into the CHIME model does seem to relate to many of the themes captured within this review. The current review did, however, find specific processes relating to Recovery in voice hearing, which included more challenging experiences which do not feature in the CHIME model (Stuart et al., 2017). Stigma, for example, appeared across all included papers and could be a significant barrier to Recovery in voice hearing. Within many Western societies, voice hearing stigma is pervasive and can impact on individuals' functioning and wellbeing (Yanos et al., 2008), so it is perhaps understandable this constituted a Recovery barrier.

Supportive services and HVN groups emerged as Recovery enabling experiences. This occurred differently for individuals, with some speaking of the benefits of medication, others of psychological therapy and connecting with other voice hearers. Generally, taking a supportive stance that listened to the need and preferences of participants seemed to be the underlying significance of this subtheme. When this occurred, it appeared to have a further enabling effect on other facilitators such as changing beliefs and relationships with voices, sense making and empowerment. There have been calls for services to offer interventions which are tailored to the subjective meaning of voices (Lonergan, 2017) and HVN groups' advocate for sharing of stories and mutual respect for individuals' explanatory framework (Dillon & Hornstein, 2013). Conversely, services were viewed as disempowering when participants meaning was not considered or support was inadequate, corroborating existing literature (Coffey & Hewitt, 2008). The suggested model depicted a continuation of managing voices, particularly the negative impacts the experience might have, as being relevant to Recovery. This perhaps reflects the ongoing nature of Recovery in voice hearers and although this model proposes a final phase, this does not denote a cessation of Recovery processes. This finding bears resemblance to psychosis literature pointing to continuing management of challenges that arise when in Recovery (Dilks et al., 2010; Dixon et al., 2010).

Limitations

Whilst previous models have been suggested, this is the first-time results from across qualitative studies have been combined to elucidate personal Recovery processes in voice hearing. Although phases of Recovery emerged in the results, the produced diagram can be seen as a guide as opposed to having universal applicability to all people who hear voices and may only be relevant to the participants who took part in the included studies. Outcome studies were excluded from this review if processes were not associated with Recovery by participants. Though this ensured Recovery was defined by voice hearers themselves, this may have limited the available literature on the ways in which services and therapeutic interventions enable Recovery in voice hearing. The results of this review are also limited given Recovery is a personal process that varies across cultures (Tse & Ng, 2014), and participants in the included studies were mostly White or their ethnicity was not reported.

Finally, there were no studies included in this review which examined the journey of voice hearers whose voices are positive or encouraging, which is a documented phenomenon in the literature (Sanjuan et al., 2004). This review attempted to be inclusive of various voice hearing experiences and included research with clinical and non-clinical populations, however, participant accounts tended to refer to distressing rather than positive voice hearing. Therefore, it is unclear whether the model reflects the journey of people who only hear positive or neutral voices, or indeed, whether ideas around Recovery are relevant to this group.

Implications

From the synthesised studies, it was apparent that individuals' journey of Recovery was perceived to have started before the onset of voices and was associated with adversity and stress. At a population level, practices may be adopted in health and social care and wider organisations which seek to mitigate acute levels of stress experienced by individuals that have already experience adversity, such as trauma informed care (Harris & Fallot, 2008). This may also include resources for managing emotional wellbeing being widely shared to support individuals before any need for clinical services, for example, self-help coping strategy resources. Given the role of shame, fear and stigma in blocking help-seeking and stalling recovery journeys, attempts should be made to destigmatise and normalise the experience of voice hearing in the UK. This is especially important within healthcare, but also institutions like the media which may perpetuate harmful narratives of voice hearers being violent or criminals (Vilhauer, 2015).

The search for meaning pathway within this model appeared to relate to more significant Recovery processes for voice hearers in the included studies. Clinical services should continue to promote psychological interventions with an aim to explore individual's sense making. The Maastricht interview, developed by Romme and Escher (2000), may hold promise in supporting voice hearers to make sense of the seemingly bewildering experiences, however further evaluation of this technique is still needed (Steel et al., 2019). Equally, clinical work could be informed by the Power Threat Meaning framework which would situate voice hearing as a response to threatening experiences, encouraging sense-making and an awareness of social factors contributing to distress (Johnston et al., 2018). Access to a variety of biopsychosocial intervention approaches should continue to be offered given included studies reported on medication, therapy and general connection with professionals supporting Recovery. A collaborative approach between services and HVN is likely to provide greater levels of varied support and further facilitate voice hearers' Recovery.

Future research

Future research should endeavour to utilise longitudinal research designs to discern Recovery factors at various stages of voice hearing. In particular, barriers to Recovery were not as well defined in this review and should be an area of future investigation. Another possible avenue of further study would be understanding if there were any kinds of support that voice hearers would appreciate early on in their journey with voices, for example, soon after voice onset or when voices become overwhelming. This type of study would help elucidate forms of support for voice hearers earlier and to understand why some voice hearers experience clinical levels of distress while others do not.

This review identified how supportive services can enable Recovery in voice hearing. Psychological therapy was indicated within the facilitators of making sense of experiences, changing beliefs and changing relationships with the voices. However, the current review does not suggest how psychological therapy produces positive changes for voice hearers, or whether voice hearers who receive psychological therapy perceive therapeutic changes to be enduring.

Future research could examine the process of change and maintenance in psychological interventions for voice hearing.

Conclusion

This review sought to review and synthesise current qualitative literature on Recovery and voice hearing from the perspective of people who hear voices. Recovery was a highly individual process, however, phases of Recovery are suggested within a model whereby voice hearers move from being distressed and overwhelmed by voices to accepting voices and developing a positive self-identity. Previous literature suggests voice hearers may adopt either a stance which seeks meaning or seeks distance in their relationship with voices and seems predictive of Recovery pathways. Facilitators and barriers of Recovery were identified as key themes across the voice hearing Recovery literature and have been synthesised within a model of Recovery in voice hearing, building upon previous work. Future studies should further investigate the applicability of the suggested model to both samples of clinical and non-clinical voice hearers using empirical methods. Psychological interventions for voice hearing were also noted to support key Recovery facilitating processes. Examining the change processes involved in interventions for voice hearing and how positive change is supported would be an avenue for further study, as this may too support Recovery in voice hearing.

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Section B: Empirical Paper

A Grounded Theory Study Exploring Change Processes Following Cognitive Behavioural Therapy for Distressing Voices.

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Section B: Empirical Paper

Abstract

Rationale: Cognitive Behavioural Therapy for voice hearing (CBTv) has been shown to be effective at reducing distress and improving functioning. However, it is unclear why voice hearers might deteriorate or continue to benefit post-intervention.

Objectives: This study aimed to explore the processes by which voice hearers maintain therapeutic changes following CBTv.

Methodology: A critical realist, grounded theory methodology was utilised. 1:1 interviews were conducted with 12 participants who had experienced distressing voice hearing and had finished CBTv intervention in the last 3-12 months. Participants were recruited from a specialist hearing voices service.

Results: Three categories were found to be facilitative of positive change within CBTv: 'New Ways of Managing', 'Overcoming Challenges' and 'Gaining New Perspectives'. Five categories supported the maintenance or furthering of positive change following intervention. These were 'Having a Sense of Control', 'Standing on My Own Two Feet', 'Voices Are Just Part of My Life', 'Investing in Sustaining Relationships', and 'Rediscovering and Developing Identity'. Challenging circumstances were also faced by participants and are incorporated into a model for maintaining change following CBTv.

Conclusions: The model adds to current literature on change processes occurring with CBTv and the maintenance of change following a psychological intervention. The results support the need for therapies to foster enduring therapeutic change with people who hear distressing voices.

Keywords: Distressing voice hearing, Auditory verbal hallucinations, CBT, Change process, Grounded theory.

Introduction

Hearing voices

Voice hearing (auditory verbal hallucinations) has been defined as a meaningful incident of hearing a voice in the absence of an observable source, which is experienced as real for the hearer (Beavan, 2011). Voices are more prevalent amongst individuals who have experienced trauma, such as abuse (Corstens & Longden, 2013). Voice hearing is reported to occur in psychiatric populations and 10-15% of the general population (Larøi et al., 2012; Beavan et al., 2011). Those that do use psychiatric services are more likely to be distressed by voice content, hear voices more frequently, struggle to cope with, and seek distance from the voices (Beavan & Read, 2010; Romme et al., 1992; Krakvik et al., 2015). Research indicates distressing voice hearing occurs in a range of different mental health difficulties (Larøi et al., 2012). However, it is still often associated with psychosis populations rather than an experience with shared characteristics and beliefs across diagnoses[4] (Waters & Fernyhough, 2017; Hepworth et al., 2013). Therefore, an exclusive focus on voice hearing in psychosis populations may pay insufficient attention to the needs of other voice hearers (Hazell et al, 2018a).

CBT for psychosis

Traditionally, distressing voice hearers have been offered support in the form of Cognitive Behavioural Therapy for psychosis (CBTp) based on models of positive symptoms (e.g. Garety et al., 2001). CBTp aims to normalise psychotic experiences, reduce distress related to unusual experiences and improve functioning (National Institute for Health and Care Excellence [NICE], 2014). A previous meta-analysis on CBTp has demonstrated a medium effect size on a range of outcomes including positive symptoms, such as voice hearing and delusional

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[4] Much debate exists around the validity and usefulness of psychiatric diagnoses (Jablensky, 2016). Diagnostic labels are however discussed in this research given this is the dominant language used in the literature. Their inclusion in this research does not intend to suggest the existence of illness and terms such as ‘experiences’ and ‘distress’ will be used where possible.

thinking (Wykes et al., 2008). However, CBTp effectiveness is contested with some 50% of clients receiving little benefit and other meta-analyses finding small effects that were not sustained at follow-up (Laws et al., 2018). Predictors of outcome are indicated to be familial support (Garety et al., 2008), the quality of the therapeutic relationship (Evans-Jones et al., 2009), clients' ability to use the therapist's frame of reference (McGowan et al., 2006), client motivation and openness to change (Garety et al., 1997).

Within CBTp literature, studies have highlighted the important role of beliefs in therapy. Reductions in negative beliefs about voices have been shown to be predictive of improved outcome (Morrison et al., 2012), and being able to adopt an observational perspective and receptivity to alternative explanations of experiences have been indicated as crucial to the change process in psychological therapy for psychosis (Dilks et al., 2008). CBTp follow-up data shows sustained improvements at 9 and 18 months follow up for those that improved (Kuipers et al., 1997), although this tends to rely on expert therapists delivering the intervention and specialist supervision (Jolley et al., 2015; Peters et al., 2015). Lecomte & Lecomte (2002) hypothesise the long-term effects of CBTp may endure due to the coping skills learned which continue to be used after therapy has ended. However, the authors speculate that client empowerment and socio-environmental factors may too play a role and suggest further research on the maintenance of change resulting from CBT interventions over time. Despite NICE (2014) guidance recommending CBTp for clients experiencing psychosis, only 26% are offered CBTp (Royal College of Psychiatrists, 2018). Possible explanations for this have been insufficient funding, therapist resource, clinician attitude and engagement (Johns et al., 2019; Hazell et al., 2017; Hazell et al., 2018a).

CBT for distressing voices

CBT for distressing voices (CBTv) is an alternative, experience-specific form of CBT offered to increase access to psychological therapy for voice hearers, and generally involves enhancing coping (Tarrier et al., 1990), reducing unhelpful beliefs and bolstering personal resources (Hazell et al., 2018b). Negative beliefs about the voices and one's self are thought to maintain distress and are focussed upon in CBTv (Chadwick & Birchwood, 1994; Chadwick et al., 1996). Suggestions have been made that this targeted approach could produce enhanced results compared to generic CBTp (Lincoln & Peters, 2019).

CBTv is not limited to psychosis populations and has been suggested to be applicable to voice hearers with a diagnosis of personality disorder (Hepworth et al., 2013), experiences of trauma (Steel, 2016), and has encouraging outcomes trans-diagnostically (Hazell et al., 2018b). Approximately half of those that receive CBTv show benefits, with a quarter experiencing large improvements (Paulik et al., 2019). Those with increased rates of negative affect and negative symptoms are less likely to benefit from CBTv (Paulik et al., 2018; Thomas et al., 2011). This likely relates to negative emotional states being a trigger for the onset of voices (Freeman & Garety, 2003; Delespaul et al., 2002) and negative symptoms impacting on functioning and motivation (Fervaha et al., 2014). Negative beliefs about the self, perceived omnipotence of voices and high voice-related distress have also been associated with poorer CBTv outcomes (Hazell et al., 2018b; Paulik et al., 2018; Thomas et al., 2011). Research has suggested a focus on positive self-schema building interventions could be a vehicle to elicit enduring therapeutic change (Birchwood et al., 2000). Trower et al. (2004) found reductions in maladaptive behaviour and voice-related distress from CBTv, were which was maintained at 12 months' follow-up.

CBTv outcomes have largely been sustained at follow up in a schizophrenia population, however some go on to improve further after treatment whereas others show a deterioration (Wiersma et al., 2001). Theoretical explanations may offer some insight into the change processes of voice hearing and psychological therapy.

Cognitive theory of voice hearing

The cognitive model of voice hearing considers appraisals of experiences to mediate voice-associated distress (Chadwick & Birchwood, 1994). Beliefs regarding the voices' perceived power, control and ill-intent, and self-schema are of importance in the model. Morrison et al. (1995) proposed voice hearing to occur due to a misattribution of internal intrusions to an external stimulus. The model suggests cognitive appraisals of these misattributions influence the subsequent behaviours and affective responses, creating a cycle which maintains difficulties. Thus, cognitive therapy aims to reduce maladaptive appraisals of voices and build self-esteem in an attempt to reduce distress (Chadwick et al., 1996; Close & Garety, 1998).

A systematic review demonstrated voices appraised as malevolent and powerful, and rejecting responses to voices, predicted higher rates of distress (Mawson et al., 2010). Paulik (2012) proposed the addition of social schema into the cognitive model due to voice hearers' perceptions of their social standing mediating their beliefs about the voices and themselves. Echoing previous research, findings suggest voice hearers often had a lower perceived social rank relative to others (Birchwood et al., 2000). A meta-analysis found small effect sizes for social skills training reducing the rate of relapse at 6-12 months, suggesting healthy social interactions to be of importance in maintaining positive wellbeing post-intervention (Kurtz & Mueser, 2008). Research would suggest that stress, including unpredictable life events, family environment & high expressed emotion of carers are all predictors of relapsing distress in psychosis (Hooley & Gotlib, 2000).

The cognitive model therefore posits cognitive appraisals of voices, the self and social rank are predictive of distress and are targets for change within therapy. However, self-esteem and beliefs about voices have not consistently been shown to mediate reductions in voice related distress (Paulik et al., 2019). Authors suggest further research is needed to understand factors that may be underlying change processes as it is currently unclear how the psychological process of change occurs and is sustained after therapy for distressing voices. Several change theories may be relevant in addressing this.

The processes behind changes occurring from psychological interventions have attempted to be captured using qualitative outcomes such as the Client Change Interview (CCI; Elliott et al., 2001). Within the CCI, clients are asked what factors were facilitative and hindering of positive change processes. This interview has proven to be a useful follow up outcome in a trial of social and motivational interventions for alcohol dependency and demonstrated discernible intervention-orientated and general factors that support client change following treatment (Orford et al., 2009).

Rationale and research aims

Given the current access issues of CBTp, it is vital that alternative, more targeted interventions like CBTv provide the maximum possible benefit. In examining the process by which changes are sustained, or improved upon, we can elucidate factors that support positive change and build this into treatment pathways following CBTv, potentially leading to improved outcomes at follow-up and more durable therapeutic changes.

In this grounded theory study, the following questions will be addressed:

I. What aspects of CBTv do people who have attended the therapy perceive to have been helpful and unhelpful for change?

II. What do clients perceive is needed for therapeutic change to take place in CBTv?

III. What do people who have attended CBTv believe is needed for changes to be maintained or built upon after intervention?

Methodology

Design

A modified grounded theory[5] was deemed appropriate due to the lack of existing theory on CBTv change processes (Urquhart, 2012). This approach allows for the study of subjective change, given the individual meanings behind personal growth (Corstens et al., 2014). A critical realist epistemology was adopted. This approach acknowledges that participant responses may be imperfect representations but do however still give valuable insights into the individual's reality, whilst also providing information on the "real world" (Bhaskar, 2013). This approach to grounded theory has previously been used successfully (Cooke et al., 2019), and has been recognised as highly compatible in terms of research objectives and perspectives (Oliver, 2012).

Context

Recruitment occurred through a transdiagnostic service which offers CBTv interventions. Clients are typically offered 6-16 individual sessions of manualised CBTv that aims to enhance coping (Hayward et al., 2018), reappraise beliefs (Hazell et al., 2018b) and improve relationships with voices (Hayward et al., 2017). Sessions are delivered by a range of therapists (e.g. clinical psychologists, non-expert). Therapists are provided one-off training and offered regular supervision by a clinical psychologist. The service works alongside clients' existing teams as an 'add-on' to usual treatment.

Participants

12 participants were recruited. Recruitment followed a partly opportunistic and partly purposive sampling strategy. This reflects how precise eligibility criteria were set (see Table 5) however a limited sample pool meant all potential participants were invited to take part.

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[5] Modified grounded theory refers to theoretical sampling not being applied to participant recruitment due to sampling constraints.

Theoretical sampling was not possible in terms of influencing who was next recruited, however, did occur through collected interview data informing on-going data collection (Corbin & Strauss, 2008). For example, initial interviews resulted in the addition of further questions to the interview schedule regarding experiences directly after CBTv ended.

Table 5 *Inclusion and exclusion criteria*

Inclusion criteria:

- Adults who have completed CBTv in the previous 3-12 months.
- Must have attended 6+ sessions of CBTv.
- Must speak fluent English.

Exclusion criteria:

- Clients who accessed an alternative intervention to CBTv.
- Clients who attended <6 sessions.
- Clients experiencing acute distress or where serious risk issues are identified.

Participants were recruited until theoretical sufficiency was achieved and no new major categories were produced by interviews. The number of participants was in accordance with estimations of eight to sixteen participants being needed to reach theoretical sufficiency (Dey, 1999). Demographic data was collected using a questionnaire (Appendix D; See Table 6).

Table 6 *Summary of participants' collected demographics*

Participant	Age	Gender	Employment	Ethnicity	Marital status	Education level	Mental health diagnosis	Voice onset (age)	Contact with MH services
P1	57	Female	Not stated	White (British)	Separated/ divorced	High school	Treatment resistant schizophrenia	37	10+ years
P2	45	Male	Unemployed	White (British)	Single	College/Sixth form	Not stated	16	10+ years
P3	39	Male	Unemployed	White (British)	Single	Foundation degree	Paranoid schizophrenia	25	10+ years
P4	23	Male	Employed full-time	White (British)	Cohabiting	College/Sixth form	No diagnosis	7	2-3 years
P5	56	Female	Unemployed	White (British)	Separated/ divorced	No formal qualifications	Personality disorder and bipolar	6	10+ years
P6	56	Female	Retired	White (British)	Separated/ divorced	No formal qualifications	Bipolar and schizophrenia	23	10+ years
P7	60	Male	Long-term sickness	White (British)	Married/civil partnership	High school	Schizophrenia	55	4-6 years
P8	42	Female	Employed part-time	Asian/Asian British	Single	University degree	Schizoaffective disorder	22	10+ years
P9	62	Female	Unemployed	White (British)	Single	High school	Schizoaffective disorder	30	10+ years
P10	55	Female	Unemployed	White (British)	Single	College/Sixth form	Depressive disorder and anxiety disorder	9	10+ years
P11	57	Female	Long-term sickness	White (British)	Separated/ divorced	College/Sixth form	Depression, anxiety and psychotic episode	56	7-9 years
P12	51	Female	Not stated	White (British)	Single	High school	Schizophrenia	30	10+ years

Interview design

A semi-structured interview schedule was developed in collaboration with research supervisors and consultation from a service-user research advisory group. The schedule was largely based upon the CCI (Elliott & Rodgers, 2008) and was designed to draw out in-depth experiences of change (see Appendix E). Interviews were completed over the telephone and lasted between 42-76 minutes. Interviews were audio recorded and transcribed. Notes taken during interviews captured potential categories and memos. Initial interviews followed the schedule closely, with later interviews being influenced by emerging results (Charmaz, 2006).

Ethical considerations

Ethical approval: NHS ethics and HRA approval was granted for this study (Appendices F and G), and the host trust's Research & Development department provided internal approval (Appendix H). A results summary was sent to the ethics committee, R&D department and participants who opted to receive a copy (Appendices I-K).

Informed consent: A study leaflet and participant information sheet (Appendix L and M) were developed detailing the nature of the study for potential participants. Consent was received via an informed consent form (Appendix N). These documents were developed in consultation with the Trust's service-user research advisory group to ensure clarity. Details of the study were discussed with potential participants, with the opportunity to ask questions. Potential participants' understanding was checked before interviews. Participants were made aware of their right to withdraw.

Confidentiality: Transcripts were anonymised and stored on a password protected computer to protect participants' confidentiality. Other study information was stored on an encrypted memory stick.

Minimising potential harm: Potential participants were initially contacted via telephone to discern current mental state. With participants' consent, Care Coordinators were contacted before interview to ascertain any issues that would suggest taking part was not appropriate. No participants were excluded on these grounds. Participants were made aware that they could pause or end the interview. Participants were asked how they found interviews and how they were feeling afterwards to assess wellbeing. Sharing resources, signposting to relevant support and contacting Care Coordinators took place to support participants, where appropriate.

Data analysis

To begin, four interviews were completed and initial analyses took place. Following this, analysis occurred through an iterative process, moving between coding, data conceptualisation and theory building (Corbin & Strauss, 2008). Line-by-line coding was initially used to encourage data-driven analysis rather than being guided by researcher assumptions (Saldana, 2009). Focused coding captured and synthesised initial codes, facilitated by memo writing and diagramming, and eventually contributed to concepts via theoretical sorting (Lempert, 2007). Constant comparisons were used throughout analysis to distinguish and group emerging codes, concepts and categories (Glaser & Strauss, 1967). Finally, categories sorted into an explanatory model of change following CBTv.

Quality assurance

Grounded theory analysis involves subjectivity (Charmaz, 2008), however, a bracketing interview was conducted with an independent researcher to highlight potential bias and a reflexive position statement was produced (Tufford & Newman, 2012; Appendix O). A research diary recorded the author's responses in relation to the research and promoted an awareness of the influence on analysis (Appendix P; Yardley, 2000). Memo writing occurred throughout analysis to capture reflections, thoughts on how concepts were connected and questions that were provoked by this, building analysis toward theoretical concepts.

