

**Group psychological treatment for young
people with distressing auditory
hallucinations**

The Young Peoples' Voices Group

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*I would like to dedicate this thesis to two very special people
to my mum and best friend, Sandra Rose Newton
without her I would not be who I am today
and to Kevin Hook
who helped, encouraged and believed in me
and now watches over me
I miss him very much*

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ABSTRACT

For a significant proportion of people who develop schizophrenia, onset occurs during adolescence. This group tends to suffer from a more chronic course of illness with less favourable outcomes than those whose onset occurs during adulthood. The experience of auditory hallucinations is the most common and distressing symptom experienced by people suffering from schizophrenia. It has been suggested that auditory hallucinations may be most frightening and difficult to cope with shortly after their onset. However, this may also be the period in which auditory hallucinations will be most responsive to psychological treatment.

Recent efficacy studies of group psychological therapy for voices have found significant reductions in symptoms and distress, and increases in coping. This study investigates the efficacy of group psychological therapy for young people (15 to 21 years) suffering from distressing auditory hallucinations and explores their experiences of receiving treatment. It uses a mixed-method approach. Changes in symptoms over a six-week waiting period, treatment and follow-up period were investigated using structured interview schedules and self-rating questionnaires. In addition, a sub-set of participants were interviewed using a semi-structured interview schedule to collect detailed verbal accounts of their experiences of the therapy group in which they had participated.

Significant reductions in auditory hallucinations and significant increases in coping and activity level were found following treatment. The qualitative data supported the quantitative findings; the benefits of the treatment group were clearly articulated by those who attended. These findings are consistent with the literature that suggest that psychological therapies should be an integral part of treatment for young people with psychosis.

CHAPTER 1 - INTRODUCTION

INTRODUCTION

Background

There are a significant number of adolescents who require treatment for distressing auditory hallucinations. The prognosis and clinical outcome for adolescents with psychosis is poor, yet no specific psychological treatments with proven efficacy are available for this group. The current study's aims are two-fold, firstly, to address this gap in the literature by conducting an efficacy trial of group psychological therapy for auditory hallucinations with young people with adolescent-onset schizophrenia. Secondly, to investigate the young people's experience of the therapy in which they participated in order to further our understanding of the treatment.

The introduction to the current research will begin by describing schizophrenia, its symptomatology, epidemiology and the course of the disorder in adults and young people. (Etiological factors will not be covered in the introduction as they are not directly related to the current research.)

The second part will focus on auditory hallucinations, reputedly the most common and distressing symptom of schizophrenia and will move on to review psychological theories of auditory hallucinations and psychological treatments for voices. A brief presentation of the qualitative literature relating to patients' experiences of psychotic symptoms and of receiving psychological treatment for these, will be given. Finally, the introduction will place the current study in the context of previous research and identify the

dearth of research in the area of adolescence. The aims of the current study will conclude the introduction.

Epidemiology of Schizophrenia

Schizophrenia has been called 'the most enigmatic and tragic disease' to be treated by psychiatrists (Black and Andreasen, 1999, p233). Onset of the illness typically occurs during late adolescence or early adulthood, which means that in the majority of cases sufferers are prevented from ever leading a normal adult life. Schizophrenia is the largest mental health problem in the UK in terms of the disability that it causes and its cost to the National Health Service (Tarrier, Harwood, Yusupoff et al., 1990). One in every hundred people in the UK will suffer from schizophrenia during their lifetime and estimates suggest that there are twenty new cases of schizophrenia per 100,000 population each year (Jablensky, Sartorius, Ernberg et al., 1992).

Several factors have been demonstrated to be associated with increased incidence of schizophrenia, (the etiological hypotheses of which are beyond the scope of this thesis). However, it is important to note that schizophrenia is conceptualised as a 'multiple-hit' illness which requires a combination of factors to be present in order for it to manifest (Black and Andreasen, 1999). Evidence for this comes from biological, psychological and anthropological studies which, have proposed 'vulnerability' factors, associated with higher incidence of the disorder. For example, a raised incidence of schizophrenia is found in people with a family history of mental illness (Gottesman and

Sheilds, 1982), and those with lower socio-economic status or living in urban areas (Eaton, 1985). Research into ethnicity and schizophrenia, largely fuelled by the over-representation of people from minority ethnic groups on acute admission wards, suggests that these findings are related to higher exposure to adverse factors, such as low socio-economic status, poor housing and discrimination (Boydell, van Os, McKenzie, et al., 2002).