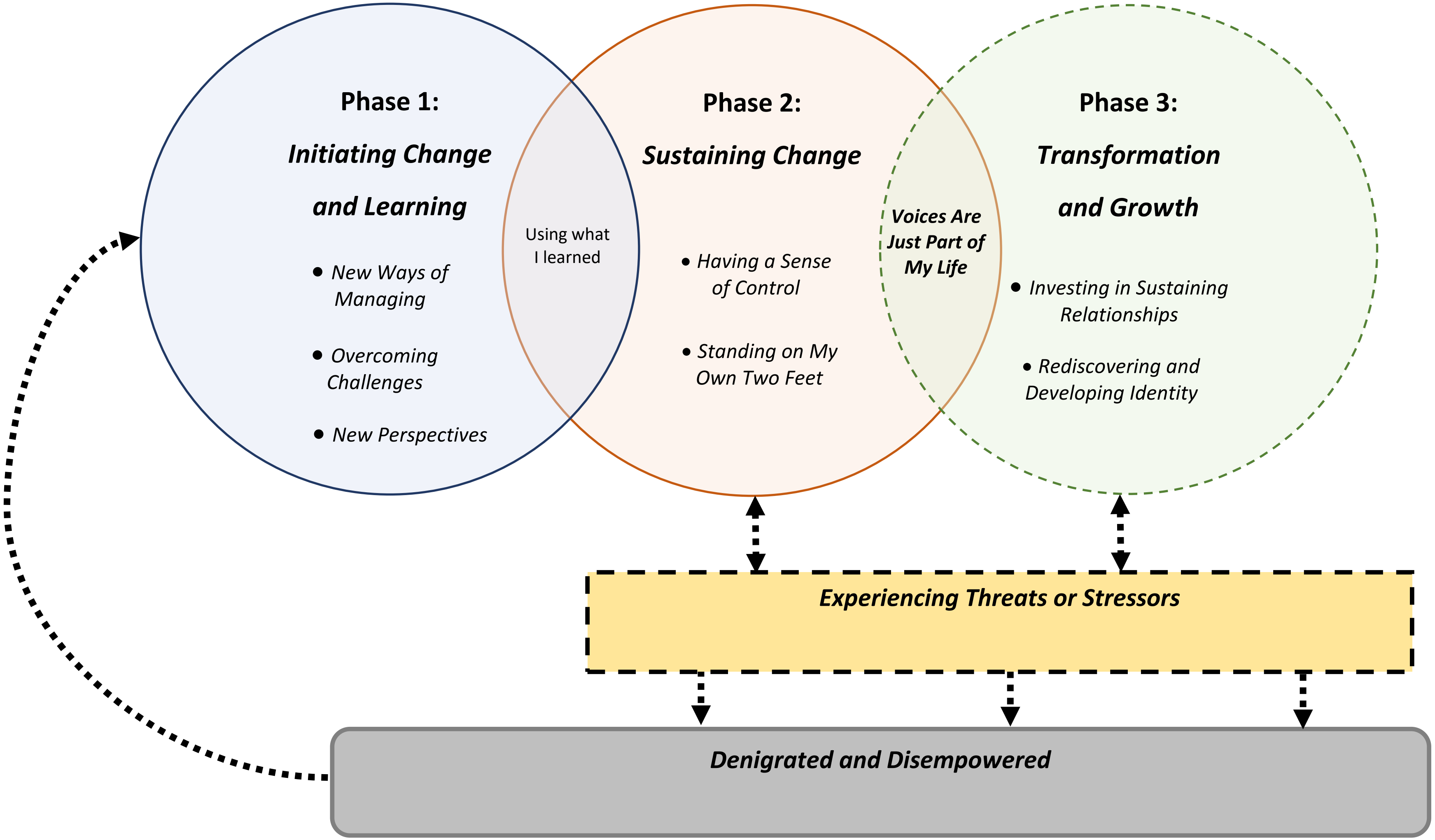
A portion of transcripts were validated for accuracy by an independent researcher. Coding was cross-checked against that of a supervisor with experience using a grounded theory methodology, and regular discussions of the author's analytic processes took place. Unfortunately, due to time constraints the respondent validation that was intended to take place could not be included in the current report. This is planned to be undertaken and participants' feedback incorporated into the theory and published versions of the report.

Results

The categories and model described within this section aim to elucidate a theoretical representation of therapeutic change processes relevant to voice hearers who have completed CBTv. This includes how positive changes can be maintained and built upon, possible facilitators and challenging experiences captured across interviews with 12 people who heard voices. The diagrammatic model (see Figure 4) is followed by a written summary and comprehensive discussion of each category.

Figure 4

A theoretical model of change built from participants' perceptions of CBTv and the time following.



Model summary

From the analysis, three non-linear, phases were hypothesised to reflect the study data, covering ‘Initiating Change & Learning’, ‘Sustaining Change’, and ‘Transformation and Growth’, and the processes described in each were not necessarily discrete. Eight categories denote the experiences participants described which facilitated the process of initiating, sustaining or building upon positive change. These are summarised in Table 7 alongside the phase in which they are situated and relevant subcategories.

Participants described occasionally occupying a ‘Denigrated and Disempowered’ place. This was characterised by increased distress and was most common before accessing CBTv. It was apparent that encountering difficulties along their journey had the potential to push participants to feeling denigrated and disempowered. Within the model, acute challenges and more enduring difficulties at each phase are referred to as ‘Experiencing Threats or Stressors’ to reflect the manner in which, in the right conditions and with sufficient support, individuals may be able to overcome these. The dashed lines are intended to demonstrate that encountering these challenges is not necessarily a loss of change, indeed, where participants were well supported the change process was strengthened. Therefore, even the category ‘Denigrated and Disempowered’ refers to an active process whereby participants were trying to overcome the various challenges facing them.

Table 7 *Concepts contained within the proposed change model*

Phase	Category	Sub-categories
	Denigrated and Disempowered	Difficulties Coping Punishment from Self and Voices Having Minimal Support Diminishing Identity
	Experiencing Threats or Stressors	Everything Changed Overnight (The Pandemic) Voices Getting Worse Again Having Physical Health Crises Interpersonal Stressors & Limited Support Fighting with & Being Distressed By Voices Others Treating Me Differently
Phase 1: Initiating Change and Learning	New Ways of Managing	Learning Skills Practicing Ways of Coping
	Overcoming Challenges	Working with and Overcoming Challenges of Therapy Talking About Voices Connecting and Rapport Building
	Gaining New Perspectives	Understanding Self and Voices Moving to Different Perspectives Building Confidence in Myself
Phase 2: Sustaining Change	Having a Sense of Control	Using What I Learned Being More in Control Taking an Active Role with Voices Regulating the Closeness of Voices
	Standing on My Own Two Feet	Feeling Stronger and Engaging Voices as Equals Building and Improving Self-Esteem Being Independent and Determined
Phase 3: Transformation and Growth	Voices Are Just Part of My Life	Accepting the Voices Focusing on Emotional Wellbeing Continuing to Function Despite Voices Fearing Voices Less
	Investing in Sustaining Relationships	Refocusing on Social Life Benefitting from Relationships
	Rediscovering and Developing Identity	Accepting Myself and My Needs Engaging with Meaningful Activity Having a Purpose and Role Being Myself vs Someone with Mental Health Difficulties

Denigrated and Disempowered

Participants feeling denigrated and disempowered could occur at each phase of the change process, and all participants described experiencing this before accessing CBTv. This was often extremely challenging and distressing for participants and described both their interactions with voices and wider life experiences. Voices were perceived as punishing, powerful and having control over participants.

> *They* [voices] *were persecuting me and just like, all day long um, having people run me down in the ground and you know threatening to kill me and stuff like that.* – Participant 8

Difficulties managing were common, with participants very often feeling like they had limited effective coping strategies or relied on less adaptive ways of coping that only provided short-term relief.

> *I would have woke up, voices are bad, have a cry, go to bed and just ca...cancel everything I had to do and that'd be it* – Participant 1

These challenges were reflected in participants' views of themselves as disempowered, lacking self-esteem and a negative view of one's own identity.

Experiencing Threats and Stressors

Acute threats to wellbeing were challenging and often intense crises that individuals had to manage whilst attempting to maintain earlier therapeutic change. These crises varied across participants but could centre around therapy ending, feeling alone with voices, problems with physical health, housing insecurity and voices getting worse again with no apparent trigger.

> *They used to tell me a lot afterwards that I've been abandoned and, and that I was left alone like I always had* – Participant 4

The impact of the COVID-19 pandemic was also clear in the narratives of participants. This was captured in participants sharing feelings of increased isolation, receiving less support from loved ones and services, experiencing worry around the contagious nature of the virus and voices being exacerbated by these additional pressures.

> *No, they, it's been a little bit worse lately I think because I'm not, all of the centres are shut because of COVID and like I'm on my own* – Participant 7

If the individual had sufficient resources to manage 'Threats', for example through professional support or drawing on personal strengths, their sense of control and empowerment was reinforced.

> *I think knowing that I could go back to the* [service name] *if I need to stopped me from freaking out* – Participant 10

If interpersonal relationships were unsupportive and professional help limited, individuals experienced this as a stressor. 'Stressors' relates to enduring and more long-term challenges faced by participants which had the potential to be resolved but if not, individuals could end up in a 'Denigrated and Disempowered' place similar to before therapy.

> *Um, they* [mental health service] *stopped me from approaching them directly asking for help, no, I just suffer, I won't ask them for help* – Participant 2

Continued challenges could come in the form of the voice-voice hearer relationship being viewed as a battle or a struggle. This was related to conflict, tension and ongoing disturbing phenomena, and if prolonged could result in denigrated and disempowered experiences.

> *Yeah, I take every day like I've got a sword and shield in my hands. So, I'm fighting at every turn, I don't how long I can fight for that's my trouble* – Participant 7

Several participants described others treating them differently, which formed another potential stressor. Responses here described experiencing stigma from significant others and within society that was at odds with their identity, which was explained by a lack of understanding about voice hearing perpetuated by the media and resulted in having to hide the voices from others.

> *I don't want to be treated differently to what they treat everybody else, and, they will do.* – Participant 12

Phase 1: Initiating Change and Learning

While the suggested model is non-linear, the majority of the ‘Initiating Change and Learning’ phase was described in relation to participants’ experiences of CBTv. As indicated in Figure 4 however, occasionally participants’ journey moved through this phase after experiencing overwhelming difficulties following CBTv. The three categories within this phase were facilitated by a connection to others and rapport building, either with the therapist or other professionals. Participants described feeling understood, supported and listened to by the therapist.

> *Yeah well when I was going to see* [therapist], *because I'd already built a rapport, I wasn't nervous or stressful, so they were quite controlled.* – Participant 5

Learning New Ways of Managing

Participants described experimenting with coping strategies and skills within CBTv, including using distraction, relaxation techniques and ways of interacting with voices.

> *Yeah yeah because I didn’t know of another way of dealing with how I react to the voices. I had various ways but I never heard of the way the therapist was telling me about.* – Participant 2

Further ways of managing included being able to challenge the voices, which had the potential to reduce participants' fear and enhance their perceived control over the voices. This was associated with improvements in functioning and distress levels.

> *I think where the therapy helped me was in not letting them control me completely, you know, I stand up for myself a bit more.* – Participant 5

Overcoming Challenges

'Overcoming Challenges' relates to participants' experiences of the difficulties that came with initiating change. In terms of attending CBTv, this could be the taxing nature of therapy, voices being upset about this or talking with the therapist being a reminder of past struggles or trauma.

> *I think the worst like when they just attack you all the time during therapy. Like "you should tell them to F-off", "she's talking shit" and stuff like that* – Participant 7

> *…although I used to go home and be very tired, at least I'd learned something and I felt that I was getting somewhere*. – Participant 1

Talking about the voices was a challenge for participants, who referred to this as a novel experience for them, something they had not had the opportunity to do before or had been fearful of doing. Whilst this seemed to be particularly difficult and could take an emotional toll on individuals, it was associated with a shift in participants' ability to be more open about voices.

Gaining New Perspectives

During periods of initiating change and learning, participants described shifts in their perspective or beliefs. Gaining new understandings about the voices and oneself was an integral part of the therapy for some participants. Being able to make sense of current difficulties and having information about voice hearing seemed to lessen participants' anxiety and distress surrounding voices.

> *Because like the things the voice say, like sometimes they say they're going to get you, which is, the work I did with* [therapist], *because that's a reflection of what my brother used to say to me, about men in white coats in a white van, taking me away and putting me in a padded cell because I kept talking to someone who wasn't there.* – Participant 10

Additionally, participants could gain new perspectives on how they viewed themselves. Initial changes related to building confidence in one's own ability, focusing on self-esteem and centring participants' thoughts over that of the voices.

> *It was the talking as much as anything and trying, him trying to get me to think in a different way, not the way that the voices wanted me to think, but to have my own thoughts and opinions. And that my thoughts and opinions were, were more important than the voices.* – Participant 12

Changes in thinking could either occur during CBTv sessions or in the time between appointments. Self-reflection, re-evaluating their experience of voice hearing and what voices said to them, and hearing insights about voice hearing from the therapist were all enablers for participants to gain new perspectives. Participant 8 described how the content of CBTv sessions was not always relevant for the difficulties she experienced. Despite this, positive change still occurred due to therapy prompting her to further examine personal ideas of how to meet her needs and manage voices.

> *It did make me think about things, but the advice I felt like the therapy was giving me um, didn't match with what I think works for me, um, but it did make me realise what I thought worked for me.* – Participant 8

Phase 2: Sustaining Change

Having a Sense of Control

When moving between initiating change and sustaining change, participants described using therapy knowledge or finding therapeutic spaces as a transition process. The continuation of specific skills practiced in CBTv, self-help material or actively creating personally therapeutic spaces at home were all examples of how participants achieved this, represented as the subcategory ‘Using What I Learned’.

> *I suppose I don't want all the therapy that I did have to be waste, so that's why I'm pushing to incorporate what I've learned every day when I'm hearing the voices*– Participant 10

Participant accounts spoke to an increased perception of control of their voices and in their lives more generally. Having a sense of a control with voices was an important process for participants to sustain therapeutic changes achieved previously.

> *The voices were angry at me but I could kinda handle them better. I was obeying them more before, I’m not obeying them as much now after therapy.* – Participant 7

One participant spoke about their difficult journey with alcohol and substance use. They shared how they were able to use other coping strategies during therapy and managed to refrain from harmful drinking after, affirming their sense of control.

> *I quit beer whilst I was in therapy, now that I'm out I have a drink on the weekend but I'm in full control of it, um, I basically I gained control, that was it. I gained control of my life again.* – Participant 4

This continued sense of control afforded participants agency in their interaction with voices. Many spoke of making choices in how they responded to voices in a way that was not available to them beforehand, such as challenging voices. Within this category, participants' responses generally reflected them holding a more active role in managing their voices.

> *I still react like that today, I hear voices every day, I still react like that. I still don't shout back at them or threaten them or anything like... I don't self harm so much.* – Participant 2

> *…when I say my assertive statements, I believe what I'm saying, so I'm not believing the voices as much as I used to.* – Participant 10

Participants spoke of specific ways they might use their enhanced control over voices, for example through using distractions to tune out from voices or attempts at blocking out voices all together. This served to regulate the voices or participants' closeness to them and could provide voice hearers with a sense of respite from distressing voices.

Standing on My Own Two Feet

Participants spoke of a fundamental feeling of being stronger and being able to draw on personal strengths such as determination. This was both within themselves and in their interactions with voices.

> *...being able to, uh, basically stand on my own two feet because I would have never of got to this place if I couldn't of done it.* – Participant 6

Although participants described feeling stronger generally, it was apparent that this was not always the case and could vary day-to-day.

> *I am a strong person although I give in to the voices sometimes, I am a, strong minded on days, on good days, I'm strong minded.* – Participant 12

Participant 5 was open to building on their perceived strength further.

> *I'd be more confident to go ahead. So, in one way, I'm hoping to make it, make me even stronger.* – Participant 5

Alongside feeling empowered, participants spoke of noticing improvements with their self-esteem or wanting to work on building upon positive views of themself.

> *I find that building, trying to build confidence and trying and talk to people would be a good thing. Yeah, so I've been trying to get out a bit more. And I think on that line, I think it's, my confidence is building.* – Participant 11

> *It's helpful yeah, I mean obviously it's helping me to get good opinions of myself and yeah, you know get on with life again, get on with doing my regularly stuff.* – Participant 3

Participants commonly shared how they had begun to feel empowered in relation to voices through changes in beliefs. Within this category, participants were often engaging voices as equals using assertive communication or through reasoning with voices to speak their own view or opinion.

> *I think I was just braver because I'm stronger than him, I wasn't that weak person that closed down.* – Participant 6

> *I was going to employ a new attitude toward my relationships and how I spoke to people and how I interacted with my voices, I took it from the assertiveness and now I even try to apply my voices* – Participant 4

This sense of empowerment seemed to allow some participants to be able to accept themselves and their physical health and psychological needs more readily.

> *I'm just realising things I've been saying, like just doing what I want to do and accepting myself you know, and, and not every one size fits all and I just need to accept that I'm different to everyone that I know really* – Participant 8

Phase 3: Transformation and Growth

This final phase related to the experiences participants described in which previous changes evolved and were built upon in a personally significant way, or new changes occurred which were not a direct result of the learning taking place in the first phase of this model. This phase contains the transformational nature and personal growth which participants spoke of, spanning vital changes in how they viewed voices, their relationships with others and their sense of identity. Not all participants contributed to the final categories within this phase, which appeared contingent on the relationship with voices.

Voices Are Just Part of My Life

Some participants described fundamental shifts in their relationship with their voices. This was enabled by, and further facilitative of, participants' sense of control and empowerment described earlier. Participants shared a different attitude being adopted with voices, one that was accepting of their existence and what they said.

> *I've learnt how to deal with them, like it's just part of my life so I need to deal with them.* – Participant 7

Alongside accepting the voices, some participants were able to be more open about the voices to others and found benefits in doing so. For one of the participants, this was supported by her engagement with a Hearing Voices Network group.

> *…now I can talk about them. I don't need to block them out. I can almost live with them* – Participant 10

Responses generally reflected the relationship between voice hearer and voices improving, becoming closer, becoming more harmonious and living a fuller life as a result. This was associated with being less distressed and fearful of voices, having days of respite from voices and being more able to function and manage other areas of life.

> *I'm able to interact with the voices and what they say may be harsh but I'm able to kind of process it and take it in and find the positives in what they say and find the positives in what they mean…and that was really helpful.* – Participant 4

Some participants spoke about the intersection of their emotional state and voice hearing. Focusing on emotional wellbeing tended to support participants to be less distressed.

> *So, and obviously stress on my part, um, makes them worse, so if I keep calm then they're not so bad, it's when I get stressed more.* – Participant 5

Investing in Sustaining Relationships

Voices being accepted and integrated allowed for further changes to occur for some participants. Individuals directed more toward important relationships in their lives, and subsequently experiencing benefits from this. Some participants shared how they were more sociable now, spent more time with friends and were more confident in communicating with others. This could provide motivation for further changes to take place.

> *…being able to be there for the people I care about really, probably the other major thing, just being able to be there for other people…because they, they inspire you to push further.* – Participant 4

Investments gave individuals the opportunity to identify with others with shared difficulties, receive practical and emotional support, have people around them and to feel more present in the world.

> *I ring up one of my friends, she's got a couple of kids and we can chat about the kids and what they've been doing, you know it just takes your mind off of what's been going on in your head, you know it's just nice to be able to talk about other things* – Participant 1

Some participants shared how they now had the resources and social skills to bridge social connections they were previously unable to due to the significant changes they had experienced.

> *I'm friends with people who I wasn't even ever friends with because they didn't like who I used to be, and now being able to interact with those people* – Participant 4

Focusing on sustaining relationships provided some participants with a sense of purpose and denoted a change in how they viewed themselves. Many of the benefits of social investment described within this category were facilitative of a changing sense of identity.

Rediscovering and Developing Identity

Both reinforced by and facilitating an investment in sustaining relationships, this category pertained to participants building their identity and essential changes in how they viewed themselves.

> *I s'pose I don't really recognise myself and I've had that for ages and I'm sort of learning more about myself now* – Participant 8

For some, identity developed in the context of changing relationships.

> *…they trust my ability and trust that I'm making myself a better person and, seeing that was was probably the biggest thing for me* – Participant 4

Rather than relationships with others, two participants shared how they invested in building a positive relationship with themselves, which involved spending less time with others, and was seen as beneficial.

> *I s'pose the challenges are that I'm, I've accepted that I'm changing and I'm just going to be more selfish and I just decided to cut other people out, I've got nothing to come up against really *laughs** - Participant 8

Further changes were achieved through engaging in meaningful activity that were either personally significant or had a therapeutic function for participants.

> *I've become more outdoors, outdoorsy now, um, I don't quite know why that is, but I barely spend any time in a building now. It doesn't matter what the weather is, *laughs* I'm out in it! I've got all the like equipment and clothes, the knowledge and the experience* – Participant 2

Participants shared ways in which taking on certain roles through employment or volunteering had provided them a direction and a cause, further shaping their identity.

> *I really found working to be good for me, a lot of it is to do with self-esteem. There's a feeling of a victim and everything happening to you, and then there's getting out there and doing something positive. And my work does make me feel like I'm doing something good* – Participant 8

Several participants described being a more hopeful person, adopting a positive outlook and having a sense of moving forwards.

> *I never used to be an optimist, but I can be a bit optimistic now and look towards the future.* – Participant 10

Some participants spoke about the way in which they had been developing their interests and identity, however, the COVID-19 pandemic had disrupted this.

> *I used to go to the* [day service]*, but obviously because the lockdown it's shut. So, I've not really been going anywhere after else, I don't know anyone else. And I used to go to an art class at the town and I used to meet up once a week and sometimes go for a coffee afterwards* – Participant 10

Finding and strengthening an individual identity separate to someone with mental health difficulties or a 'voice-hearer' was important to others. Participants' descriptions equated this to their behaviours, abilities and outward expression being more congruent with their internal view of themselves, as if returning to who they are with voices being a smaller part of their lives.

> *Makes me feel like I haven't got a mental health problem, I can just get on with my life. I can get on with myself more*. – Participant 3

Discussion

The current study sought to understand how voice hearers perceived therapeutic changes to occur and be maintained after accessing a targeted CBT intervention for distressing voice hearing. The resulting model captures eight facilitative categories, conceptualised within three overarching phases, which are thought to contribute to the maintenance of therapeutic changes following CBTv. Various contextual experiences were also included which could provide specific challenges or support the maintenance of change.

Change processes within CBTv

Results indicate participants valued the opportunity to develop adaptive coping strategies, ways of responding to the voices and new ways of thinking. This maps on to targeted outcomes of several CBT-based interventions for distressing voice hearing, for example: coping strategy enhancement (Tarrier et al., 1990), relating therapy (Hayward et al., 2017), and general aims to foster changes in cognition (Chadwick & Birchwood, 1994). The perceptions of participants within this study then supports the use of such interventions to promote therapeutic change.

Similarly, previous research has found changes in perspectives of clients to be a core process in psychological therapy for psychosis (Dilks et al., 2008). It may well be that there are shared experiences of voice hearers and those experiencing psychosis and it has been suggested that this process of meaning making can alleviate distress (Romme & Escher, 1989; Corstens et al., 2014). Cognitive theories relating to voice hearing are largely premised on the idea that the meaning behind voice hearing is the main predictor of distress (Morrison, 2001).

CBTv provided opportunities for participants to develop positive self-efficacy beliefs and effective coping, as previously reported (Morrison et al., 2004; MacDonald et al., 1998). Improvements in self-efficacy during CBTv was associated with a sense of control and empowerment afterwards, however, self-efficacy was not specifically described by participants as a central facilitating process. Instead, the importance of connection and rapport building when initiating change was emphasised, in accordance with the wealth of literature on the need for a strong therapeutic alliance in psychological therapies (Bentall et al., 2003). Participants commonly reported learning from therapists, perhaps through a process of scaffolding (Bruner, 1986; Vygotsky, 1978). If this were a social process, it is understandable then that participants struggled to maintain changes in the context of social isolation or a lack of support, which has been reported in a previous review on psychosis Recovery (Wood & Alsawy, 2018). The pandemic clearly contributed to social isolation, potentially resulting in greater importance placed on this context by participants, however.

Maintaining change beyond therapy

Key processes contributing to maintaining change seem to bear some resemblance to the categories relating to therapy, namely, changes in perceptions and improvements in control and coping. These findings are reflective of cognitive models of voice hearing and distress (Chadwick & Birchwood, 1994). Potential researcher bias may have influenced data analysis, given both the author and lead supervisor are familiar with cognitive theory. Alternatively, CBTv may have provided participants a framework by which to share their experiences. Sense making has been indicated as particularly relevant in psychological therapy for voice hearing (Longden & Corstens, 2019) and participants may have adopted ways of understanding their experiences.

Results seem to depart from existing cognitive theory during the final phase of the model. Within this phase, categories conceptualise experiences of integration with voices, developing relationships and living a meaningful life. These processes perhaps reflect the aims of Acceptance and Commitment Therapy, which seeks to foster psychological flexibility and engage in values-based actions, with some emerging results in psychosis studies (Shawyer et al., 2017). Whilst this study has not intended to investigate Recovery experiences, these categories are akin to those present in both distressing voice hearing and general Recovery literature (Romme & Morris, 2013; Soundy et al., 2015). For example, the categories discussed in phase three of the model are similar to the CHIME personal Recovery model: Connectedness, Hope, Identity, Meaning and Empowerment (Leamy et al., 2011). While Recovery styles have been investigated in voice hearing (De Jager et al., 2016), examining the utility of the CHIME model with Recovery and distressing voices may help to clarify these experiences and ways to facilitate them, as has been studied with people with psychosis (Leendertse et al., 2021). These results also point to the importance of individuals having identities beyond being ‘a patient’. Social constructionist principles underpinning approaches such as narrative therapy offer a framework by which to thicken and strengthen identity beyond that of psychiatric language, and may be beneficial to voice hearers (Thornhill et al., 2004)

Another possible mechanism in phase three of the presented model centred around participants' investment in sustaining relationships. A hypothesis might be that this led to changes in the individual's perceived social rank, echoing previous research that social performance and schema are indicated in maintaining long-term wellbeing (Kurtz & Mueser, 2008; Paulik, 2012). While this seems intuitive due to the association of relationships and identity found in this study, beliefs around social rank were not formally explored and would be an avenue for future study.