It appears that incidence rates of schizophrenia are equal for men and women. However, because age of onset differs significantly between men and women, a 1:1 ratio is not true of every age group (Lewine, Burbach and Meltzer, 1984). The mean age for a representative male sample is 27 years and the mean age for a typical female sample 30 years (Goldstein, 1992). Whereas most males onset between 15 and 30 years, women have a second onset peak between the ages of 40 and 45 (Hambrecht, Maurer, Hafner and Sartorius, 1992). Before thirteen years of age, schizophrenia is rare, but the rate of onset increases sharply during adolescence. Before the age of 13 males are significantly more likely to have an onset of schizophrenia than females, but as age increases from childhood through adolescence this sex difference disappears (Werry, McClellan and Chard, 1991).

Early onset schizophrenia (EOS) is defined as onset between thirteen and eighteen years of age (Remschmidt, Schulz, Martin, Warnke and Trott, 1994). The prevalence of EOS has not been systematically or adequately

investigated but reports suggest that a significant proportion of people with schizophrenia have a first-onset of symptoms during adolescence. The only epidemiological study looking at those with onset in teenage years (Gillberg, Wahlstrom, Forsman, Hellgren and Gillberg, 1986) found that 0.54% of all teenagers were treated for a psychotic episode. Other epidemiological studies have grouped adolescents with those in their early twenties. Hambrecht et al. (1992) found that 15% of females and 19% of males with a diagnosis of schizophrenia had a first-onset before the age of age 24, and a World Health Organisation study, across nine countries, reported that 51% of people with schizophrenia were aged between 15 and 25 years (Jablensky and Cole, 1997). Recent research from the Early Psychosis Prevention and Intervention Centre in Australia reported a crude mean annual incidence rate of 15 persons per 10,000 population in the age bracket 15 to 19 years, rising to 16 per 10,000 between the ages of 20 and 24 (McGorry, Edwards, Michalopoulos et al., 2002). Clinical reports suggest that at least half of adolescent inpatient beds in London are filled by adolescents suffering from psychotic illness; two thirds of these with a diagnosis of schizophrenia (Corrigal and Browning, 2002). These rates, although somewhat variable, suggest that the incidence of EOS is sufficiently high to warrant further investigation and to require specific clinical intervention.

Diagnosis and Symptoms

Traditional methods of classifying mental illness position schizophrenia as the most common of the 'psychotic' disorders, (i.e. disorders in which a

person's sense of reality becomes acutely disturbed). More recently it has been given an operational definition as the occurrence of delusions and hallucinations (Black et al., 1999). Schizophrenia differs from the other psychotic disorders such as schizoaffective disorder, brief psychotic disorder and schizophreniform disorder, in the both the nature and duration of the psychotic symptoms observed (APA, 1994). Collectively, these disorders are viewed as opposite to 'neurotic' disorders, in which a sense of reality is preserved. On occasions, psychotic symptoms may be observed in anxiety disorders such as PTSD and uni-polar depression, but these symptoms are not primary to diagnosis.

The most frequently used diagnostic criteria in clinical practice are the Diagnostic and Statistical Manual (fourth edition), (American Psychiatric Association, 1994), and the ICD-10 (World Health Organisation, 1992). Both of these require at least two of the following primary symptoms to be present in order for a diagnosis of schizophrenia to be made:-

- Delusions i.e. false beliefs about the world, which may be bizarre
- Hallucinations i.e. perceptions of objects or sounds that are not actually present
- Disorganised speech e.g. derailment or incoherence
- Grossly disorganised or catatonic behaviour
- Negative symptoms i.e. flattened affect, alogia or avolition

These criteria also require a person to have two of a list of secondary symptoms such as social or occupational dysfunction.

Since the publication of DSM-III (APA, 1980) children and adolescents have been diagnosed according to adult criteria (Hollis, 2000). However, there are difficulties associated with the early diagnosis of schizophrenia. In particular, EOS is associated with a high rate of mis-diagnosis for example a large proportion of those receiving a diagnosis of schizophrenia in adolescence are later given an alternative diagnosis such as bipolar disorder or personality disorder (e.g. Werry et al., 1991). Patients have been reported to deny or minimise their symptoms at early stages of their illness and diagnosis of early onset schizophrenia has been reported as being especially problematic (McGorry, Edwards, Michalopoulos, Harrigan and Jackson, 1996).

Secondary impairments, consequences and outcome

Although the primary symptoms of schizophrenia are distressing there are also secondary impairments, created by both the primary symptoms themselves, and by the stigma attached to having a diagnosis of schizophrenia (Birchwood and Jackson, 2000). Secondary impairments include unemployment, social adversity (e.g. reliance on benefits and poor housing) , hospitalisation and loss of social and family networks. These secondary consequences are closely inter-linked and may place the sufferer into a vicious, downward spiral. They put a person at a higher risk of relapse

of their illness (Nuechterlein and Dawson, 1988), and have negative psychological consequences such as creating and maintaining social isolation, low-self-esteem, depression and anxiety.

Co-morbidity of depression in those with a diagnosis of schizophrenia is estimated to be between 22% and 75% (Birchwood and Iqbal, 1998). Over 33% of all people with a diagnosis of schizophrenia will attempt suicide, and over 10% will be successful. Those most at risk include patients below 40 years of age and those with a recent onset of illness (Allebeck, Varla and Wistedt, 1987). Psychosis-related death is high in early-onset groups. Below 18 years of age successful suicide or accidental death caused directly by psychosis in those with EOS is at least 5% (Werry, McClellan, Andrews and Ham, 1994). One quarter of those with EOS are reported to have attempted suicide before their first admission to hospital (Pelkonen, Marttunen, Pulkkinen, Laippala, Lonnqvist and Aro, 1998).

Few studies have documented secondary impairments in early-onset psychosis, but those that have suggest that secondary impairments are more detrimental to this group than to those with adult-onset schizophrenia. Seventy-four percent of those with adolescent onset schizophrenia are reported to experience downwards socio-economic shift compared to the socio-economic status of their family (Lay, Blanz, Hartmann and Schmidt, 2000). This is partially related to the failure of the sufferer to reach

developmental and social milestones before the onset of psychosis. A higher level of morbidity is associated with a younger age of onset for example older adolescents who have reached more social and developmental milestones before their first episode of psychosis, have better outcomes (Haas and Garratt, 1998).

There is much evidence to suggest developmental disruption in EOS. Of a sample of sixty-one young people with psychosis (Pelkonen et al., 1998) only 6% were attending school and 25% had been hospitalised for a period exceeding 6 months. Sixty percent of people with EOS have been reported to leave school with no formal qualifications and to do no further training. It is highly unlikely that this group will be able to earn a living. Long-term follow-ups have reported that over half of those with EOS are reliant on state disability benefit by the age of 30 or are reliant on their families for financial support; very few have studied or worked for more than two months (Gillberg, Hellgren and Gillberg, 1993; Hollis, 2000). Although these recent studies have small sample sizes and have yet to be replicated, they are consistent with the hypothesis that early disruption of development may relate to long-term negative consequences for the person with EOS. This means that the impact of schizophrenia is worse for early onset groups than for those with a first onset of symptoms during adulthood.

Studies also report poor psychosocial outcomes, for example twenty-two out of fifty adults who received a diagnosis of schizophrenia in adolescence had no social contacts other than relatives or professionals, only seven reported having friends, and none were married (Hollis, 2000). The impoverished social networks of people with EOS have been linked to the limited opportunities for friendships or to enter into loving partnerships and a failure to reach autonomy and individualisation from the family; in normal development these stages occur in adolescence (Harrop and Trower, 2001). Higher levels of social impairment, in turn, are linked to a poorer outcome (Hafner and Nowotny, 1995).