Managing challenges after CBTv

Disempowering experiences were described which could disrupt therapeutic change. Negative affect and life stressors have been associated with increases in distressing voices (Chadwick et al., 2007; Romme & Escher, 2010). This was present in some participants accounts whereby overwhelming experiences could result in increased distress, disrupting change maintenance, corroborating previous research that stressors can precipitate poorer wellbeing (Hooley & Gotlib, 2000). Participants were also concerned with 'Others Treating Me Differently'. Research on Recovery in psychosis has discerned the disruptive effects of stigma on processes of positive change (Wood & Alsawy, 2018). Within this study, stigma seemed to act as a long-term or contextual stressor for participants and was a potential obstacle in maintaining changes.

Limitations

Due to the specialist nature of CBTv interventions, recruitment within this study was limited to a small pool of participants. As all participants were recruited from one service and mostly identified as White British, this could have introduced bias into the research. Black, Asian and people from minority ethnic backgrounds are overrepresented in the prevalence of psychosis diagnoses, however, were not represented in this study (Fernando, 2017). Young voice hearers and those with a shorter duration of voices are also underrepresented.

The current study worked toward theoretical sufficiency of categories, as opposed to saturation, meaning there are potentially further codes to be explored within the research questions. It is not possible to infer causal relationships from the results of this study, given the design was non-experimental and the presented model is theoretical and relevant to the small number of participants. Further research would be needed to test hypotheses within the model.

Within grounded theory, triangulation is recommended to offset bias and validate categories (Jonsen & Jehn, 2009). Unfortunately, this was not possible within the remit of this study but could have added other perspectives had the sample included others who had not necessarily accessed CBTv. For example, recruiting participants' loved ones or clients who did not complete CBTv.

Clinical implications

Many participants within this study perceived CBTv as helpful. Efforts should be made to increase access to CBTv, which would require further training of therapists and services being supported to identify clients. CBTv groups may be another possible avenue for increasing access, building coping, fostering connection and bolstering support networks. Clinical psychologists could play an integral role in training, supervising, and evaluating interventions for distressing voices. The findings highlight the need for clinical services to strengthen the ties between therapy and the processes which maintain change afterwards. One way this may be achieved is by building conversations of change and learning into the ending of psychological interventions, much like relapse prevention plans used in psychosis services (Birchwood et al., 1989), to support clients to consider how potential challenges can be managed and therapeutic changes maintained. At this stage, an explicit focus on goal setting with clients for how they wish to further changes could encourage processes in phases two and three of this model.

Therapists may invite clients to share details of or include significant people who support them in therapy, such as family members and professionals. Reinforcers may support the process of therapeutic change, as in Dialectical Behaviour Therapy (Linehan, 2014). Participants described how changes were difficult to maintain in the face of overwhelming challenges. Voice hearing has been known to be a potentially long-term experience which can continue to cause distress (Harrow et al., 2014). Psychological therapies endeavouring to signpost clients who hear voices to places of ongoing support when needed, such as their GP or HVN groups, may be more likely to facilitate enduring changes. Similarly, providing people who hear voices with resources, such as self-help, or potentially access to support groups following CBTv could work to mitigate some of the challenges participants faced. In this way, those who have accessed CBTv may feel best supported, with changes being more readily sustained and built upon. Anti-stigma campaigns through social media, within schools and utilising psychosocial frameworks may also reduce the burden of stigma on voice hearers (Sampogna et al., 2017; Pinfold et al., 2003; Longdon & Read, 2017).

Theoretical and research implications

Within change research, explanations of change are often geared toward initiating change (Norcross et al., 2011). The current study has demonstrated benefits in examining enduring change processes in a specific population of voice hearers, and current and future theories may benefit from consideration of the maintenance of changes within models. This seems particularly important within research on psychological interventions given that the potential of therapeutic change lessening, such as with CBT (Garety et al., 2008). Theories relating to enduring change should consider an emphasis on meaning, social relationships, identity and integration with people distressed by voices specifically, as these processes are also well supported in the literature (Leamy et al., 2011). Long-term research combining outcomes and qualitative methods to triangulate results on the durability of changes from psychological interventions with people who hear distressing voices may further highlight specific factors and their influence over time. Similarly, family members' and Care Coordinators' insights about sustaining change were not examined in this study and could provide enriched perspectives.

Future research could examine socio-cultural differences in the change processes outlined following CBTv. CBT interventions generally have been criticised for not being culturally sensitive without adaptation (Naeem et al., 2019). This suggests the results of this study do not represent experiences of voice hearers from different cultural and ethnic backgrounds to the predominantly White British participants in this study and requires further exploration.

Conclusion

In examining experiences of change in and after CBTv, this study found therapeutic change to be enduring when experiences following interventions facilitated positive appraisals about the self and voices. The current model describes an ongoing process whereby participants accessing CBTv could move from disempowerment toward increased agency and empowerment by using learnings from therapy and with the support of others. Challenges arose for participants within this study, however, with adequate support and positive self-efficacy beliefs, these could be overcome and reinforced the maintenance of change. The final phase suggests voices being integrated within the individual and their life, focusing on positive relationships and exploring identity to support enduring change. In contrast, fighting with voices and experiencing stigma were barriers that could disrupt participants' maintaining changes. This model adds to current literature on people who hear distressing voices and reinforces the need to examine facilitating and excluding processes of change following psychological interventions.

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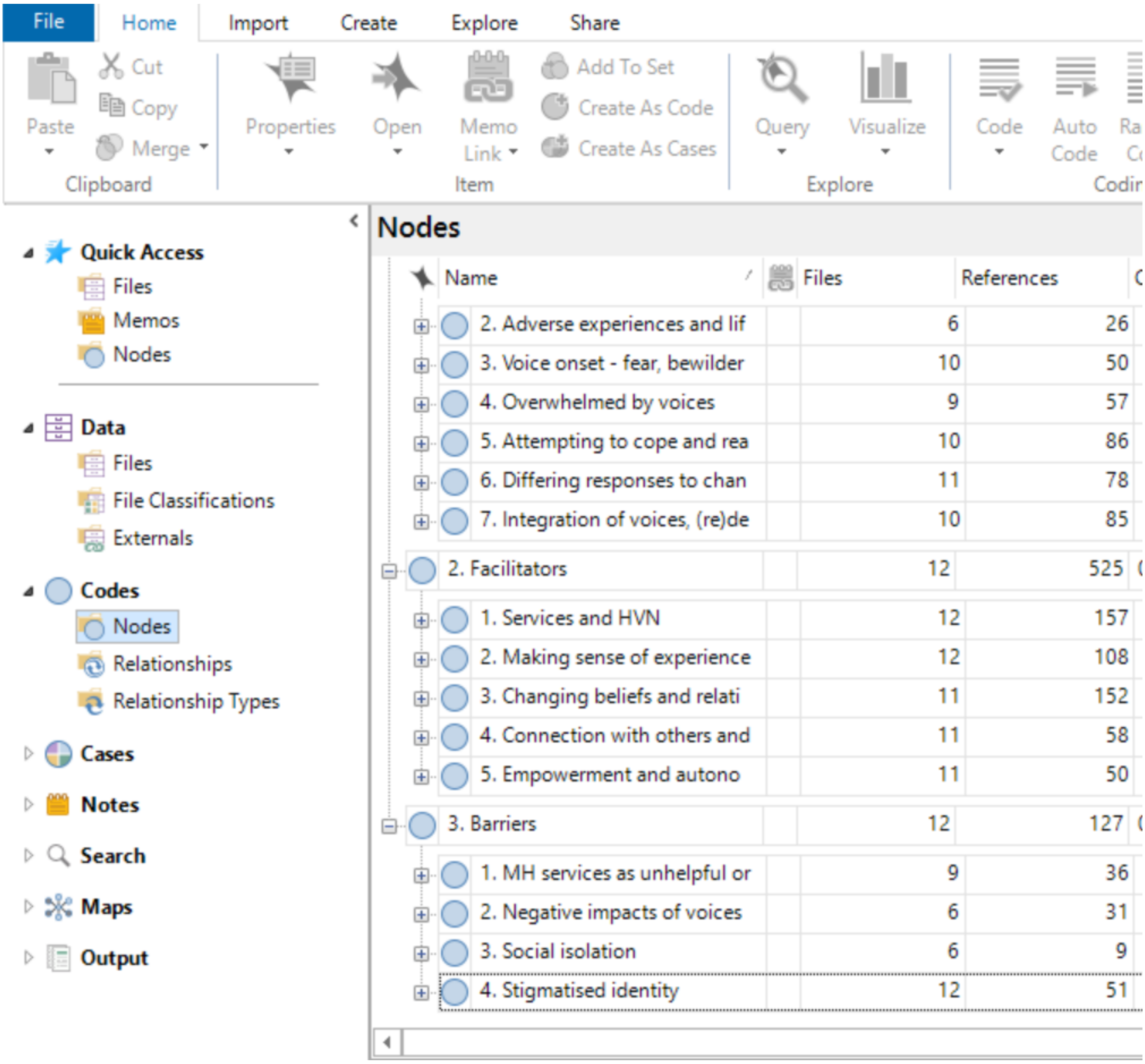
Appendices

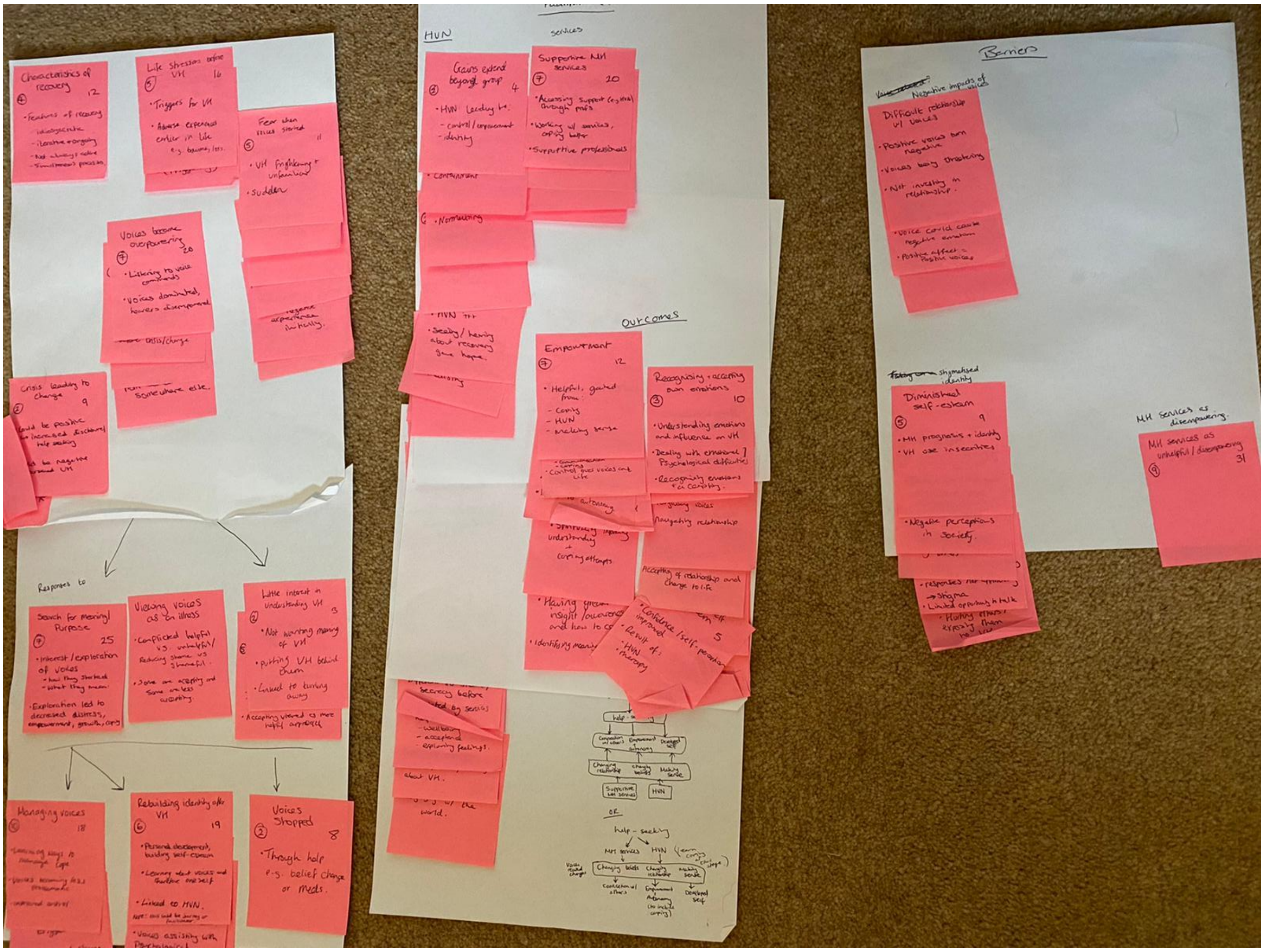
Appendix A: NVivo coding and sorting for the thematic synthesis (Section A)



Nodes

Name	Files	References
2. Adverse experiences and lif	6	26
3. Voice onset - fear, bewilder	10	50
4. Overwhelmed by voices	9	57
5. Attempting to cope and rea	10	86
6. Differing responses to chan	11	78
7. Integration of voices, (re)de	10	85
2. Facilitators	12	525
1. Services and HVN	12	157
2. Making sense of experience	12	108
3. Changing beliefs and relati	11	152
4. Connection with others and	11	58
5. Empowerment and autono	11	50
3. Barriers	12	127
1. MH services as unhelpful or	9	36
2. Negative impacts of voices	6	31
3. Social isolation	6	9
4. Stigmatised identity	12	51

Sorting codes into initial themes



NVivo codebook

Name	Files	References
1. Recovery journey	12	398
Characteristics of recovery	3	16
Recovery as idiosyncratic	3	8
Being supportive not prescriptive	1	2
Recovery varies in effort	1	1
Recovery as iterative and ongoing	2	5
Not linear	2	2
Recovery involves rests (not always being active)	1	1
Recovery processes occurred simultaneously	1	2
2. Adverse experiences and life stressors	6	26
Experience of trauma before voices started	3	4

Name	Files	References
Life stressors before voices started	6	17
Interpersonal or attachment stressors	1	3
Poor mental health before voices	3	5
3. Voice onset - fear, bewilderment and shame	10	50
Believing voices would go away	2	7
Confused when voices started	5	12
Didn't know anyone else that heard voices	1	1
Not knowing or understanding VH at first	2	2
Fear when voices started	5	11
Feeling ashamed when voices started	3	4
Poor mental health after voice onset	1	3
Secrecy when voices started	3	6
voices negative or critical at first	3	7
4. Overwhelmed by voices	9	57
Feelings of hopelessness	5	11
Feeling fatigued by voices	1	2
Increased distress from VH	3	10
Voices became overpowering	8	28
Behaved aggressively toward others	1	1
Bracing for voice hearing	1	1
Voices get worse after initial onset	2	5
Voices seen as separate at first	2	8
5. Attempting to cope and reaching out	10	86
Others encouraging help-seeking	7	31
Friends and family being supportive	4	5
Having supportive relationships	5	13
Others encouraging me to seek support	4	13
Discovering hearing voices group	1	4
Attempts to cope	6	29
Attempting to manage	5	8
Experimenting with coping	4	21
Crisis leading to change	2	14
Voices and wellbeing reach crisis point	1	5
Starting to talk about voices	5	12
6. Differing responses to change	11	78
Search for meaning or purpose of VH	8	29
Unable to make sense or still searching	1	1
Searching for a purpose	2	2
Trying to get distance from the voices	11	49
Battling with voices	2	4

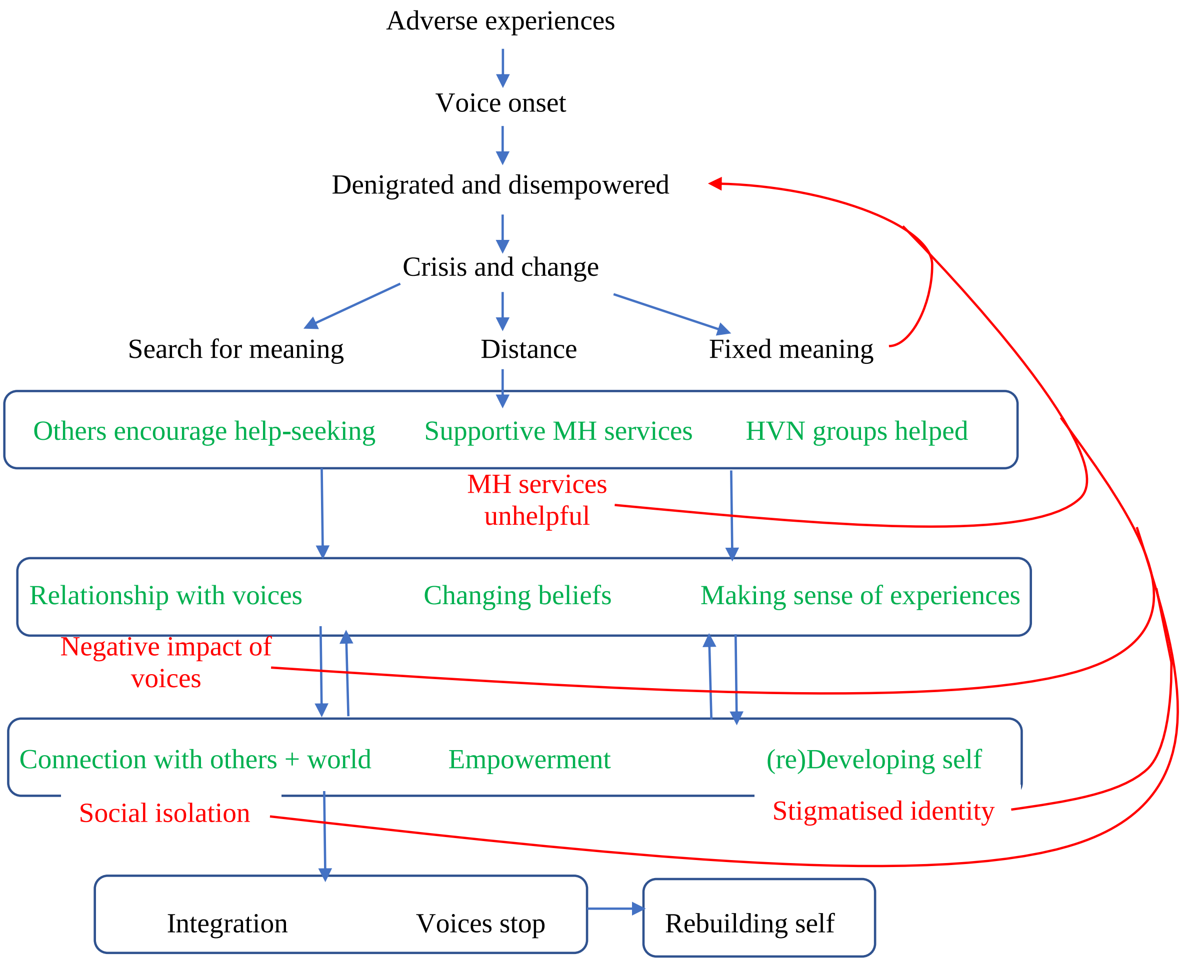
Name	Files	References
Blocking out the voices	1	3
Fixed meaning	9	30
Little interest in understanding voices	3	7
Understanding remained the same	2	8
No explanation or meaning for voices	1	1
Viewing voices as an illness	7	15
7. Integration of voices, (re)developing self	10	85
(re)developed sense of self	9	46
Improved self-esteem	4	8
Being valued	1	1
Finding new interests	1	2
Living a meaningful life	2	2
Rebuilding identity after voice hearing	6	19
Personal growth through voice hearing	3	12
Voices integrated within self	7	16
Adjusting to voice hearing	1	1
Recognising and accepting own emotions	5	14
Becoming closer to others	1	2
Voices facilitate healing	1	2
Unaccepted parts of the self	2	3
Managing voices	10	22
Still hearing voices in recovery	2	4
Owning the voices	1	4
Voices carried on	1	2
Voices stopped	2	11
Worried voices will come back	1	3
2. Facilitators	12	525
1. Services and HVN	12	157
Supportive MH services	8	45
Effective medication was a turning point	3	7
Engaging with therapy	2	8
Benefitting from therapy	1	4
Medication improved ability to cope	4	7
Supportive MH services	8	23
Hollistic approach by services	2	2
Support via mental health professionals	5	9
Therapy as supportive	1	1
3. Engaging with HVN	7	112
Gains extend beyond group	2	9
Being able to share more after group	1	5

Name	Files	References
Getting feedback in HVN groups	2	7
HVN group as supportive	4	32
Caring for self better	1	1
Encouragement by group members	1	2
Hearing from other voice hearers	1	3
HVN group is reliable	1	5
Integrating in group	2	3
Learning from others	1	1
HVN groups as beneficial	5	14
HVN plugs gaps from NHS services	1	1
Personal growth through HVN	1	2
Trusting in the group	2	3
Viewing voices outside of the illness model	1	3
Promoting the possibility of recovery	5	11
Promoting hope in HVN group	1	3
Sharing their story in HVN group	3	10
Social connection in the group	6	29
Community and HVN group	1	3
Treatment not being clinical	1	2
2. Making sense of experiences	12	108
Changing understanding of voices	10	47
As an ongoing process	1	2
Improved psychological understanding	1	2
Making sense of voice hearing	3	11
Considering alternative understandings of voices	4	12
Exploring spirituality and VH	4	7
Making links to past trauma or adversity	5	22
Normalising voice hearing	4	9
Understanding voices better	7	11
3. Changing beliefs and relationships	11	152
Changing beliefs	8	55
Beliefs about power and control	5	22
Challenging voices	5	9
Changing beliefs about the voices	5	19
Initial beliefs	2	2
Testing beliefs about voices	3	5
Not believing what the voices said	3	5
Changing relationship with voices	9	97
Accepting the voices	7	31
General wellbeing improved with voices	1	1

Name	Files	References
Communicating with the voices	7	22
Increased experience of positive voices	1	2
Engaging with voices	3	4
Not acting on the voices	1	2
Positive relationship with some voices	1	7
Social skills and social life	2	4
4. Connection with others and the world	11	58
Connection with others	5	15
Others hear voices too	2	4
Engaging in meaningful activities	3	7
Engaging in work	1	1
Having a purpose	1	2
Other people accepting me and the voices	4	10
Talking about the voices as helpful	6	16
Speaking about voices was liberating	2	4
5. Empowerment and autonomy	11	50
Being in control	8	18
Having a sense of agency	3	4
Empowerment	7	14
Feeling stronger	2	2
Facing problems	4	7
Coping with problems at the root of the voices	1	2
Less fearful of voices	3	5
Managing general mental health helps	2	6
3. Barriers	12	127
1. MH services as unhelpful or disempowering	9	36
Let down by the system	1	2
Medication unhelpful	5	8
MH services invalidating experiences or perspective	6	19
Risks involved in disclosing to MH profs	5	7
2. Negative impacts of voices	6	31
Changes in affect and voices	4	9
Difficult relationship with voices	3	10
Ongoing fluctuations in VH distress	3	10
Negative event or trigger leading to increased distress	1	2
Ongoing struggles with mental heath	1	2
3. Social isolation	6	9
Continued social difficulties	1	1
Disconnection from others	4	7
Not being heard in HVN group	1	4

Name	Files	References
Never spoke to anyone about voices	1	1
4. Stigmatised identity	12	51
Diminished self-esteem	6	10
Fearing judgement from others	6	9
Others having a negative response to VH	4	9
Stigma	9	17
The impact on others	2	6

Initial model of theme groupings



Appendix B: CASP for qualitative research

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Appendix C: Summary of CASP evaluation

Appendix C *Section A CASP review summary table*

Paper	Aims	Method	Research Design	Sampling	Data Collection	Bias and Reflexivity	Ethical Issues	Data Analysis	Findings	Research Value
Dos Santos & Beavan (2016)	Yes	Yes	Yes Semi-structured interviews	Yes Purposive sampling from HVN groups. No reasons for non-participation.	Yes Clear description of methods and rationale. No discussion of saturation.	Yes Bracketing, reflexivity, and quality checks used.	Partially Little detail on attempts to maintain ethical standards or issues raised by the study. Ethical approval was granted.	Partially In-depth analysis with clear procedure and examples. Contradictory data and researcher bias not considered in selection of data.	Yes Findings are discussed in a detailed and balanced way. Credibility checks across analysis discussed. Researchers note that respondent validation did not occur and suggest triangulation in future.	Yes Situate findings in literature base and practice. Suggest avenues for future research.
De Jager et al. (2016)	Yes	Yes	Yes Semi-structured interviews using narrative inquiry.	No Recruitment procedures not clearly stated, nor rationale or total number invited to take part.	Yes Clear description of methods and rationale. No discussion of saturation.	Yes Bracketing, respondent validation and quality checks used. Interview responses informed questions.	Yes Procedures outlined clearly, participant wellbeing considered and approved by ethics committee.	Partially Analysis procedures not clearly defined. Adequate data presented and researcher stated methods do not intend to be objective.	Yes Findings are discussed in a detailed and balanced way. Credibility checks across analysis discussed. Respondent validation, triangulation, focus groups all used to check credibility.	Yes Situate findings in literature base and practice. Suggest avenues for future research.