Outcomes for those with a diagnosis of schizophrenia vary greatly between individuals. The majority of long-term outcome studies agree that approximately 16% of people never have another episode; 32% have several episodes with little impairment between episodes and approximately 9% have several episodes, never returning to normality in between with an exacerbation in symptoms following each relapse of the illness. In the largest proportion of people (43%), impairment in between episodes and severity of symptoms increases with each subsequent episode (e.g. Shepherd, Watt, Falloon and Smeeton, 1989). In one of the best known follow-up studies as few as 20% of people with schizophrenia were found to be psychiatrically well at follow-up whilst 54% continued to be incapacitated by their symptoms. Only 21% had been married and 35% were rated as economically

productive, less than 35% of the sample had lived independently (Tsuang, Wollson and Fleming, 1979).

Between 60 and 70% of people with schizophrenia return from hospital after first episode to live with their families (Stirling, Tantum, Thonks, Newby and Montague, 1991). Reports associate living with families with greater risk of relapse (e.g. Brown, 1959). This has been linked to 'expressed emotion' (EE), the amount and intensity of positive or negative emotion, hostility at home and critical comments directed towards the person with schizophrenia. There has been much research in this area and a review of studies reported that a higher rate of relapse is consistently found in high EE groups (Bebbington and Kuipers, 1994). Clearly, this is of particular concern for young people with EOS as they are more likely to live with their families and may never progress to the stage of independent living. Less than one quarter of people with EOS followed up in adulthood have lived independently (Hollis, 2000).

In every area it appears that the picture is worse for those with early-onset schizophrenia. EOS is related to a particularly poor prognosis (Eggers and Bunk, 1997) and in comparison to adult samples, the outcome of those with EOS is unfavourable (Weiner, 1982). For example, only 14% of adolescents in comparison to 25% of adults are reported to have just one episode of schizophrenia followed by full remission (Remschmidt et al., 1991). Similarly, the proportion of those with EOS reaching partial remission is significantly

lower in EOS than in adult onset schizophrenia, and in over 50% a chronic course of illness is observed (in comparison to 25% of adults) (Weiner,1982). Most young people with schizophrenia have more than one episode of the illness and moderate to severe impairments have been found in up to 90% of those who have had two or more relapses in a five year period (Asarnow, Thompson and Goldstein, 1994;Werry and Taylor, 1994).

Although few studies of EOS have been carried out, and those that have often have small numbers, the evidence overwhelmingly supports the idea that EOS has a poorer outcome and more chronic course than schizophrenia with an adult onset. In addition, because early age of onset disrupts normal developmental processes, psychosocial and vocational outcomes for this group are grave. A high level of secondary impairment is experienced by early onset groups creating downwards social drift, itself leading to higher rates of relapse, depression and suicide.

Diagnostic critiques

The diagnosis of schizophrenia has been called into question by a number of psychologists and psychiatrists (e.g. Laing, 1967; Szaz, 1979; Boyle, 1990; Bentall, 1992). In its strongest form, the argument against the concept of schizophrenia suggests that the medicalisation and categorisation of 'madness' is used purely to control those who are different , by diagnosis, sectioning and hospitalisation (Szaz, 1979; Pilgrim, 1990). Others, whilst recognising mental illness as a meaningful concept and as an entity which is

distressing for individuals, have questioned the validity, reliability and utility of the diagnosis of schizophrenia (Boyle, 1990; Bentall, 1992). In depth descriptions of these critiques are not given here but it is important to highlight some of the difficulties associated with the diagnosis of schizophrenia, in particular, when referring to early-onset groups.