Paper	Aims	Method	Research Design	Sampling	Data Collection	Bias and Reflexivity	Ethical Issues	Data Analysis	Findings	Research Value
Racz et al. (2017)	Yes	Yes	Yes Not much discussion of why IPA was appropriate.	Partially Info on how participants were recruited (those known to research or suggested by team). No description on why P were appropriate or who declined.	Partially Setting and methods described without justification. Description of interviews but unclear how progressed. No mention of saturation.	Can't tell No accounts of possible bias / researcher's relationships to project.	Partially No discussion of how consent procedures nor issues raised by the study. Ethic approval granted by ethics committee, however.	Partially Description of how themes were arrived at. Not enough description of analytic process, few inclusions of data, no discussion of contradictory data or researcher selection of data.	Partially Findings explicit and discussed in relation to research Q. Not a very balanced discussion (all in support of argument) and no discussion of credibility checks.	Partially Contribution to literature discussed. Little suggestion for future research or how findings can be transferrable.
Clements et al., (2020)	Yes	Yes	Yes Rationale for interviews and IPA clearly given.	Yes Mostly explained except why some did not take part.	Yes Saturation not discussed.	Partially Bracketing and research diary discussed but researcher relationship to participants/service isn’t.	Yes Approval sought, distress managed/ assessed, and capacity considered.	Yes Good use of data and justification for themes. No critical examination of researcher role in selecting data.	Yes Tensions in the data are discussed. Respondent validation not mentioned.	Yes Clearly discussed

Paper	Aims	Method	Research Design	Sampling	Data Collection	Bias and Reflexivity	Ethical Issues	Data Analysis	Findings	Research Value
Romme & Morris (2013)	Yes	Yes	Can't tell Little/no rationale for chosen methods or analysis.	Partially Explained how Ps were recruited but not why these Ps nor reasons for non-participation.	Partially Does not say what proportion were written or interviews. No justification of methods. Good indication of questions/what was involved. No discussion of saturation.	Can't tell Does not discuss bias / relationships with Ps.	Partially Good explanation of study but little info on ethical considerations and no inclusion of ethical approval.	Can't tell Data is presented but no explanation of procedure or even type of analysis. No examination of own role.	Partially Findings related to literature and data. No discussion of credibility of findings.	Partially Authors discuss contribution to research base but limited by no indication for future research nor wider populations.
Hayward et al. (2015)	Yes	Yes	Yes Rationale provided for interviews and analysis.	Yes No discussion of reasons for non-participation.	Yes Clear description of procedure, rationale, alterations to research and discussion of saturation/ sufficiency.	Partially Does not discuss bias except in analysis. There is a mention of questions changing to allow for unexpected experiences/answers.	Partially REC approval, capacity assessed and informed consent. No discussion of issues raised by the study.	Yes Analysis with procedure and examples provided, along with discussion of possible bias and steps to reduce this risk.	Yes Clearly discussed	Yes Clearly discussed

Paper	Aims	Method	Research Design	Sampling	Data Collection	Bias and Reflexivity	Ethical Issues	Data Analysis	Findings	Research Value
Milligan et al. (2013)	Yes	Yes	Yes Justification of interviews and IPA in introduction.	Yes Good explanation of why these P. No discussion of reasons for non-participation.	Yes Mentions sufficiency briefly - saturation not attempted - but covers everything else well.	Partially Some consideration but limited discussion on bias when formulating research.	Yes Little detail on how research was explained. Informed consent and REC approval covered.	Yes Clear procedure but no discussion around how quotes were selected. Researcher does discuss potential bias.	Yes Everything is discussed e.g. validation even though this did not happen.	Yes Discussion of results in relation to Romme and Escher's phases.
Oakland & Berry (2015)	Yes	Yes	Partially Little justification for methods and TA.	Yes Good discussion of why these P. No discussion of non-participation.	Partially Procedures are discussed but little rationale. Data saturation achieved.	Yes Recognition of researcher-p relationship and reflexive stance taken to research.	Yes Ethics approval given. Unclear exactly how research was explained.	Partially Well supported by data but little consideration of researcher's bias in selecting data.	Yes Little discussion of evidence against or credibility of findings.	Yes Clearly discussed
Payne et al. (2017)	Yes	Yes	Yes Clear rationale for qualitative interviews and IPA.	Yes No discussion of reasons for non-participation.	Partially Good justification. No description of interview schedule questions or data saturation.	No No discussion of researcher role/bias in research process	Partially Approval given. No mention of other ethical considerations (consent, distress, capacity etc).	Yes Good use of data and rationale. Attempts to reduce bias. Little consideration of contradictory data.	Yes Well discussed with balanced arguments.	Yes Clearly discussed

Paper	Aims	Method	Research Design	Sampling	Data Collection	Bias and Reflexivity	Ethical Issues	Data Analysis	Findings	Research Value
Ng et al. (2012)	Yes	Yes	Yes Reasons for qualitative approach discussed.	Yes Non-participation not discussed	Yes Saturation not discussed.	Can't tell Not discussed.	Can't tell States ethics was approved by NGOs, no mention of ethics committee.	Can't tell Unclear analysis process, no justification for which quotes are used or discussion of bias.	Partially Findings are not very clear - unsure whether the results are themes or categories, or how they were arrived at. No discussion of credibility checks.	Partially Little discussion of research's contribution, nor it's place in the literature base.
Bogen-Johnson et al. (2019)	Yes	Yes	Yes Rationale given for qualitative work and for thematic analysis.	Yes Good discussion of why these P. No discussion of non-participation.	Yes All of the data collection points are addressed (saturation not reached)	Yes Bias considered for data collection but not formulation. Changes are considered.	Partially Approval given. No mention of other ethical considerations (consent, distress, capacity etc).	Yes Brief description of analysis, method of data selection not discussed. Good amount of data presented, and bias considered.	Yes Findings are clear and relevant to aims and credibility checks discussed. Minimal discussion of evidence against researcher views.	Yes Implications and avenues for future study well discussed.
Holt & Tickle (2015)	Yes	Yes	Yes Rationale given for qualitative interviews and benefit of grounded theory.	Can't tell Inclusion criteria and theoretical sampling described, but other recruitment procedures not discussed.	Partially Data collection procedure mostly clear. Setting not described and not stated how recordings were used. Saturation not discussed.	Can't tell Reflective journal used but no accounts of possible bias / researcher's relationships to project.	Partially Approval given. No mention of other ethical considerations (consent, distress, capacity etc).	Partially Brief description of analysis, method of data selection not discussed. No data presented for theoretical coding and bias not considered.	Yes Findings are clear and relevant to aims. Credibility checks not discussed and no argument against author's findings.	Yes Implications and avenues for future study well discussed.

Appendix D: Demographics questionnaire

Information About You

1) How old are you?

Age in Years ☐☐

2) Please indicate your gender (please tick the box).

Female ☐ Male ☐ Other ☐ Prefer not to say ☐

3) Please tick the box that best describes your ethnic group.

White (British)	☐	White Other	☐
Chinese/Chinese British	☐	Black/African/Caribbean/Black British	☐
Asian/Asian British	☐	Mixed Ethnicity	☐
Other	☐	Prefer not to say	☐

If you ticked other, please describe:

…………………………………………………………………………………………………

4) What is your country of birth?

…………………………………………………………………………………………………

5) What is your first language?

…………… …………………………………………………………………………………..

6) Please tick the box that best describes your current employment status.

Employed/self-employed full-time	☐	Home-maker	☐
Employed/self-employed part-time	☐	Prefer not to say	☐
Unemployed	☐	Retired	☐
Student	☐	Other	☐

If you ticked other, please provide details:

……………………………………………………………………………………………

7) What is your marital status? (please tick the box).

Single	☐	Married/Civil Partnership	☐
Cohabiting	☐	Separated/Divorced	☐
Widowed	☐	Prefer not to say	☐

8) Do you have any children? (please tick the box).

Yes ☐ No ☐ I would rather not disclose ☐

If you ticked *yes*, how many children do you have?

Number of children ☐☐

9) Please indicate which of the following best describes when you left education:

Left school before 16	☐	Left school at 16	☐
Left school at 17/18	☐	Completed/completing college course	☐
Completed/completing university course	☐	Prefer not to say	☐

10) What is the highest level of educational qualification that you have?

No formal educational qualifications	☐
Secondary/high school qualification (GSCE, O level or equivalent)	☐
College/Sixth form qualification (A levels or equivalent)	☐
Undergraduate degree or equivalent	☐
Postgraduate degree or equivalent	☐
Other	☐
Prefer not to say	☐

If you ticked other, please describe:

……………………………………………………………………………………………………

11) What age were you when you started hearing voices?

Age in years ☐☐

12) What is your diagnosis?

…………………………………………………………………………

13) How long have you been in contact with mental health services?

0-1 year	☐
2-3 years	☐
4-6 years	☐
7-9 years	☐
10+ years	☐
Prefer not to say	☐

14) What kinds of support do you have around you?

Friends	☐	Mental health workers	☐
Family	☐	Other health professionals	☐
Work colleagues	☐	Government worker	☐
Neighbours	☐	Charity/voluntary group	☐
Other (please state)	☐		

……………………………………………………………………………………………………

Appendix E: Interview schedule

How are changes maintained following CBT-based interventions for voice hearing?

MRP Interview schedule

Introductory questions:

- When did you attend [service name] appointments?
- How many sessions did you have? How did these sessions go?
- What did you make of it?

Changes during therapy:

- How were things for you before therapy?
- Did anything change for you during therapy?
- Why do you think they are (different/the same)?
- What things were, if any, better by the end of therapy?
- What things were, if any, worse by the end of therapy?
- Looking back on your therapy now, what would you say was helpful about your therapy? Please give examples. (For example, general aspects, specific events)
- Looking back on your therapy now, is there anything about the therapy that you would say was hindering, unhelpful, negative or disappointing for you?
- Were there things in the therapy that were difficult or painful but are now OK or perhaps helpful? What were they?
- Was anything missing from your therapy?
- How were the voices just after the therapy?
- How did you feel about therapy ending?
- What was helpful or difficult about this time?

Maintaining changes after therapy:

- How are the voices now?

- What changes have you noticed about yourself since therapy ended? In what way?

- What helped you to keep up changes?

- Since therapy ended, is there anything you have been able to do that you couldn’t do before therapy?
  - (How much do you attribute that to the therapy?)

- What personal strengths helped you since therapy has ended?

- What things in your current life situation helped you since therapy ended?

- Have any social or community activities been helpful in keeping up positive changes? (e.g. groups you are a member of or family who support you).

- Has anyone supported you to keep up positive changes?

- Are there any factors that helped you keep up positive changes?

- Has anything changed for the worse?

- What made things harder for you since therapy ended?

- What else would have been helpful? (in therapy or support afterwards?).

- What would you want to happen next for you?

- Do you have anything else that you want to tell me or think is important?

Appendix F: REC approval letter

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Appendix G: HRA ethics approval letter

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Appendix H: R&D approval letter

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Appendix I: Summary of results letter to the REC

Dear Research Ethics Committee member,

REC reference: 20/LO/0306
IRAS reference: 272469
Study title: A grounded theory study exploring how changes are maintained following CBT for distressing voice hearing.

I am writing to inform you that the above research project has been completed and a thesis has been submitted in partial fulfilment of the degree of Doctor of Clinical Psychology at Canterbury Christ Church University. Included is a brief summary of the research.

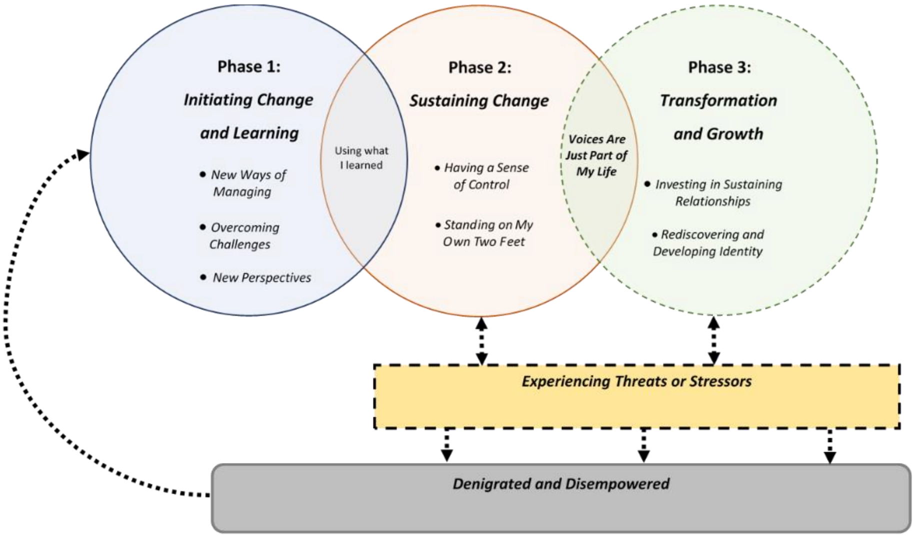
Summary

Voice hearing can be a distressing experience impacting on individuals' wellbeing and ability to function. Hearing voices is a phenomenon that occurs in clinical and non-clinical populations, and across populations with different mental health diagnoses. Targeted CBT for distressing voices (CBTv) interventions has shown some promise in increasing access to psychological therapy and reducing distress. This study aimed to investigate the perceived therapeutic change processes within and following access to CBTv.

12 participants in total took part in the study. The participants were all recruited from a specialist hearing voices service where they had previously accessed CBTv. Transcripts from semi-structured interviews were analysed using a critical realist grounded theory approach. A model was devised to capture the experiences of change within therapy and the process of maintaining change after therapy that participants described.

The model depicts a non-linear, three phase journey of change during and after CBTv. Before CBTv all participants described feeling denigrated and disempowered by voices. Therapy and having a supportive therapist seemed to enable participants to learn new ways of managing, overcome challenges and foster more helpful perspectives. Following this, change was typically maintained through interconnected processes of participants feeling empowered and having a sense of control in managing voices. The final phase, which was only described by a subset of participants, demonstrates how change within CBTv can be built upon following therapy. Categories here related to participants being able to integrate voices within their lives, investing in sustaining relationships and developing a meaningful identity separate to being a voice hearer. Crises and stressors had the potential to disrupt change without adequate resources to manage, which could push individuals to feeling denigrated and disempowered again.

The model adds to the literature on targeted interventions for distressing voices and change research. The results of this study provide useful information about what participants felt were helpful aspects of CBTv for initiating change and the conditions necessary for maintaining changes following therapy. Relevance to previous literature, limitations and clinical and research implications were considered.



It is intended that the findings of this study will be prepared for submission to the Journal of Qualitative Health Research for dissemination. A report has also been prepared to send to the participants of the study who opted to received this.

Kind regards,

Bradley Hall
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology

Appendix J: Summary of results letter to R&D department

Dear XXXXXXXXXX R&D department,

REC reference: 20/LO/0306
IRAS reference: 272469
Study title: A grounded theory study exploring how changes are maintained following CBT for distressing voice hearing.

I am writing to inform you that the above research project has been completed and a thesis has been submitted in partial fulfilment of the degree of Doctor of Clinical Psychology at Canterbury Christ Church University. Included is a brief summary of the research.

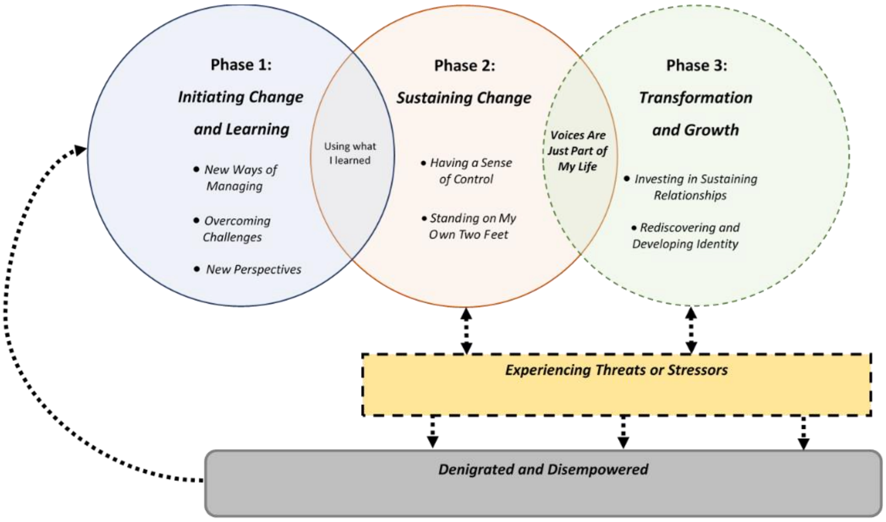
Summary

Voice hearing can be a distressing experience impacting on individuals' wellbeing and ability to function. Hearing voices is a phenomenon that occurs in clinical and non-clinical populations, and across populations with different mental health diagnoses. Targeted CBT for distressing voices (CBTv) interventions has shown some promise in increasing access to psychological therapy and reducing distress. This study aimed to investigate the perceived therapeutic change processes within and following access to CBTv.

12 participants in total took part in the study. The participants were all recruited from the [service name] where they had previously accessed CBTv. Transcripts from semi-structured interviews were analysed using a critical realist grounded theory approach. A model was devised to capture the experiences of change within therapy and the process of maintaining change after therapy that participants described.

The model depicts a non-linear, three phase journey of change during and after CBTv. Before CBTv all participants described feeling denigrated and disempowered by voices. Therapy and having a supportive therapist seemed to enable participants to learn new ways of managing, overcome challenges and foster more helpful perspectives. Following this, change was typically maintained through interconnected processes of participants feeling empowered and having a sense of control in managing voices. The final phase, which was only described by a subset of participants, demonstrates how change within CBTv can be built upon following therapy. Categories here related to participants being able to integrate voices within their lives, investing in sustaining relationships and developing a meaningful identity separate to being a voice hearer. Crises and stressors had the potential to disrupt change without adequate resources to manage, which could push individuals to feeling denigrated and disempowered again.

The model adds to the literature on targeted interventions for distressing voices and change research. The results of this study provide useful information about what participants felt were helpful aspects of CBTv for initiating change and the conditions necessary for maintaining changes following therapy. Relevance to previous literature, limitations and clinical and research implications were considered.



It is intended that the findings of this study will be prepared for submission to the Journal of Qualitative Research for dissemination. A report has also been prepared to send to the participants of the study who opted to received this and also to the REC committee who approved this study.

Kind regards,

Bradley Hall
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology

Appendix K: Summary of results letter to participants

Dear participant,

I am writing to you because you took part in a study finding out about your experiences of accessing Cognitive Behavioural Therapy for distressing voices (CBTv) in [service name] and how things have been since. Here is a summary of the findings of this study.

The study

12 participants were interviewed as part of this study. I then analysed transcripts of the interview using what is called 'grounded theory' methods. This was done to try and build a theory of therapeutic changes from what participants told me in interviews.

Findings

The findings reflect my interpretation of what people said across the interviews. This means not everything described in the theory will be relevant to everyone, but I hope this does capture some of your experiences. I have included a diagram version of the proposed theory. This theory aims to understand the processes involved in therapeutic change in CBTv and after therapy.

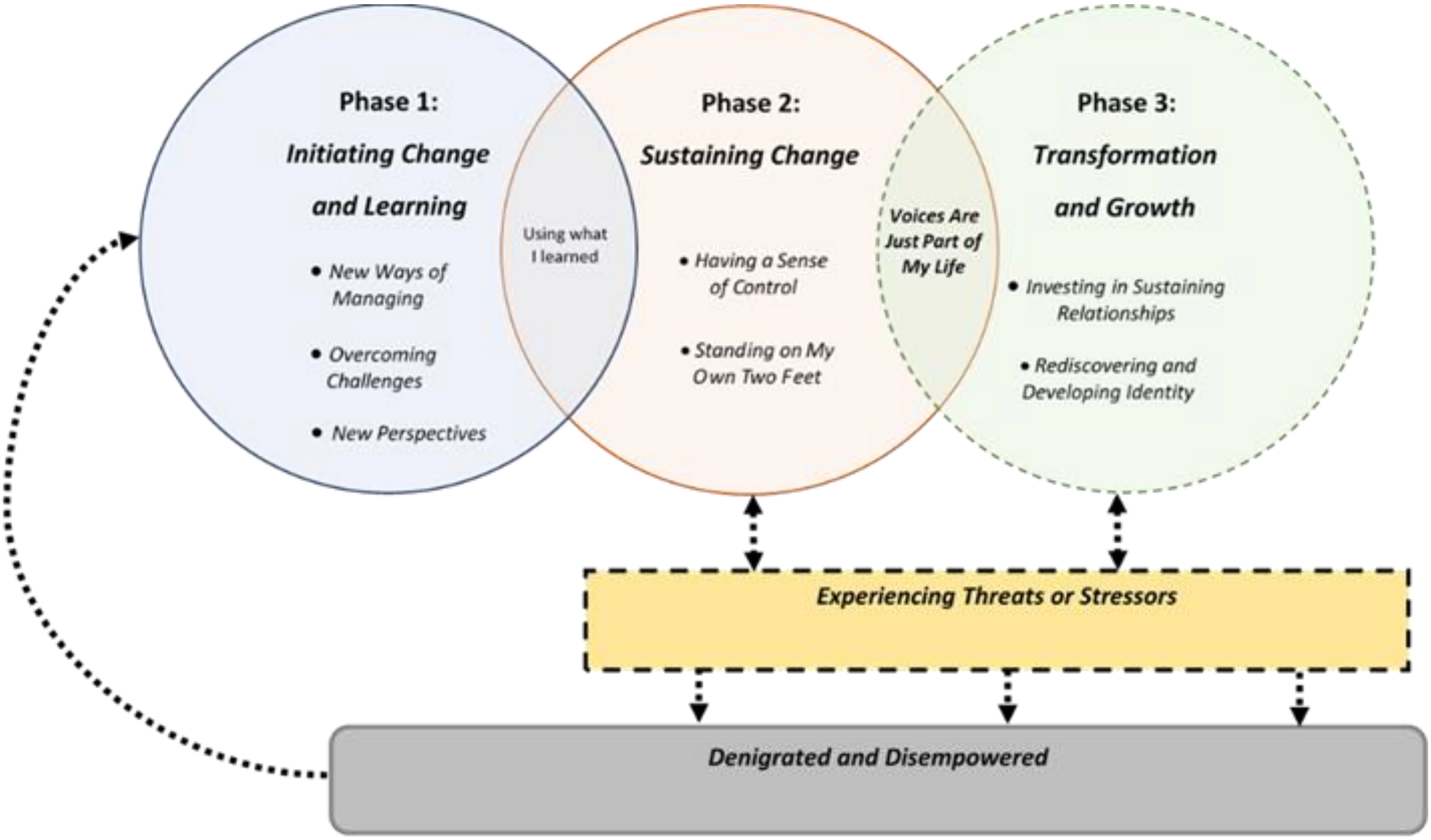
The model depicts a non-linear, three phase journey of change during and after CBT. Before CBT participants described feeling denigrated and disempowered by voices. Therapy and having a supportive therapist seemed to enable participants to learn new ways of managing, overcome challenges and foster more helpful perspectives. Following this, change was typically supported by participants feeling empowered and having a sense of control in managing voices. The final phase, which was only described by a subset of participants, demonstrates how change can be built upon following therapy. Categories here related to participants being able to integrate voices within their lives, investing in sustaining relationships and developing a meaningful identity separate to being a voice hearer. Crises and stressors had the potential to disrupt change without adequate resources to manage, which could push individuals to feeling denigrated and disempowered again.