Boyle (1990) argues that the concept of schizophrenia is used in clinical practice in the same way as any other medical diagnosis, but without the necessary scientific underpinnings and evidence that it represents a true medical pattern or syndrome reflecting a series of observable relationships between phenomena. Indeed, the validity of 'schizophrenia' has not been proven, and there are poor correlations between the symptoms of schizophrenia and its diagnosis (Bentall, 1992). The psychotic symptoms listed in diagnostic criteria such as DSM IV (e.g. delusions and hallucinations) are not specific to schizophrenia and are found in a number of other diagnoses, such as depression and post-traumatic stress disorder, and are also found in people with no psychiatric diagnosis at all. The predictive-validity of the diagnosis is low; having the label 'schizophrenia' tells us little about either a person's clinical picture, or prognosis. Nor does it necessarily tell us which medication or treatment a person may best respond to. In addition, the predictive ability of the diagnosis is reported to be lowest in first onset cases where outcome can vary dramatically from person to person (Birchwood and Jackson, 2000).

The concept of schizophrenia has also been criticised for its unreliability. Frequent cases of mis-diagnosis have been reported, most famously in Rosenthal's experiment (1973) in which a number of researchers reported hearing voices, in isolation from any other symptom of schizophrenia. The researchers were hospitalised with a diagnosis of schizophrenia even with only one of the necessary symptoms for making this diagnosis.

Everitt et al (1971) have used cluster analysis to group patients with different diagnoses, and demonstrated that up to 60% of patients in their sample did not fall into their assigned diagnostic categories, but rather into a 'dustbin' category containing people with different diagnoses, but sharing some similar clinical features. Diagnoses are changed frequently in everyday clinical practice and diagnosis of schizophrenia in first episode and early onset cases is reported to be extremely unreliable, with a high percentage of diagnoses being changed over time (Werry et al., 1991).

Bentall (1992) argues that in order to be useful for either research or clinical purposes, it is necessary for a diagnosis to be both reliable and valid, and that this is not the case for the diagnosis of schizophrenia. He proposes that instead of 'schizophrenia research,' alternative approaches to research with psychotic phenomena need to be considered, because current research is being hindered by diagnostic difficulties. If schizophrenia is not a unitary

phenomenon, then the practice of making comparisons between heterogeneous groups with a diagnosis of schizophrenia and a heterogeneous groups without that diagnosis probably accounts for the failure to find homogeneous explanations and treatments. Instead Bentall proposes using research methods which do not rely on psychiatric categorisation but instead make a particular symptom the subject of the enquiry. In addition, potential participants with a particular psychotic symptom may be excluded from research if they have the symptom (e.g. a delusion) but not the diagnosis (e.g. schizophrenia) as is often the case in young people who have recently become symptomatic.

A number of advances in understanding psychotic phenomena have developed from a symptom approach (e.g. Slade and Bentall, 1988 (hallucinations); Freeman and Garety, 2000 (delusions); Harvey, 1985 (thought disorder)). The approach has been demonstrated to have utility in understanding the symptom of auditory hallucinations, as can be seen in the production of a number of models and treatments of this particular symptom, reviewed below.

Auditory Hallucinations

Auditory hallucinations are the most common symptom in schizophrenia with between 60 and 74% of people with this diagnosis reporting that they hear voices (Slade and Bentall, 1988; Wing, Cooper and Sartorius, 1974). An auditory hallucination can be defined as a auditory perception occurring to a

person in the absence of the appropriate stimulus, auditory hallucinations are often reported to be noises, music or more commonly voices (Cutting,1985). They were labelled as a first-rank symptom of schizophrenia by Schneider (1959), who described them as prolonged, clearly audible, voices which often comment on a person's actions, talk to each other with reference to the person listening or repeat their thoughts.

There is both clinical and empirical evidence to suggest that the auditory hallucinations experienced by people with schizophrenia are extremely distressing (Garety and Helmsley, 1987). They have been found to have a negative effect on quality of life and are thought to be instrumental in maintenance of depression, anxiety and low self-esteem (Breier and Strauss, 1983; Tarrier, 1987). Suicide and self-harm in groups of people who hear voices is increasingly recognised (Briera, Schreiber, Dyder and Pickard, 1991) and hearing voices has been linked to behavioural disturbance and violence. Twenty to fifty percent of people with schizophrenia continue to be distressed by auditory hallucinations despite regularly taking antipsychotic medication (Curson, Patel, Liddle and Barnes, 1988). Between one quarter and one half of people suffering from schizophrenia have 'treatment-resistant' positive symptomatology even when recent advances in antipsychotic medications, such as the introduction of clozapine, are taken into account (Close and Garety, 1998). In addition, a large proportion of people with schizophrenia (over 40%) are non-compliant with their