Finally, I would like to thank you again for taking part in this research study. The results will be shared with the [service name] and published in an academic journal, with the aim to better understand and improve the support available for people who hear voices after accessing psychology. I am extremely grateful to you for sharing your experiences with me and learned a lot from talking to the participants across this study.

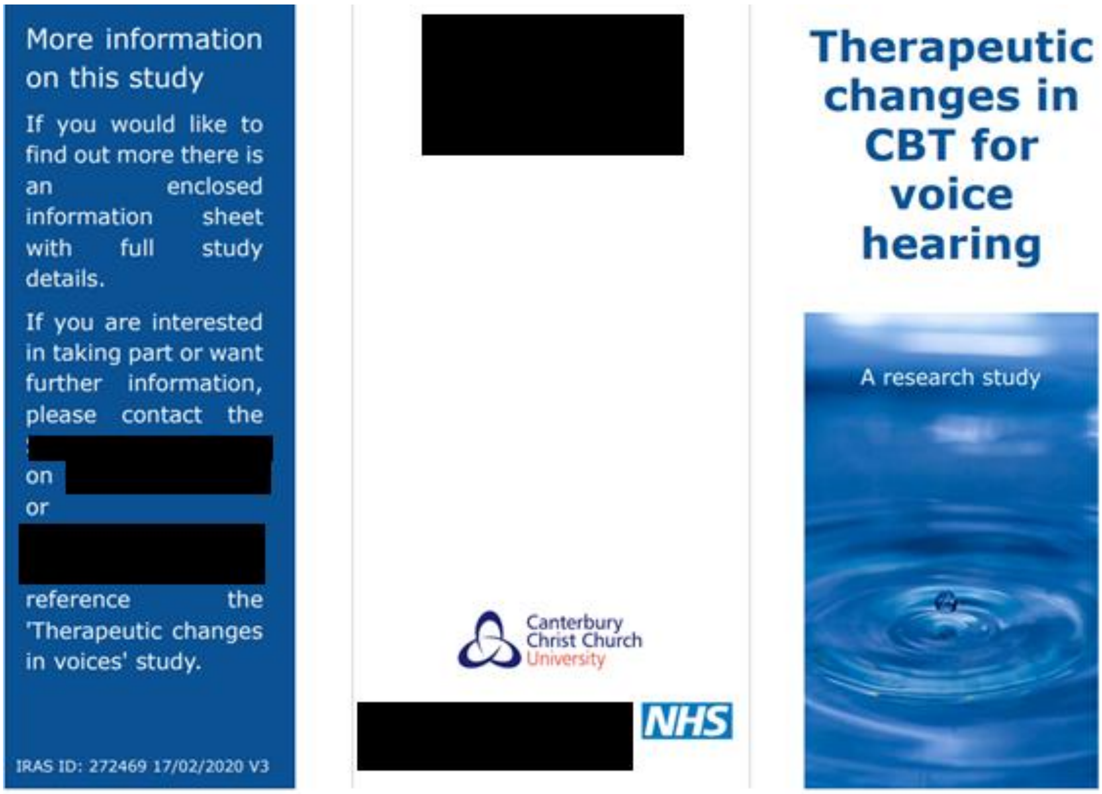
Very best wishes,

Bradley Hall
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology

Diagram: Positive change in CBTv and maintaining changes after therapy.



Appendix L: Participant study leaflet



More information on this study

If you would like to find out more there is an enclosed information sheet with full study details.

If you are interested in taking part or want further information, please contact the [redacted] on [redacted] or [redacted] reference the 'Therapeutic changes in voices' study.

IRAS ID: 272469 17/02/2020 V3

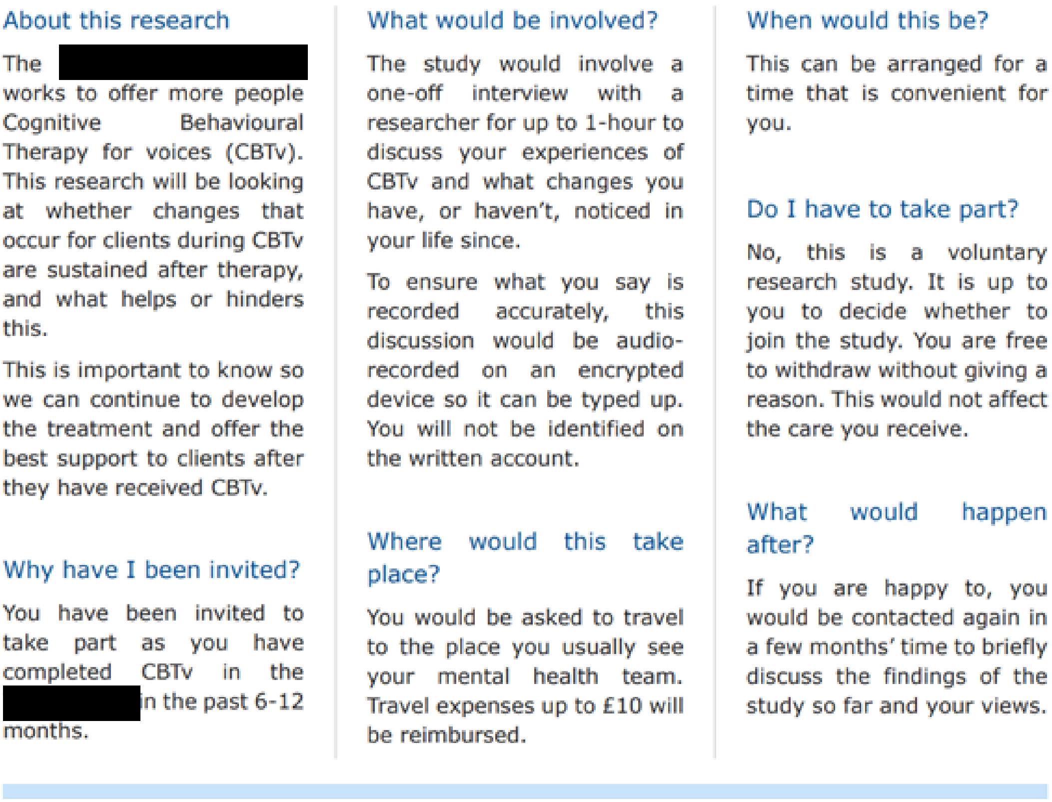
[redacted]

Canterbury Christ Church University

[redacted] NHS

Therapeutic changes in CBT for voice hearing

A research study



About this research

The [redacted] works to offer more people Cognitive Behavioural Therapy for voices (CBTv). This research will be looking at whether changes that occur for clients during CBTv are sustained after therapy, and what helps or hinders this.

This is important to know so we can continue to develop the treatment and offer the best support to clients after they have received CBTv.

Why have I been invited?

You have been invited to take part as you have completed CBTv in the [redacted] in the past 6-12 months.

What would be involved?

The study would involve a one-off interview with a researcher for up to 1-hour to discuss your experiences of CBTv and what changes you have, or haven't, noticed in your life since.

To ensure what you say is recorded accurately, this discussion would be audio-recorded on an encrypted device so it can be typed up. You will not be identified on the written account.

Where would this take place?

You would be asked to travel to the place you usually see your mental health team. Travel expenses up to £10 will be reimbursed.

When would this be?

This can be arranged for a time that is convenient for you.

Do I have to take part?

No, this is a voluntary research study. It is up to you to decide whether to join the study. You are free to withdraw without giving a reason. This would not affect the care you receive.

What would happen after?

If you are happy to, you would be contacted again in a few months' time to briefly discuss the findings of the study so far and your views.

Appendix M: Participant information sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Information about the research

How are changes maintained following CBT-based interventions for voice hearing?

This information sheet has been sent to you as you are being invited to take part in a research study by Bradley Hall, who is a trainee clinical psychologist at Canterbury Christ Church University. Any reference of ‘we’ in this document refers to Canterbury Christ Church University as the study sponsor.

Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

The information pack tells you more about this. Talk to other people too if you wish.
Part 1 gives you a summary of the study.
Part 2 gives you more detailed information about the conduct of the study.

What is the purpose of the study?

The [service name] works to offer more people Cognitive Behavioural Therapy for voices (CBTv). This project will be looking at whether changes that occur for clients during CBTv are sustained after therapy, and what helps or hinders this. This is important to know so we can continue to develop the treatment and offer the best support to clients after they have received CBTv.

Why have I been invited?

You have been invited to take part as you have completed CBTv in the [service name] in the past 6-12 months.

Do I have to take part?

It is up to you to decide whether you would like to join the study and you are free to withdraw at any time without giving a reason and this would not affect any subsequent care you might receive.

What will happen to me if I take part?

The study would involve a one-off interview with Bradley for up to 1-hour to discuss your experiences of CBTv and what changes you have, or haven’t, noticed in your life since. This would be at the place you usually see your mental health team, but if this is not possible, it may be possible to meet at another location that would be more convenient for you. There will be a short information form to complete at this meeting, where you will be asked about personal information like your age, how long you have heard voices and what support you have around you. To ensure what you say is recorded accurately, this discussion would be audio-recorded.

Your medical notes will need to be checked for any recent medication changes, as will details of your therapy with [service name], but this is a routine part of the study and there is nothing to worry about. Your Care Coordinator will also be contacted so they are aware of your participation in the study. If you are happy to receive further communication, you will be contacted again after a few months to briefly discuss the findings of the study so far and any views you might have.

Expenses and payments
You will not be paid for this study, but any travel expenses up to the value of £10 will be reimbursed. Unfortunately, there is no reimbursement available for taxis.

What are the possible disadvantages or risks of taking part?
It is possible that the discussion might bring back memories of a difficult time or highlight difficulties you have currently.

What are the possible benefits of taking part?
We cannot promise the study will help you directly, but the information we get from this study will help us understand what support is needed for people that hear voices. We would, of course, be very grateful if you decided to take part.

How will information about me be used?
In this research study we will use information from you and your medical records.

We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write.

If this information has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
If you withdraw up to 2 weeks after the interview your data will be destroyed. After these 2 weeks the interview will be transcribed and it will not be possible to withdraw your data.

Concerns and Complaints
If you have a concern about this study you should ask to speak to Bradley Hall on 01227 927070 or leave a voicemail and any issues will be addressed as best as possible. Please leave a contact number for Bradley Hall and he will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can contact Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute at fergal.jones@canterbury.ac.uk and the [trust name] Patient Advice and Liaison Service (PALS) on [PALS number] or at [pals email].

How will we use information about you?
We will need to use information from you and from your medical records for this research project.

This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?
- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- If you would like to withdraw your data from the study, you can do so up to 2 weeks after your interview by contacting Bradley Hall.
- There will be the option for you to provide feedback on the interview data that has been collected from you if you wish to do so.

Where can you find out more about how your information is used?
You can find out more about how we use your information
- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by contacting the researcher on 01227 927070 or by emailing bradley.hall2@nhs.net
- by contacting Deborah Chadwick who is the named data custodian for Salomons Institute for Applied Psychology, Canterbury Christ Church University on 01227 927074 or by emailing Deborah.chadwick@canterbury.ac.uk

How will information be stored?
Interviews will be typed up and audio recordings will be deleted after the interview.

The anonymised transcripts will be kept for ten years according to the Medical Research Council guidelines. Data will be disposed of securely after ten years. You have the right to check the accuracy of data held about you and correct any errors.

All information which is collected from or about you during course of the research will be kept strictly confidential. The only time when it would be necessary to pass on information from you to someone else is if something you said raised concerns about your safety or the safety of someone else.

What will happen to the results of the research study?
The results of this study may be published in academic journals. A summary of the results will also be shared with the [trust] Research & Development department, [Trust lived experience research group] and the Salomons Advisory Group of Experts as they have helped design the project.

Direct quotes may be used in reports and publications but will be anonymised.

Compliance with General Data Protection Regulation (GDPR)
We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Canterbury Christ Church University is funding this research and will keep anonymised information about you for ten years after the study has finished. Identifiable information, such as the consent form, will be kept for one year and then destroyed.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. To safeguard your rights, a minimum of personally identifiable information will be used.

Individuals from Canterbury Christ Church University and regulatory organisations may look at your research records to check the accuracy of the research study. The only people in Canterbury Christ Church University who will have access to information that identifies you will be people who need to contact you to audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the [REC location] NHS Ethics Committee and The Salomons Institute for Applied Psychology Ethics Panel, Canterbury Christ Church University.

You will be given a copy of the information sheet and a signed consent form, and these will both be uploaded to your electronic records.

Further information and contact details
More information can be found on health research online at https://www.nihr.ac.uk/. There are also online resources for more information on voice hearing, for example the Hearing Voices Network (https://www.hearing-voices.org/).

If you would like to speak to someone and find out more about the study or have questions about it answered, please get in touch on Bradley.hall2@nhs.net or you can leave a message on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for Bradley Hall and leave a contact number so that he can get back to you.

Appendix N: Informed consent form

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Ethics approval number: 20/LO/0306
Version number: V6
Participant Identification number for this study:

CONSENT FORM

Title of Project: How are changes maintained following CBT-based interventions for voice hearing
Name of Researcher: Bradley Hall

Please initial each box:

1. I confirm that I have read and understand the information sheet dated 24.12.2019 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care being affected. ☐

3. I understand that relevant sections of my medical notes, as specified in the information sheet, and data collected during the study may be looked at by the researcher [Bradley Hall], lead supervisor [supervisor name] and secondary supervisor [supervisor name]. I give permission for these individuals to have access to my data. ☐

4. I agree to my mental health team being informed of my participation in the study and safety issues to be discussed with them. ☐

5. I agree to be audio recorded, and for anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings. ☐

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

Name of Participant:_______________________________________

Date:_________________ Signature:__________________________

Name of Person receiving consent:___________________________

Date:______________ Signature:___________________________

Appendix O: Reflexive position statement

Reflexive position statement

I understand voice hearing from a psychosocial perspective. This means I see it as a reaction to stressful life events rather than an illness. I tend to view voice hearing as a meaningful experience and partly expect engagement and making sense of voices would support individuals during and after accessing CBTv. I also view voice hearing on a continuum of normal human experience.

I have experience working in the host service and delivering CBTv interventions for voice hearers. This means I have seen first-hand some of the benefits this approach can bring, and its limitations. It will be important for me to be wary of assuming I understand what aspect or experience of therapy a participant is describing based off my knowledge of the approach. I am aware of my assumption that clients will have taken something from therapy, even if therapy has not helped in the way they had hoped.

I often think that individuals that have experienced very difficult times, such as voice hearers, have resources to manage even if they are not aware of it or this is not immediately apparent. I have an expectation that external support will be involved (e.g. professionals, family) in sustaining changes following therapy.

Appendix P: Abridged research diary

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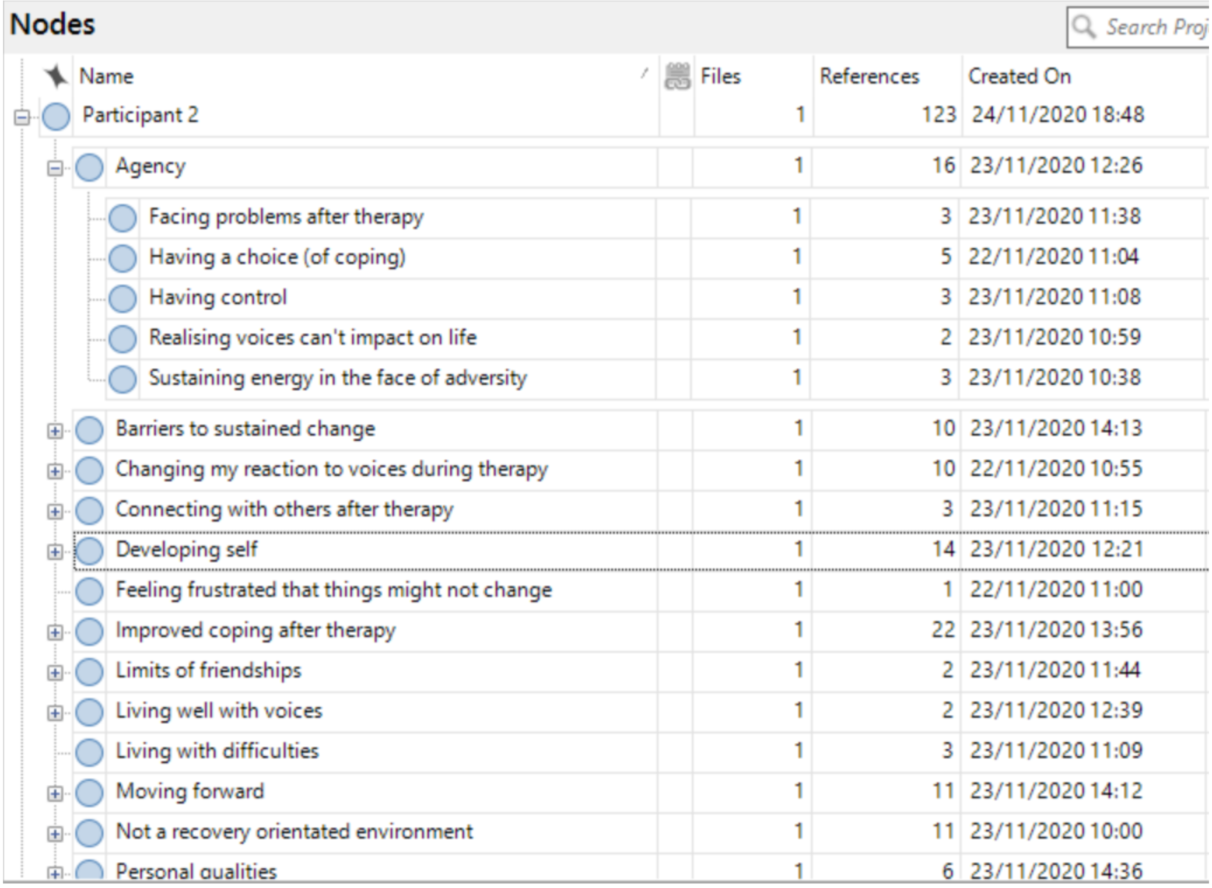
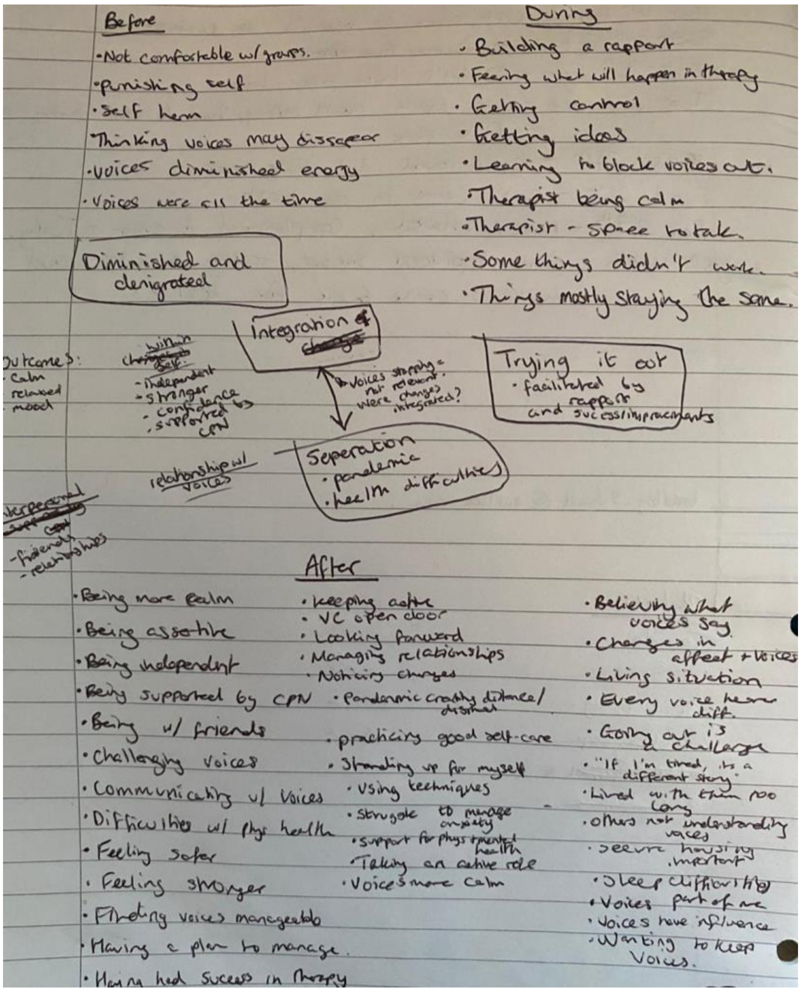
Appendix Q: Progression of category development

Initial coding was conducted for each interview.



Name	Files	References	Created On
Participant 2	1	123	24/11/2020 18:48
Agency	1	16	23/11/2020 12:26
Facing problems after therapy	1	3	23/11/2020 11:38
Having a choice (of coping)	1	5	22/11/2020 11:04
Having control	1	3	23/11/2020 11:08
Realising voices can't impact on life	1	2	23/11/2020 10:59
Sustaining energy in the face of adversity	1	3	23/11/2020 10:38
Barriers to sustained change	1	10	23/11/2020 14:13
Changing my reaction to voices during therapy	1	10	22/11/2020 10:55
Connecting with others after therapy	1	3	23/11/2020 11:15
Developing self	1	14	23/11/2020 12:21
Feeling frustrated that things might not change	1	1	22/11/2020 11:00
Improved coping after therapy	1	22	23/11/2020 13:56
Limits of friendships	1	2	23/11/2020 11:44
Living well with voices	1	2	23/11/2020 12:39
Living with difficulties	1	3	23/11/2020 11:09
Moving forward	1	11	23/11/2020 14:12
Not a recovery orientated environment	1	11	23/11/2020 10:00
Personal qualities	1	6	23/11/2020 14:36

Codes were listed before grouping by relevance.



Before

- Not comfortable w/ groups.
- Punishing self
- Self harm
- Thinking voices may dissapear
- voices diminished energy
- Voices were all the time

Diminished and denigrated

During

- Building a rapport
- Fearing what will happen in therapy
- Getting control
- Getting ideas
- Learning to block voices out.
- Therapist being calm
- Therapist - space to talk.
- Some things didn't work.
- Things mostly staying the same.

Trying it out
- facilitated by rapport and success/improvements

Integration ~~of~~ ~~change~~

within ~~changes to~~ self.
- Independent
- stronger
- confidence
- supported by CPN

Voices stopping = not relevant. were changes integrated?