medication which frequently has unpleasant side-effects (Curson, Barnes, Bamber and Werall, 1985). With these people also taken into account, the number with persistent auditory hallucinations rises still further. It has become clear to clinicians and researchers that a better understanding of the process of auditory hallucinations is necessary in order to provide new treatments which supplement medication and relieve some of the distress and suffering associated with hearing voices.

The first large-scale epidemiological study of auditory hallucinations was carried out by Tien (1991), this clearly demonstrated that they are not exclusive to populations with psychosis. The study surveyed 15,000 people from the general population by using psychiatric diagnostic measures. These instruments diagnosed 4% of the general population as suffering from auditory hallucinations, none of who were in touch with psychiatric services and only one-third reported finding these experiences distressing. These results are consistent with previous, smaller scale research that had suggested that hearing voices is on a continuum with normal experience. For example 36% of 375 college students reported hearing somebody who was not present calling their name; 39% had heard their own thoughts spoken out loud and 10% had experienced advisory voices (Poesy and Losch, 1983). Many studies have also found that hallucinations can be a normal response to stressful situations such as sleep deprivation (Oswald, 1974) and bereavement (Grimby, 1993).

The epidemiological findings shifted the focus of research in order to explore the difference between those who heard voices and needed psychiatric care and those that didn't; Marius Romme, a psychiatrist in the Netherlands and his colleague Sandra Escher pioneered much of this research. In 1992, they appeared on a Dutch chat show with the theme 'hearing voices' that requested people who heard voices call in following the program. They aimed to get two samples of people who heard voices, 'copers' and 'non-copers', hypothesising that comparison of the two groups would lead to a better understanding of the differences between those that were distressed by voices and needed psychiatric care and those that weren't. Four hundred and fifty voice hearers contacted the program, 39% of whom had never been in touch with psychiatric services and described themselves as being able to cope with their experiences without help (Romme and Escher, 1993).

Data from 173 participants who returned questionnaires following the initial telephone contact were analysed. Responses illuminated the experience of hearing voices and led to new directions in treatment and research. Most respondents said that their voices had started suddenly and could recollect the exact date and place. Six percent reported that the voices had begun before the age of 6, 10% between the ages of 10 and 20 and 74% after 20 years of age. Onset peaked between fifteen and twenty years of age. The majority of the sample (70%) linked the onset of the voices to a traumatic or emotional

event, for example a bereavement, accident, significant relationship or moving house. Fifteen percent of the sample reported hearing positive voices and 57% negative, with the remainder not responding to this question (10%) or hearing a mixture of both types of voice (18%).

'Copers' and 'non-copers' were divided according to their response to the question 'Are you able to cope with the voices?'. The non-coping group formed the majority of the sample (61%) and sought the most psychiatric support. Differences in demographics, coping strategies and characteristics of the voices between the two groups were investigated. There were no differences in demographics but there were significant differences in the characteristics of the voices. The non-coping group rated the voices as significantly more powerful, negative in content and as more frequently giving commands than the coping group. In terms of coping, the coping group used strategies that were more diverse and the non-copers used significantly more distraction techniques (e.g. watching T.V.). Both groups reported discussing their experiences with others, although the non-coping group rated this as being less supportive than the coping group.

In addition, the study suggested that the effect of voices was most startling and severe when their onset was during 'the vulnerable years of adolescence' (Romme and Escher, 1993, p17). This finding is consistent with reports from some of the studies of EOS cited above, which have associated

the severity of positive symptoms such as hallucinations in adolescence as predictive of poor outcome in adulthood (e.g. Maziade et al, 1996; Werry et al., 1994). Werry et al. (1991) found auditory hallucinations to be one of the symptoms that occurred most frequently in adolescents with schizophrenia. This is not surprising when related to epidemiological data reporting that 8% of all children sometimes experience hallucinations (McGee, Williams and Poulton, 2000) which is twice the rate of hallucinations found in adults. Persistent hallucinations at the age of eleven have been found to a sixteen-fold increase in risk of later psychotic disorder (Poulton, Caspi and Moffit et al., 2000).