Seperation
- pandemic
- health difficulties

relationship w/ voices

Outcomes:
- Calm relaxed mood

~~interpersonal~~ ~~support~~ ~~CPN~~
- friends
- relationships

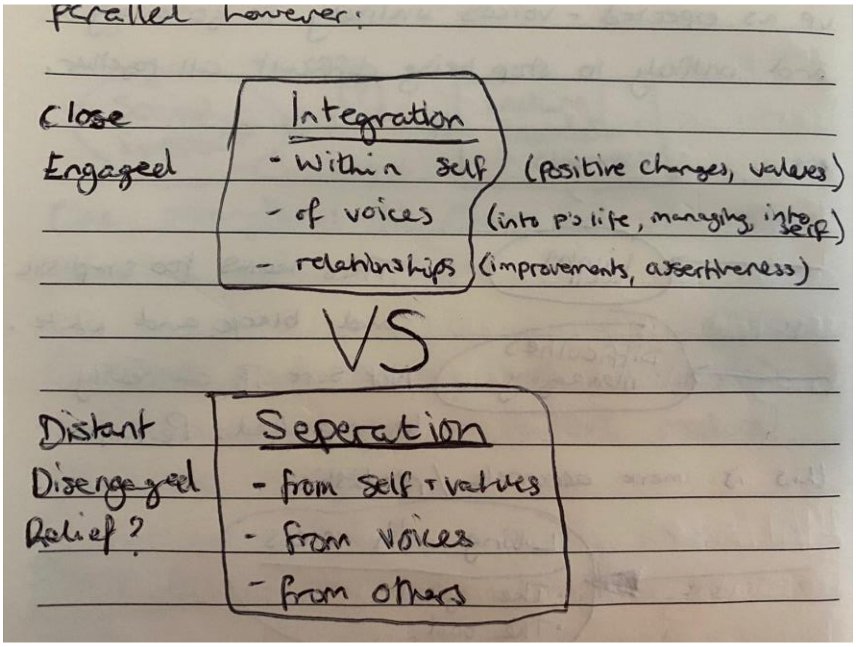
After

- Being more calm
- Being assertive
- Being independent
- Being supported by CPN
- Being w/ friends
- Challenging voices
- Communicating w/ Voices
- Difficulties w/ phys health
- Feeling safer
- Feeling stronger
- Finding voices manageable
- Having a plan to manage.
- Having had success in therapy

- keeping active
- VC open door
- Looking forward
- Managing relationships
- Noticing changes
- Pandemic creating distance/ dismal
- practicing good self-care
- Standing up for myself
- Using techniques
- Struggle to manage anxiety
- support for phys + mental health
- Taking an active role
- Voices more calm

- Believing what voices say.
- Changes in affect + voices
- Living situation
- Every voice hears diff.
- Going out is a challenge
- "If I'm tired, it's a different story."
- Lived with them too long
- others not understanding voices
- secure housing important
- Sleep difficulties
- Voices part of me
- Voices have influence
- Wanting to keep Voices.

Memos attempted to map out early relationships in the data.



parallel however:

Close
Engaged

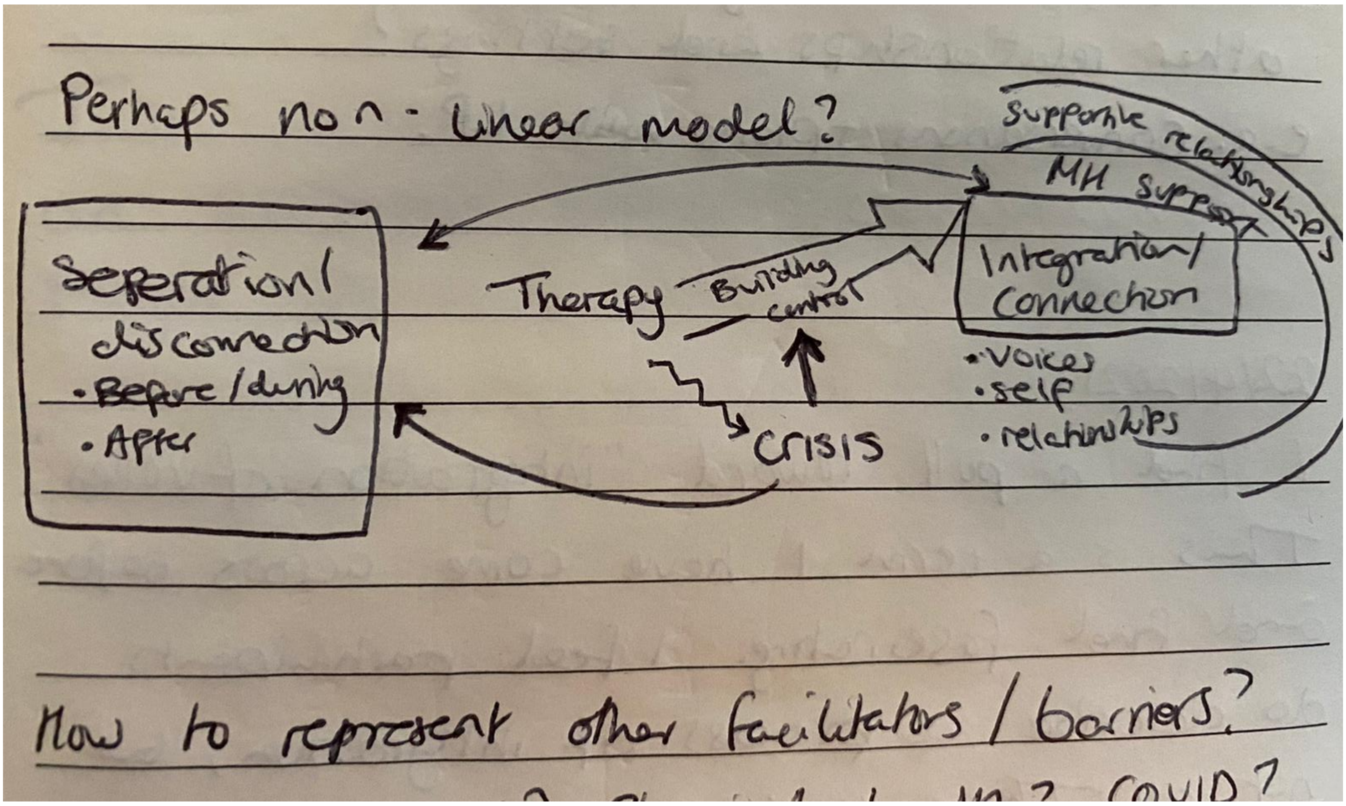
Integration
- within self (positive changes, values)
- of voices (into P's life, managing, into self)
- relationships (improvements, assertiveness)

VS

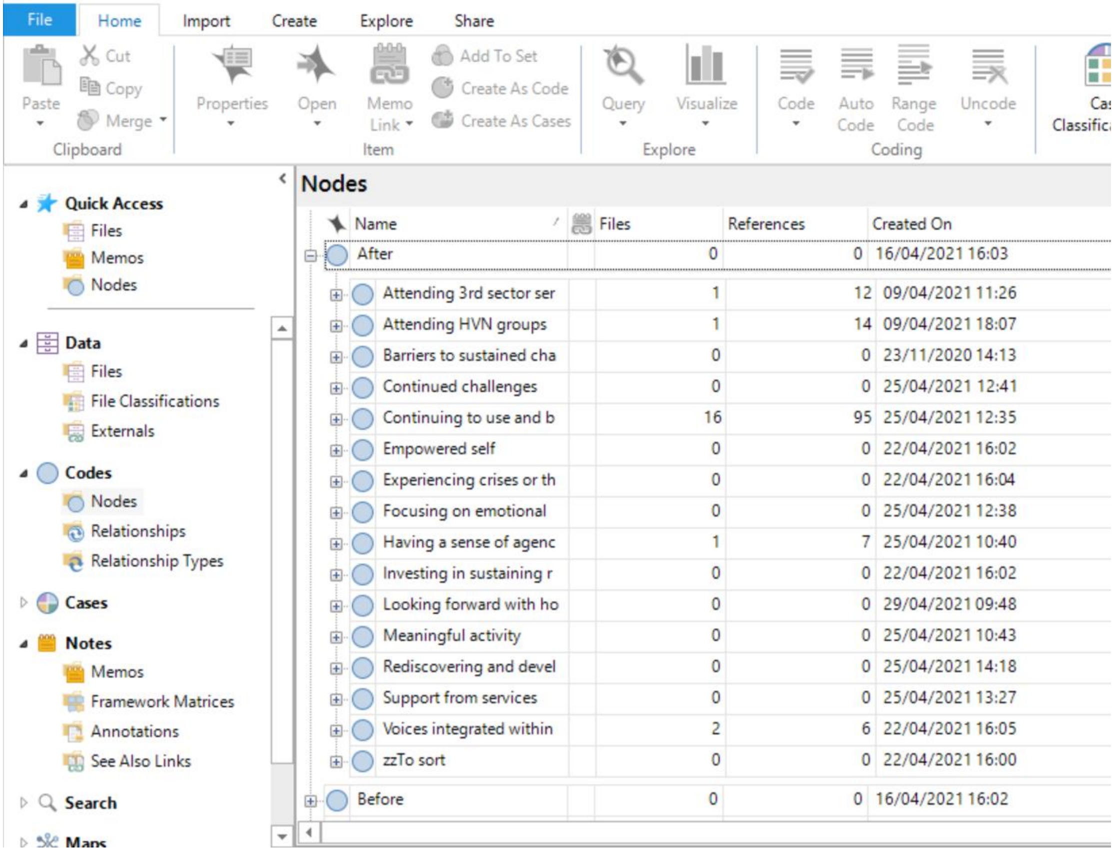
Distant
Disengaged
Relief ?

Seperation
- from self + values
- from voices
- from others

Diagrammatic memos as part of theoretical coding.

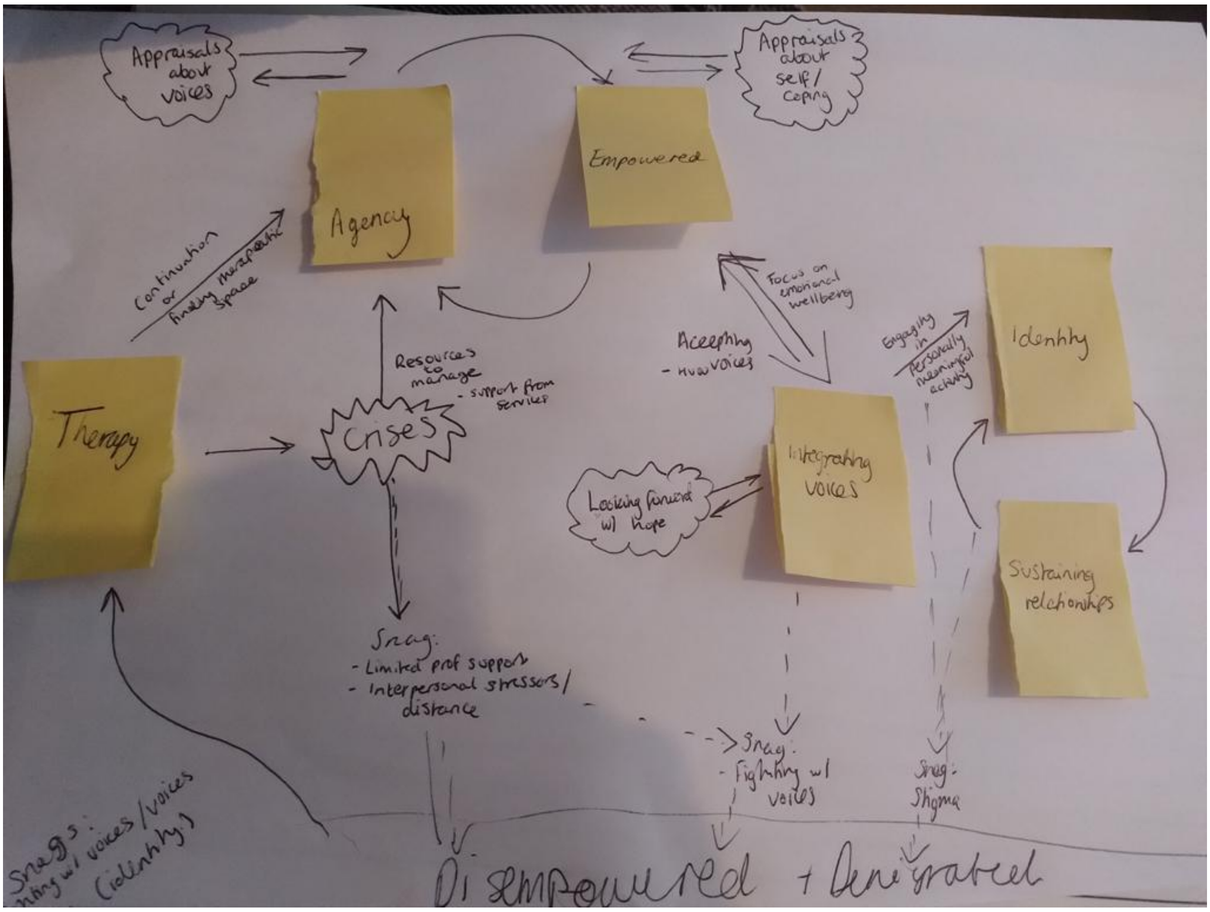


Codes in NVivo merged and grouped across interviews.



Name	Files	References	Created On
After	0	0	16/04/2021 16:03
Attending 3rd sector ser	1	12	09/04/2021 11:26
Attending HVN groups	1	14	09/04/2021 18:07
Barriers to sustained cha	0	0	23/11/2020 14:13
Continued challenges	0	0	25/04/2021 12:41
Continuing to use and b	16	95	25/04/2021 12:35
Empowered self	0	0	22/04/2021 16:02
Experiencing crises or th	0	0	22/04/2021 16:04
Focusing on emotional	0	0	25/04/2021 12:38
Having a sense of agenc	1	7	25/04/2021 10:40
Investing in sustaining r	0	0	22/04/2021 16:02
Looking forward with ho	0	0	29/04/2021 09:48
Meaningful activity	0	0	25/04/2021 10:43
Rediscovering and devel	0	0	25/04/2021 14:18
Support from services	0	0	25/04/2021 13:27
Voices integrated within	2	6	22/04/2021 16:05
zzTo sort	0	0	22/04/2021 16:00
Before	0	0	16/04/2021 16:02

Theoretical sorting and modelling of categories and subcategories.



Appendix R: Coded transcript example

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Appendix S: Diagram of participant 1 codes

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Appendix T: Diagram of participant 7 codes

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Appendix U: Table of example codes

Included open codes, quotes and memos provide an example of the process of analysis and are not exhaustive.

Category: Denigrated and disempowered			
Subcategories	Example open codes	Example participant quotes	Memos
Difficulties Coping	Struggling to cope	“I was almost ripping my hair out.” (P10)	Participants seem to be conveying how overwhelming the experiences were at this time and how difficult it was to manage. Certain experiences were emphasised (e.g. “a nightmare”) to demonstrate how difficult it was. Some of these experiences seem to be around control and I wonder if they are retrospectively contrasting it with greater feelings of control they hold at interview?
	Things were a real nightmare	“Well things before the therapy were a real nightmare. Yeah, it was terrible. Every day and every night I had this” (P6)	
	Using drugs and alcohol	“I'd leave work or even at work I'd be sniffing coke and I'd go home and smoke some crack and smoke loads of cannabis and fuck myself in the head to oblivion kind of thing, and that would make them stop visiting for the time that I wasn't at work” (P4)	
	Feeling powerless	“I don’t like it when it’s like that. Yeah. You don't feel in control at all.” (P12)	
Punishment from Self and Voices	Hurting myself more	“I think before therapy I was self-harming a lot more than I am now.” (P10)	Participants have described being punished by voices and themselves – seems to relate to feelings of powerlessness and being demoralised by ongoing experience without relief.
	Voices persecuting me	“I honestly thought I was going to be dead within a few years and I was quite happy for that because I didn't want to deal with the voices anymore” (P4)	
	Voices unrelenting	“Well, it's awful cos they go on and on and on. And I tried shutting my door to shut ‘em out, but that doesn't work.” (P9)	
	Feeling scared	“Yeah. That did scare me.” (P11)	
Having Minimal Support	Keeping voices a secret	“Well I just clammed up and couldn’t talk to anybody.” (P9)	This subcategory links in with descriptions of disconnection, loneliness and feeling unsupported. I wondered if support at this stage would have been helpful? And what this would have looked like?
	Voices isolating me	“it isolated me from people and from everything” (P8)	
	Other people can’t help	“they couldn't help me because they didn't know what was going on with me and neither did I really.” (P11)	
	Feeling helpless	“It was frustrating to start with because I couldn't see how it was going to change anything” (P2)	
Diminishing Identity	Poor self-esteem	“I always, always have had problems with my self-esteem” (P10)	Participants sense of self seemed to be very negative and there to be a troubles with identity. This appeared linked to difficulties with coping and punishment from self and voices – either it enabled these to occur or perhaps was the outcome of them.
	Thinking I was ‘mad’	“I thought if you went to a therapist it was because you were mad” (P4)	
	Experiencing worthlessness	“I, I saw nothing for it, I saw nothing for my life”	

Category: Experiencing Threats or Stressors			
Subcategories	Example open codes	Example participant quotes	Memos
Everything Changed Overnight (The Pandemic)	Pandemic as challenging	“Because it's very difficult, you know you've got social distancing and everything else” (P5)	This subcategory reflects the many ways the pandemic impacted on the process of maintaining change for some participants. For participants who had finished therapy, this was seen as a sudden and quite shocking experience where anxiety was heightened. Links to limited support.
	Pandemic exacerbating voices	“it's the virus that's really caused the problems to sort of start again” (P1)	
	Disrupting physical health care	“So, but, it’s them having time to do it isn't it? Because of COVID and everything” (P12)	
	Losing existing support	“when the... lockdown and everything started, everything was taken away from me, and, I felt completely lost.” (P1)	
Voices Getting Worse Again	It’s harder to cope	“I don't really cope very well. I-still, when I get into a panic... I have, well I've been to the hospital like 92 times, for, like banging my head and my seizures” (P6)	This subcategory related to voices getting worse again without obvious cause. There are similarities here to the denigrated and disempowered category, in particular difficulties coping.
	Voices trying to be more controlling	“I did at the time, but they’ve come back again. And I couldn't control them.” (P9)	
	Having struggles	“So I could do now, more, like even now I’m struggling, I just tell them to shut up” (P7)	
Having Physical Health Crises	Physical health worsening	“I've had a few traumatic sessions, as in like my health, so it makes it a bit unmanageable” (P5)	Several participants described deteriorating physical health as being a significant challenge. It was related to pain, stress and increases in voice hearing.
	Struggling to care for self because of the voices	“And the voices don't want me going to hospital cos they're convinced I'll be fine” (P12)	
	Limited emotional support for physical health	“my GP thinks it'd be better if they could spend more time with me.” (P12)	
Interpersonal Stressors & Limited Support	Not having relationships that support me	“I live on my own and, as I said before, my family don't really support me” (P1)	This subcategory discusses where support was lacking and how this acted as a stressor. These were associated with feelings of isolation and being unsupported in some areas of the individuals life. Responses here might represent how there was a sense of very limited support from services.
	Not talking to friends	“I've made some friends recently um, that I won't say much about mental health to” (P2)	
	Professional support not offered or not enough	“as I said to you there is only Mary. And I only basically see her once a month for a depot.” (P6)	
	Trusting relationship with services lacking	“I can't establish trust, I can't establish rapport. There's no consistency because it's 15 minutes every time I see someone and it's the same questions over again.” (P2)	

Fighting with & Being Distressed By Voices	Fighting against the voices	“I just think I've got to fight and don't let them win, because if you let them win then you lose” (P7)	Fighting with takes energy, time, effort. It positions the individual in opposition to voices and tends to focus on conflict. Voices at times would become more distressing when this stance was taken, or participants might describe generally having short periods of increased distress.
	Wanting voices to go away	“I just wanted them gone.” (P11)	
Others Treating Me Differently	Having to hide voices	“I told my sister and even she treats me different, so I tend not to tell people” (P12)	Descriptions relate to being treated differently / experiencing stigma. This needing to hide voices and not being understood may relate to why having a space in therapy to talk about voices and therapist being understanding was so valued.
	Other people thinking I’m crazy	“on the outside when you’re in public you know, you just have got mental health problems” (P7)	

Phase 1: Initiating change			
Category: New Ways of Managing			
Subcategories	Example open codes	Example participant quotes	Memos
Learning Skills	Being assertive in therapy	“I think its when writing these assertive statements, um, and like showing respect to the voices.” (P10)	Skills were often related to CBT. Participants spoke about assertiveness and challenging – perhaps these were skills in which they could reclaim some power and was a way to interact with voices where they are not left powerless.
	Challenging the voices	“Like, if I concentrated on the bad voice to try and say it has no power over me now, that sort of thing.” (P11)	
Practicing Ways of Coping	Changing my reaction	“I don’t shout at the voices anymore” (P2)	Practicing ways of coping seem to include participants being given space to explore current responses to voices and how this could be improved upon. Links to feelings of helplessness, and having a sense of control in phase 2.
	New ideas for coping strategies	“he gave me some ideas in which to help try and control them” (P5)	

Phase 1: Initiating change			
Category: Overcoming Challenges			
Subcategories	Example open codes	Example participant quotes	Memos
Working with and Overcoming Challenges of Therapy	Voices attacking me during therapy	“I think the worst like when they just attack you all the time during therapy” (P7)	Challenges were identified when starting therapy, a lot of which related to voices being at a heightened state (perhaps because of the difficult experiences before CBTv?) and some specific challenges. Participants spoke about these as things they managed during therapy and were able to get
	Therapy being demanding	“it was quite tiring but it was worth it” (P1)	
	Therapy not feeling relevant for me	“some of the things that bother the people in the book don't bother me as such” (P9)	

			through. Rather than being a stressor, perhaps this is a change process.
Talking About Voices	As a new experience	"it was new um talking so in depth about the experience of the hearing voices" (P2)	Commonly discussed in interviews as novel. Talking about voices could also be a difficult experience (links to overcoming challenges?) but ultimately seen as helpful. Seems to relate to not having a place to talk about voices before.
	Talking about voices was helpful	"I think being being asked questions and stuff sort of helped me through, and to talk about it and that." (P11)	
Connecting and Rapport Building	Therapist being supportive	"it was nice to have a compassionate voice you know, with someone. The therapist was quite compassionate" (P3)	Connection in therapy or with professionals seem to be a way to overcome challenges at this stage. It allowed participants to continue to engage with therapy, even difficult bits, and enabled them to talk about voices. Having such good rapport may explain therapy ending being so difficult for some.
	Therapist listening and understanding	"I had someone to understand me" (P9)	

Phase 1: Initiating change			
Category: Gaining New Perspectives			
Subcategories	Example open codes	Example participant quotes	Memos
Understanding Self and Voices	Making sense of experiences	"sometimes the stress that can cause a few problems with, with the voices and that so, it made me understand a bit about it." (P11)	Beginning to talk about experiences, learning about self in therapy. Seems to be a process of piece things together after experiencing quite chaotic times. Relates to feelings of empowerment – knowing oneself and knowing about voices and what might trigger them.
	Learning more about myself	"It helped me understand myself a lot better" (P10)	
Moving to Different Perspectives	Realising what works for me	"It was just talking about it and you know kind of getting some self-realisation" (P7)	Different perspectives were related to belief change (e.g. reappraisal of voice power). This could also be gaining insight, thinking in different ways etc. Belief change is a core aim of CBT. This seems to lay the ground work from the changing beliefs about oneself and voices within standing on my own two feet and having a sense of control.
	Voices being less powerful	"I found that I'm a much stronger person than I actually thought I was, and the voices haven't got the power that they had." (P10)	
Building Confidence in Myself	Improving self-esteem	"I say it was just a bit more feeling good about myself because it's the self-esteem" (P3)	Participants began to see themselves differently. Relates to empowerment / standing on my own two feet after therapy. Realising ability for self-management seems to be related to the individuals self-efficacy?
	Realising my own ability	"I didn't know I could do that to the voices, I picked it up during therapy" (P7)	

Phase 2: Sustaining Change **Category: Having a Sense of Control**			
Subcategories	Example open codes	Example participant quotes	Memos
Using What I Learned	Practising techniques from therapy	“The other, one of the other most important, influential things I've learnt was um, obviously but being able to gather evidence, positive evidence, and knowing now that I could use that to interact with my voices on a more positive level” (P4)	This subcategory captures experiences whereby therapeutic spaces are carried on or extended from therapy into other relationships or settings. It makes me think about the therapeutic space and how therapy is set up to try and encourage change, and if this space can be enabled in individuals lives perhaps it gives them the necessary environment to continue changes.
	Carrying on the work after therapy	“So we are working on one which is self-esteem and the other one is distressing voices” (P3)	
Being More in Control	Being able to challenge the voices	“I just said to them that you know, that wasn’t true, I've got friends and to erm, give them, give the voices evidence that I do have friends and people do care” (P1)	Perceived control seems to be really important for whether changes are sustained. Do other factors influence control? Crises seems to be opportunities to either reaffirm or lose control, and lack of control can push people towards denigrated and disempowered.
	Voices can’t affect things	“Because the voices, yeah, the therapist was right, they can't impact on anything in my life because it’s voices. Whereas the problem with my landlord for instance, they have very real and physical consequences and outcomes.” (P2)	
Taking an Active Role with Voices	Reacting differently to the voices	“I still don't shout back at them or threaten them or anything” (P2)	Having an active role was a contrast to descriptions of helplessness and little choice participants described. This signified agency in how individuals managed voices. This seem to be able to occur even if individuals didn’t experience voices being integrated as part of them and their life.
	Relying less on harmful ways of coping	“Because I don't get so agitated now with the voices, so, my self-harm and has come down.” (P10)	
Regulating the Closeness of Voices	Keeping voices in the background	“I do hear little bits but I try not pay any attention to it” (P8)	Keeping voices at bay seemed an effective way to reduce tension/conflict in the voice – participant relationship. Although it was apparent that participants used both strategies to distance from voices and to communicate with them. Associated with feeling stronger and having agency.
	Blocking out the voices	“well the man in the cupboard is taped up. He's taped up with masking tape so he can't come out” (P6)	

Phase 2: Sustaining Change
Category: Standing on My Own Two Feet

Subcategories	Example open codes	Example participant quotes	Memos
Feeling Stronger and Engaging Voices as Equals	Standing up to the voices	I think I was just braver because I'm stronger than him, I wasn't that weak person that closed down. (P6)	Participants began to feel stronger. Relates to skills picked up in therapy e.g. assertiveness, communication, but this subcategory captures how voice hearers are positioned in relation to voices. Earlier skill attainment seems to enable this.
	Reasoning with the voices	"if I have to do anything, rather than them become negative, I will converse with them in the sense that I will put my point across, so that I'm, um bit more in control" (P5)	
Building and Improving Self-Esteem	Feeling more confident in myself	"And stuff really now because I'm on my own, and I find that building, trying to build confidence and trying and talk to people would be a good thing. Yeah, so I've been trying to get out about it more. And I think on that line, I think it's my confidence is building." (P11)	These subcategory seems to carry over from the budding improvements in self-esteem that occurs earlier and in therapy. Feeling confident in themselves and having confidence to manage – these relate more to confidence to keep up change following learning phase.
	Having confident in my ability to manage difficulties	"it was probably the realisation that I deal with the voices in a different way now and I'm able to do it. Yeah, it was all around that 3-month mark after finishing the sessions." (P2)	
Being Independent and Determined	Being a determined person	"You know if I want to do something, I want, I'll keep on trying to do it you know, I won't give up. And I think that that sort of helped a lot" (P1)	Relates partly to individuals personal qualities, what helped them to sustain change, but also perhaps the persons sense of empowerment. Contrasts with being powerless / persecuted.
	Being able to endure adversity	"I'm resilient, very resilient. I'm able to go through long periods of hardship and suffering, won't be easy, but I'll do it." (P2)	

Phase 3: Transformation and Growth			
Category: Voices Are Just Part of My Life			
Subcategories	Example open codes	Example participant quotes	Memos
Accepting the Voices	Voices are part of me	I hear them every day. They don't tell me what to do, though, I don't get commands. I'll get the other symptoms… I still smell smells from childhood, I still sometimes think I'm being followed and things like that. I accept that's part of me.	This category seems to be about integrating voices, and accepting voices is key to that. This is opposed to feelings of separation and distancing from voices which is described in some stressors – fighting with voices for example.
	Accepting the voices are staying	"I've learnt how to deal with them, like it's just part of my life so I need to deal with them." (P7)	
Focusing on Emotional Wellbeing	Staying calm in the face of stressors	"because I was calm and relaxed, not anxious, they became the same. They became calmer, not anxious, do you know what I mean?" (P5)	Links between affect and voices were noted. Voices being accepted as part of life associated with participants having space to process difficult

	Being more able to express feelings	“E: Well I’m not bottling it up.” “I: yeah. And what does bottling up do to you?” “E: Well, it makes me worse. It made my hernia hurt.” (P9)	emotions. Makes me think of theories that voices are unaccepted parts of the self / own unexpressed emotional states.
Continuing to Function Despite Voices	Being able to deal with things other than the voices	“I’m not using my energy, my time, my feelings, my emotions, getting all worked up and upset over the voices and what they're saying and how I'm reacting, because I'm not reacting the way I used to react. It frees up all that have to do with what's gone on elsewhere in life and more immediate things.” (P2)	This is different to voices being “part of me” maybe. This seems more like voices are integrated within a persons life and therefore is causing less disruption. Maybe it can be both as well? But some saw voices as part of life but not “part of me”. Different forms of integration?
	Having days of a respite from voices	“A lot better, I was hearing them for less hours, and I was getting two to three days off a week, or days of respite away from the voices.” (P10)	
Fearing Voices Less	Voices can’t hurt me	“no, because they used to tell me to hang myself a lot and I don’t do that. They can’t hurt me, only I can hurt me” (P7)	This seemed to rely on successful coping being learned and reinforced earlier – without this, fear of voices tended to remain and integration could not happen.
	Being more open about voices	“I'm a lot more open, um, than I used to be, I used to be scared to say things about my voices.” (P10)	

Phase 3: Transformation and Growth			
Category: Investing in Sustaining Relationships			
Subcategories	Example open codes	Example participant quotes	Memos
Refocusing on Social Life	Being there for others	“It makes me feel happy that I'm doing something. Because I like helping people and that. So, it just makes me happy.” (P11)	I wonder if this relates somewhat to individuals identity, as previously being seen as ‘a service user’ but being a friend / heling others provides a different experience. Refocusing on social life seemed to enabled by voices being less distressing and being able to connect with others again.
	Spending time with friends is important	“I've got a couple of good friends, they’re together. And she's been asking her how I am and things like that. And basically she she's a sort of happy little soul, So anything doesn’t faze her. Yeah, so its positivity around me, I think I need” (P11)	
Benefitting from Relationships	Getting practical support	“they don't give me um, emotional support, it's mainly practical. I I'm very resourceful and independent so it's mainly yeah practical things my friends help me with” (P2)	I understand this as participants seemed to invest in but also receive back investments in relationships. “it's just nice to know someone’s listening” captures how relationships could be supportive following the sustaining change phase, and perhaps links to how participants felt worried about therapy ending / not having support. There seems to be a closeness in relationships now that wasn’t present before – enabled through talking about voices?
	Having someone to talk to	“it's just nice to know someone’s listening, you know when I go about my daily routine, to have someone to talk to when I've got time to talk to them” (P3)	

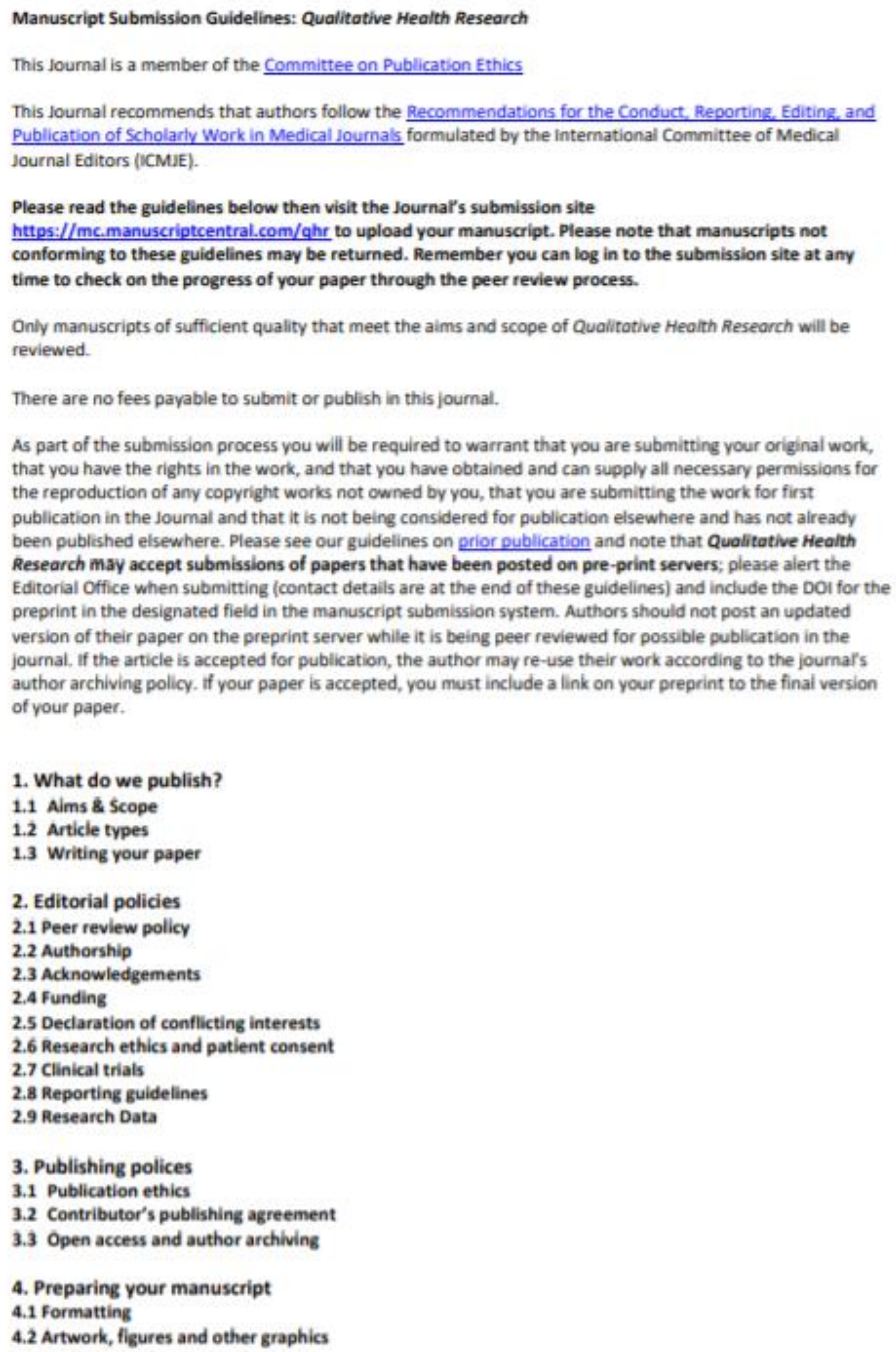
Phase 3: Transformation and Growth

Category: Rediscovering and Developing Identity

Subcategories	Example open codes	Example participant quotes	Memos
Accepting Myself and My Needs	Understanding my own needs	“I've learnt that it's you dont have to always be a good person *laughs*, I don't mean being nasty but I used to have this, because the voices used be quite evil and angelical they used to pull apart, if I didn't something or didn't say something in the right way they'd say "you made them feel terrrible, you did this and that", and by erasing the fact that I'm not going to be a good person, they don't have any ground from which to pull me apart” (P8)	I understood this as participants accepting themselves and who they are, which was related to accepting their needs and looking after themselves. Interestingly, this seemed to occur after voices were accepted into participant lives. Acceptance was an ongoing process here rather than something that can be ‘achieved’.
	Practising good self-care	“I've been really good with my insulin, been really good with my tablets um, I take them once at night and I put headphones on, so I just get on with it” (P5)	
Engaging with Meaningful Activity	Doing activities that I enjoy	“I like learning stuff which is why I've always kept studying and also it made me feel, it empowered me basically. Without studying, I panicked a bit you know, what am I going to do now to keep my brain occupied? Because my brain needs to be occupied learning stuff all the time, and with gardening there's so much to learn, you're never going to stop learning *Laughs*. And you get a garden out of it and it makes you feel good, you can just sit in it.” (P8)	I understood these responses as the things or actions participants engaged with that were reflective of who they are. These were actions that were personally enjoyable or how participants wanted to occupy themselves. Associated with ‘being myself’ and a sense of empowerment?
	Keeping busy	“uh, just try and keep myself busy, that's what I try and do. Like I've got chickens so look after the chickens and stuff like that” (P7)	
Having a Purpose and Role	Work providing a sense of purpose	“I really found working to be good for me, a lot of it is to do with self-esteem. There’s a feeling of a victim and everything happening to you, and then there's getting out there and doing something positive. And my work does make me feel like I'm doing something good, I'm like a buddy to someone so, I've been doing it for four years, I take her places.” (P8)	I interpreted this as participants communicating having a focus in life, either through a valued part of their life or having a role. This perhaps relates to the sense of empowerment participants developed with the voices earlier, however, this goes beyond relationship with voices or with themselves, and associated with changing identity.
	Being present	“yeah. it makes me feel like I'm still in the human race sort of thing.” (P5)	
Being Myself vs Someone with	Being myself again	“I've been a big one on on comedy and when I was going though the therapy and stuff and being on ESA, my levels of comedy had dropped and it was unlike me, I'm a big joke maker and people do	Investing in self/identity seems to be a separate process from the experience of hearing voices. This is where participants descriptions seem to shift

Mental Health Difficulties		claim for mem to be quite a funny guy and that is something I relied on quite heavily, being able to do that again is really quite fun and it feels nice to be able to come to that level again where I can make people look at and make people laugh, and they've got big smiles on their faces and I can know that's from me.” (P4)	focus to being more about them personally, their values etc. Perhaps this signifies the way voices can be overwhelming at the start of this journey, can dominate thoughts and attention, but some of that pressure is removed at this later phase.
	Not being consumed by the problem	“When things consume so much of a person for so long, there’s a huge risk of that person becoming that problem instead of just being consumed by it, they become that problem.” (P2)	

Appendix V: Qualitative Health Research journal author guidelines



Manuscript Submission Guidelines: *Qualitative Health Research*

This Journal is a member of the Committee on Publication Ethics

This Journal recommends that authors follow the Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals formulated by the International Committee of Medical Journal Editors (ICMJE).

Please read the guidelines below then visit the Journal's submission site https://mc.manuscriptcentral.com/qhr to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned. Remember you can log in to the submission site at any time to check on the progress of your paper through the peer review process.

Only manuscripts of sufficient quality that meet the aims and scope of *Qualitative Health Research* will be reviewed.

There are no fees payable to submit or publish in this journal.

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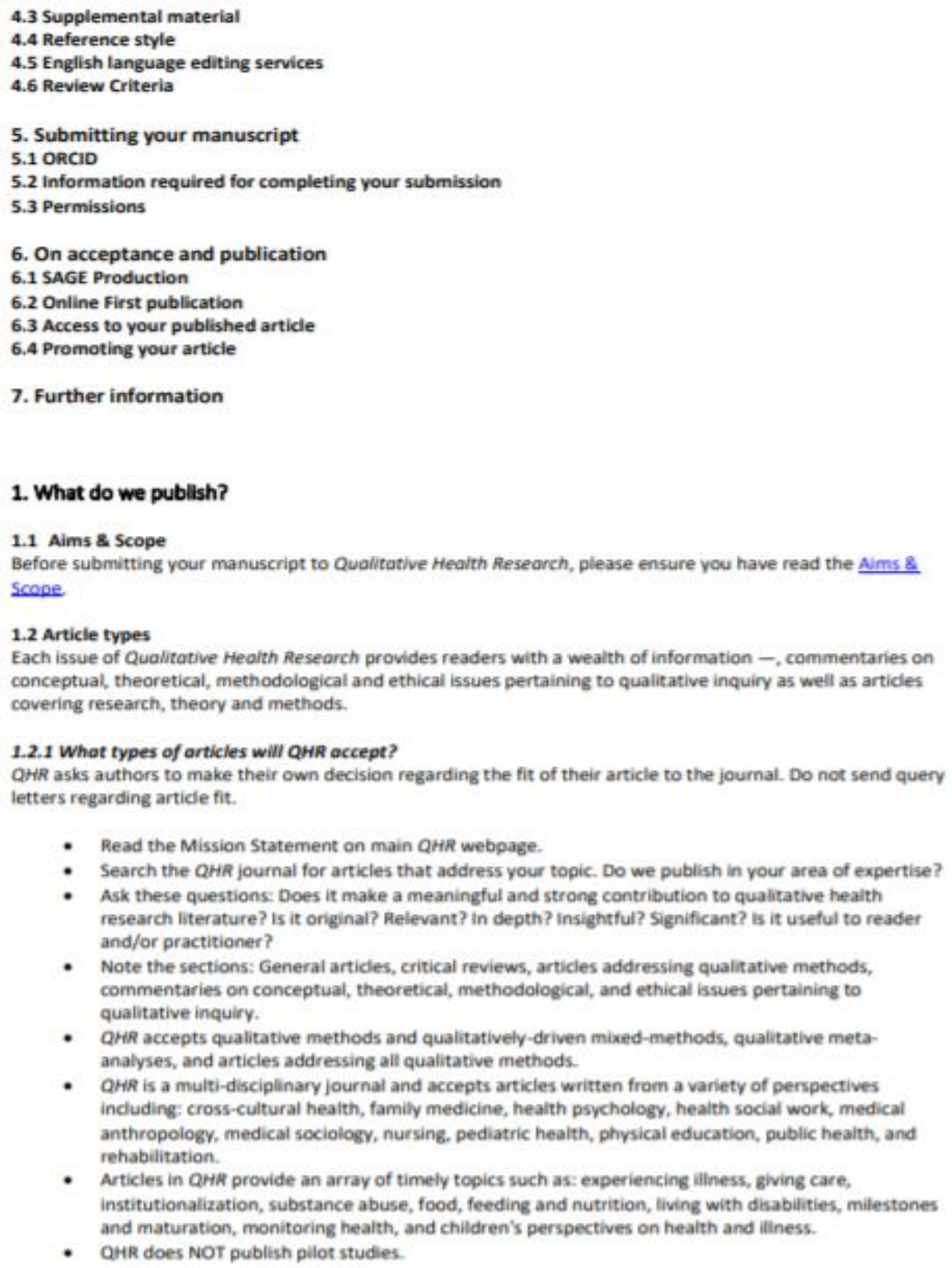


4.3 Supplemental material
4.4 Reference style
4.5 English language editing services
4.6 Review Criteria

5. Submitting your manuscript
5.1 ORCID
5.2 Information required for completing your submission
5.3 Permissions

6. On acceptance and publication
6.1 SAGE Production
6.2 Online First publication
6.3 Access to your published article
6.4 Promoting your article

7. Further information

1. What do we publish?

1.1 Aims & Scope

Before submitting your manuscript to *Qualitative Health Research*, please ensure you have read the Aims & Scope.

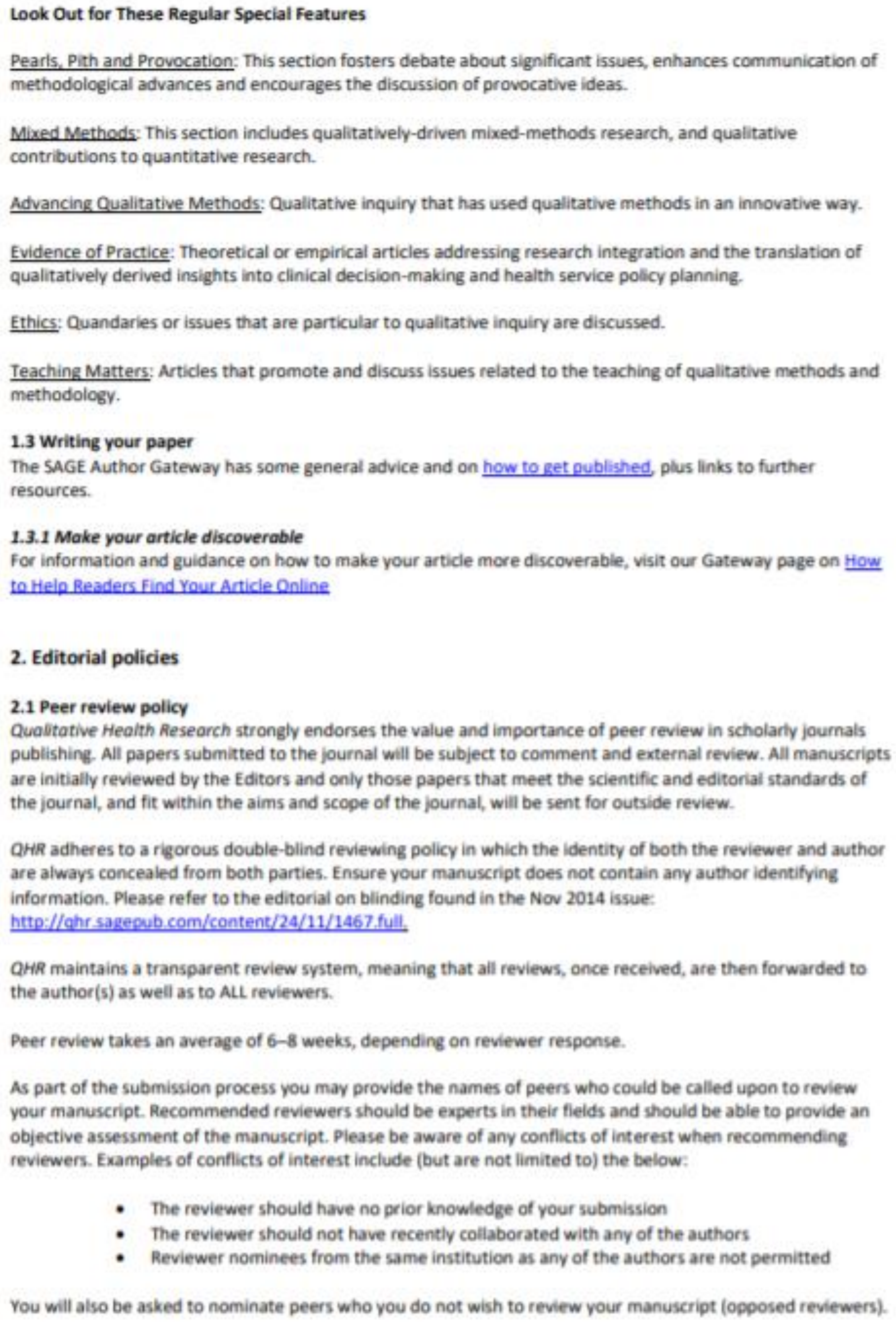
1.2 Article types

Each issue of *Qualitative Health Research* provides readers with a wealth of information —, commentaries on conceptual, theoretical, methodological and ethical issues pertaining to qualitative inquiry as well as articles covering research, theory and methods.

1.2.1 What types of articles will QHR accept?

QHR asks authors to make their own decision regarding the fit of their article to the journal. Do not send query letters regarding article fit.

- Read the Mission Statement on main *QHR* webpage.
- Search the *QHR* journal for articles that address your topic. Do we publish in your area of expertise?
- Ask these questions: Does it make a meaningful and strong contribution to qualitative health research literature? Is it original? Relevant? In depth? Insightful? Significant? Is it useful to reader and/or practitioner?
- Note the sections: General articles, critical reviews, articles addressing qualitative methods, commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.
- *QHR* accepts qualitative methods and qualitatively-driven mixed-methods, qualitative meta-analyses, and articles addressing all qualitative methods.
- *QHR* is a multi-disciplinary journal and accepts articles written from a variety of perspectives including: cross-cultural health, family medicine, health psychology, health social work, medical anthropology, medical sociology, nursing, pediatric health, physical education, public health, and rehabilitation.
- Articles in *QHR* provide an array of timely topics such as: experiencing illness, giving care, institutionalization, substance abuse, food, feeding and nutrition, living with disabilities, milestones and maturation, monitoring health, and children's perspectives on health and illness.
- QHR does NOT publish pilot studies.



Look Out for These Regular Special Features

Pearls, Pith and Provocation: This section fosters debate about significant issues, enhances communication of methodological advances and encourages the discussion of provocative ideas.

Mixed Methods: This section includes qualitatively-driven mixed-methods research, and qualitative contributions to quantitative research.

Advancing Qualitative Methods: Qualitative inquiry that has used qualitative methods in an innovative way.

Evidence of Practice: Theoretical or empirical articles addressing research integration and the translation of qualitatively derived insights into clinical decision-making and health service policy planning.

Ethics: Quandaries or issues that are particular to qualitative inquiry are discussed.

Teaching Matters: Articles that promote and discuss issues related to the teaching of qualitative methods and methodology.

1.3 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources.

1.3.1 Make your article discoverable

For information and guidance on how to make your article more discoverable, visit our Gateway page on How to Help Readers Find Your Article Online

2. Editorial policies

2.1 Peer review policy

Qualitative Health Research strongly endorses the value and importance of peer review in scholarly journals publishing. All papers submitted to the journal will be subject to comment and external review. All manuscripts are initially reviewed by the Editors and only those papers that meet the scientific and editorial standards of the journal, and fit within the aims and scope of the journal, will be sent for outside review.

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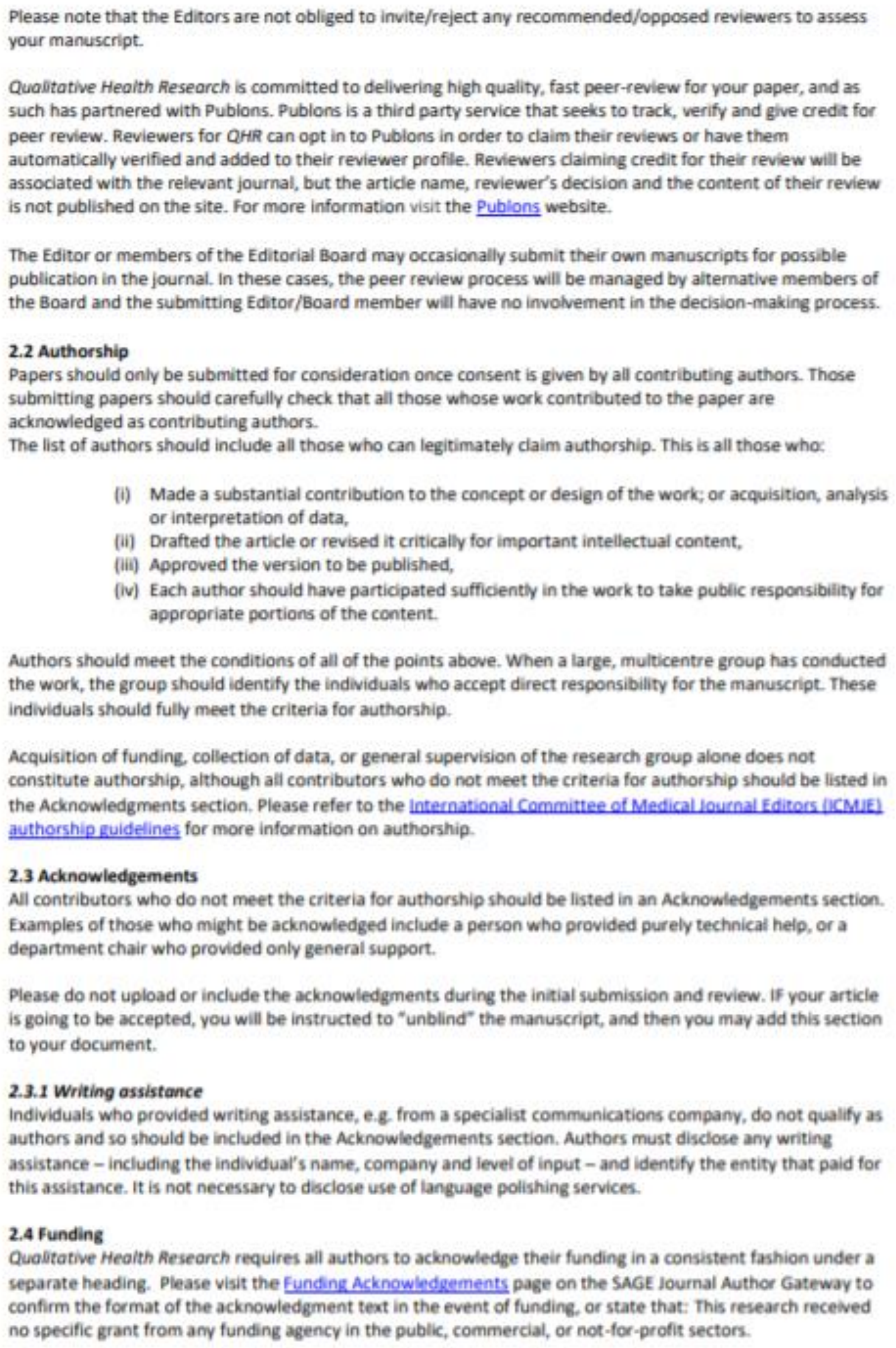
QHR maintains a transparent review system, meaning that all reviews, once received, are then forwarded to the author(s) as well as to ALL reviewers.

Peer review takes an average of 6–8 weeks, depending on reviewer response.

As part of the submission process you may provide the names of peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers. Examples of conflicts of interest include (but are not limited to) the below:

- The reviewer should have no prior knowledge of your submission
- The reviewer should not have recently collaborated with any of the authors
- Reviewer nominees from the same institution as any of the authors are not permitted

You will also be asked to nominate peers who you do not wish to review your manuscript (opposed reviewers).



Please note that the Editors are not obliged to invite/reject any recommended/opposed reviewers to assess your manuscript.

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2.2 Authorship

Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.

The list of authors should include all those who can legitimately claim authorship. This is all those who:

(i) Made a substantial contribution to the concept or design of the work; or acquisition, analysis or interpretation of data,
(ii) Drafted the article or revised it critically for important intellectual content,
(iii) Approved the version to be published,
(iv) Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

Authors should meet the conditions of all of the points above. When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section. Please refer to the International Committee of Medical Journal Editors (ICMJE) authorship guidelines for more information on authorship.

2.3 Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Please do not upload or include the acknowledgments during the initial submission and review. IF your article is going to be accepted, you will be instructed to "unblind" the manuscript, and then you may add this section to your document.

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Individuals who provided writing assistance, e.g. from a specialist communications company, do not qualify as authors and so should be included in the Acknowledgements section. Authors must disclose any writing assistance – including the individual's name, company and level of input – and identify the entity that paid for this assistance. It is not necessary to disclose use of language polishing services.

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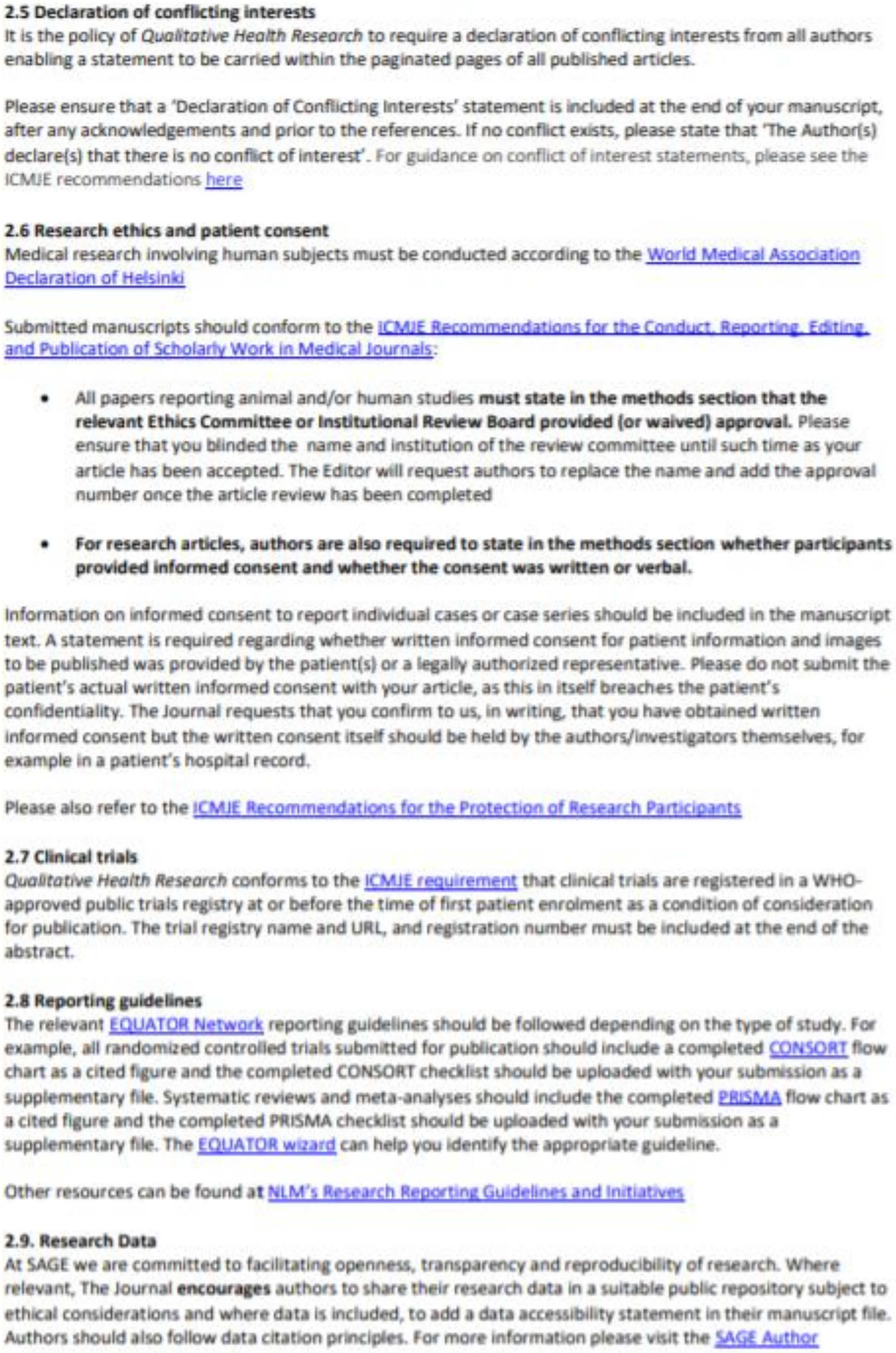
Qualitative Health Research requires all authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit the Funding Acknowledgements page on the SAGE Journal Author Gateway to confirm the format of the acknowledgment text in the event of funding, or state that: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.



2.5 Declaration of conflicting interests
It is the policy of *Qualitative Health Research* to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here

2.6 Research ethics and patient consent
Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals:

- All papers reporting animal and/or human studies **must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval.** Please ensure that you blinded the name and institution of the review committee until such time as your article has been accepted. The Editor will request authors to replace the name and add the approval number once the article review has been completed

- **For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.**

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative. Please do not submit the patient's actual written informed consent with your article, as this in itself breaches the patient's confidentiality. The Journal requests that you confirm to us, in writing, that you have obtained written informed consent but the written consent itself should be held by the authors/investigators themselves, for example in a patient's hospital record.

Please also refer to the ICMJE Recommendations for the Protection of Research Participants

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Qualitative Health Research conforms to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first patient enrolment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

2.8 Reporting guidelines
The relevant EQUATOR Network reporting guidelines should be followed depending on the type of study. For example, all randomized controlled trials submitted for publication should include a completed CONSORT flow chart as a cited figure and the completed CONSORT checklist should be uploaded with your submission as a supplementary file. Systematic reviews and meta-analyses should include the completed PRISMA flow chart as a cited figure and the completed PRISMA checklist should be uploaded with your submission as a supplementary file. The EQUATOR wizard can help you identify the appropriate guideline.

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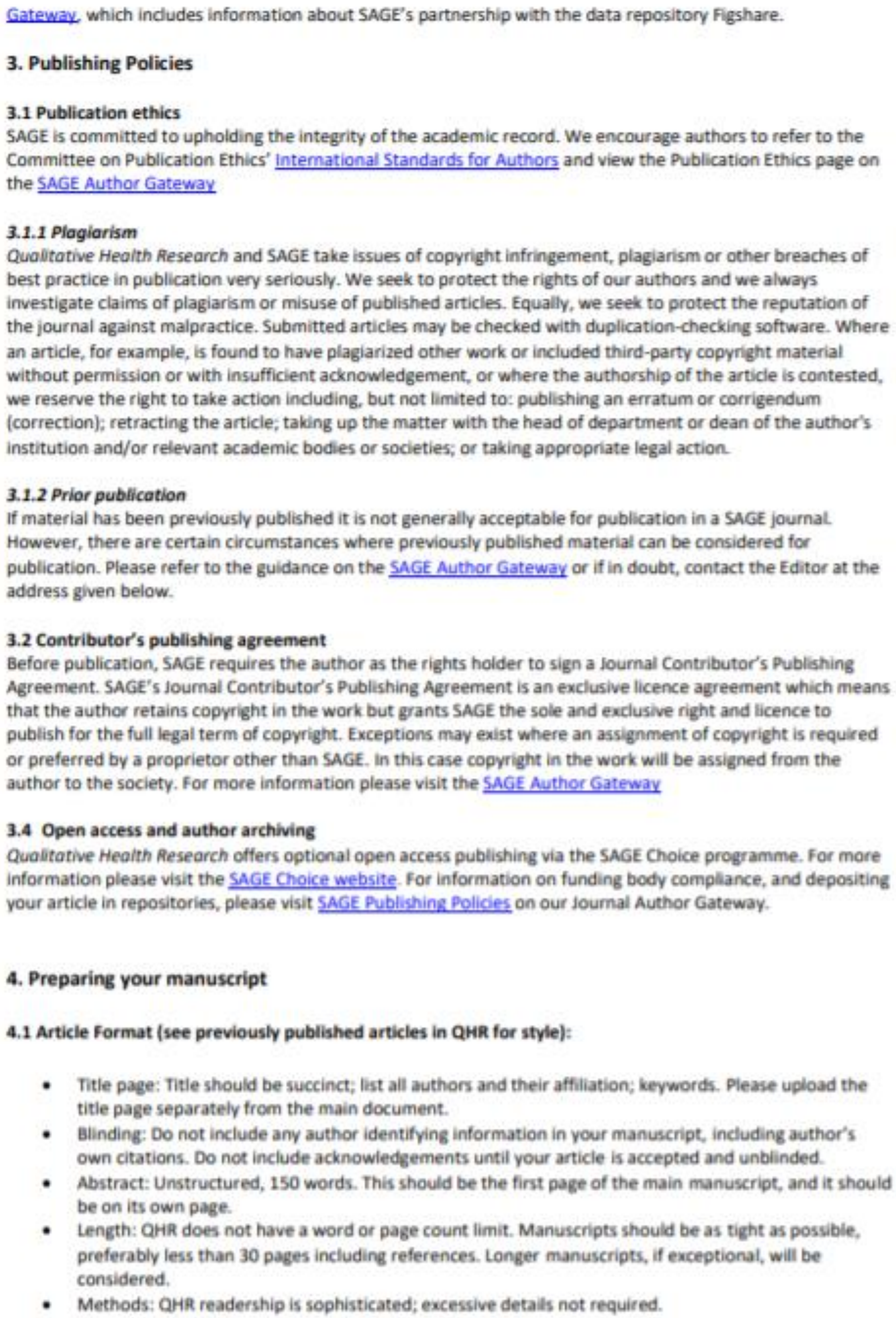
At SAGE we are committed to facilitating openness, transparency and reproducibility of research. Where relevant, The Journal **encourages** authors to share their research data in a suitable public repository subject to ethical considerations and where data is included, to add a data accessibility statement in their manuscript file. Authors should also follow data citation principles. For more information please visit the SAGE Author



Gateway, which includes information about SAGE's partnership with the data repository Figshare.

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3.1 Publication ethics

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4. Preparing your manuscript

4.1 Article Format (see previously published articles in QHR for style):

- Title page: Title should be succinct; list all authors and their affiliation; keywords. Please upload the title page separately from the main document.
- Blinding: Do not include any author identifying information in your manuscript, including author's own citations. Do not include acknowledgements until your article is accepted and unblinded.
- Abstract: Unstructured, 150 words. This should be the first page of the main manuscript, and it should be on its own page.
- Length: QHR does not have a word or page count limit. Manuscripts should be as tight as possible, preferably less than 30 pages including references. Longer manuscripts, if exceptional, will be considered.
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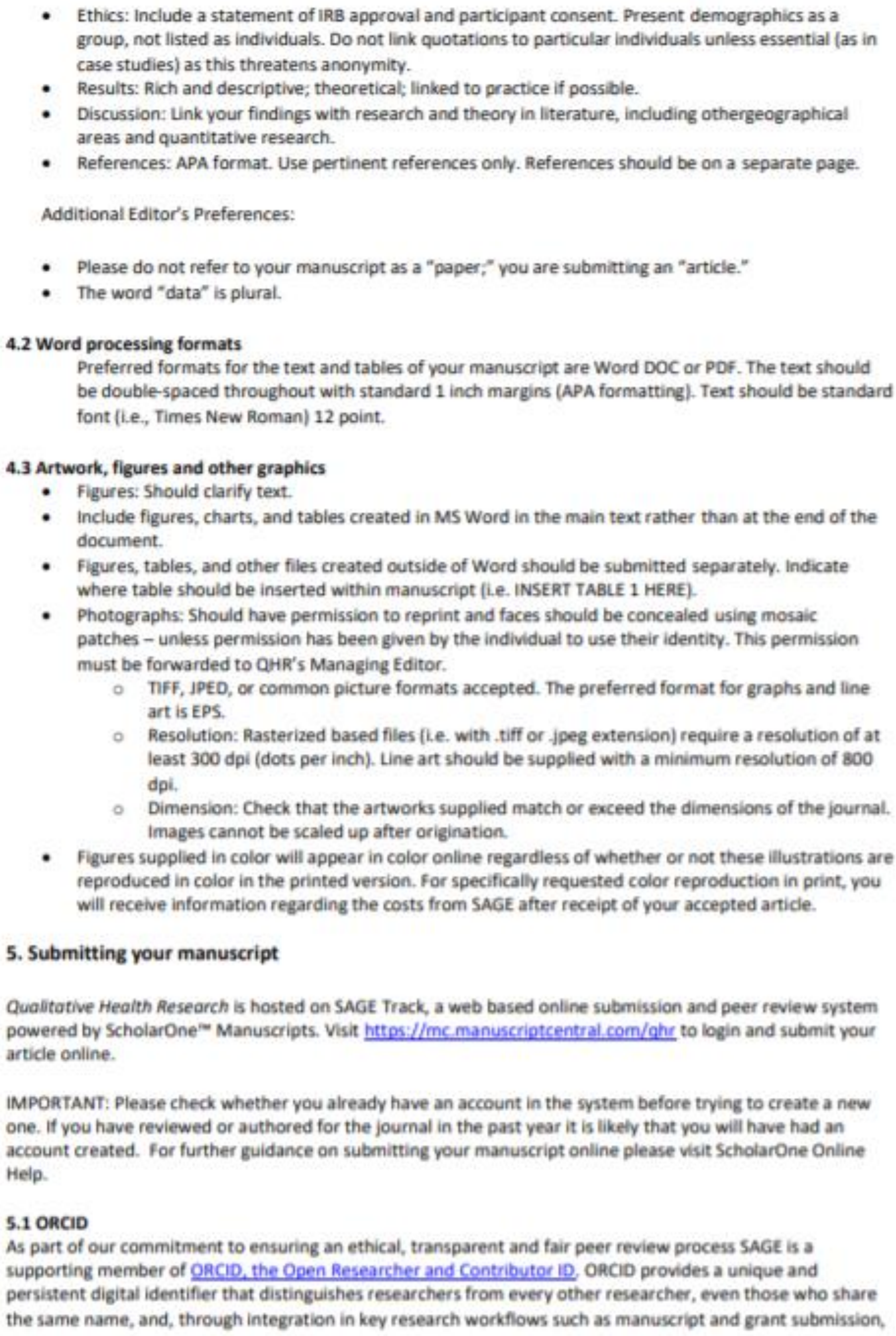

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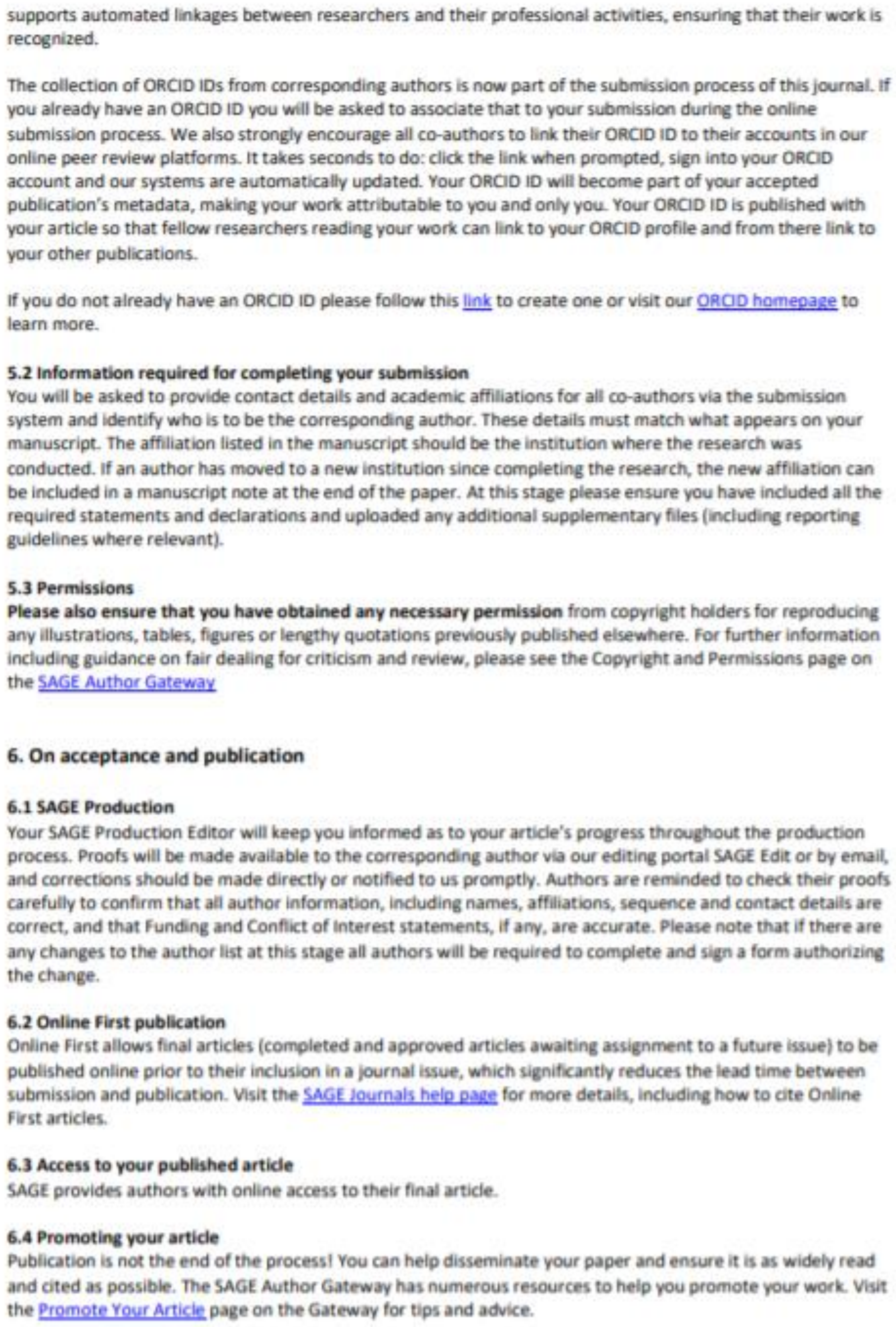

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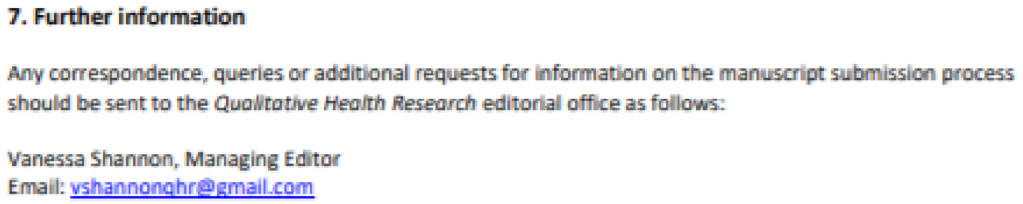

7. Further information

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