Recently, Escher, Romme, Bunks, Delespaul and Van Os (2002) have completed the first longitudinal study of children and adolescents with auditory hallucinations with the aim of investigating the experience of hallucinations and their course over a three-year period. Those who received mental health care were compared to those who did not. Eighty young people entered the study, the mean age was 13 years and half of the sample were female. Sixty percent of the sample stopped hearing voices during the three-year study period. The young people who were in touch with mental health services differed significantly from the non-patient group in many respects. They had higher symptom rating of hallucinations; they showed more problem behaviour, they were more anxious and depressed and had lower global functioning scores than their peers who heard voices but were not in

touch with psychiatric services. These children and their parents reported that the voices had more influence on their emotions and behaviour and they made more negative affective appraisals in relation to the voices than the non-patient sample. The study concludes that dysfunctional appraisals may contribute to the need for care and the persistence of the voices. In terms of coping, non-patients used more passive coping techniques, such as distraction or listening only selectively to the voice. Copers seemed more able to identify triggers for the voices (e.g. being alone or tired) than children who had difficulty in coping. More people in the young people's social network had been told about their experience of voices in the patient rather than the non-patient group, probably suggesting that the experience in the non-patient group was more severe or less well adapted to.

Both the adult and child literature suggest that the experience of auditory hallucinations is distressing for a significant proportion of people who hear them, these people do not necessarily have a diagnosis of schizophrenia. However, those who are in touch with mental health services appear less able to cope with their experiences. The difference seems to be not in the experience of voices itself but in the way the person interacts with the experience, their coping, appraisals and cognitions surrounding voices. They appear to feel less in control, rate voices more negatively and have less effective coping strategies. It has only been in the last ten years that epidemiological and psychological research has begun to look in depth at the

experiences of auditory hallucinations and at why some people cope well whilst others do not. The information about differences in coping styles, in beliefs and characteristics of the voices between groups has led to new psychological treatment strategies and has been incorporated into a number of psychological theories of auditory hallucinations, these will be discussed in the next two sections.

Psychological treatments for auditory hallucinations and links to psychological theory

The aim of psychological treatment for auditory hallucinations is to move the 'non-copers' as defined by Romme and Escher into the 'coping' category. Romme et al (1993) proposed three stages of coping through which voice hearers need to move in order to integrate their experiences. These are: -

1. Startling phase – sudden onset of voices , frightening experience
2. Organisation – selection and communication with the voices
3. Stabilisation - more consistent ongoing means of dealing with the voices

Research within this framework has demonstrated that the most frequently used strategies for dealing with auditory hallucinations are reported to be unsuccessful whilst the most effective strategies are only used by the minority of people (Carter, Mackinnon and Copolov, 1996). This has encouraged psychological interventions aimed at improving patient's coping repertoires (e.g. Nelson, 1991). However, behavioural techniques such as

wearing earplugs and using personal stereos have been found to be effective but short-lived (Wykes et al, 1999). In a study evaluating Coping Strategy Enhancement (CSE) (Tarrier, Beckett, Harwood et al., 1993), the encouragement of natural and new coping strategies was compared with a problem-solving intervention. Both reduced residual psychotic symptoms including auditory hallucinations immediately following treatment and CSE was found to be superior to problem-solving but the effect on hallucinations was lost at a nine-month follow-up in both groups. Other studies, with more enduring improvements have combined CSE with cognitive behavioural therapy (e.g. Jenner, van der Willige and Wiersma, 1998).

Since the early 1990's Cognitive Behavioural Therapy (CBT) for Psychosis have been used in clinical practice. This approach draws on Beck's approach to depression (1979) and on a multifactorial formulation of psychotic symptoms that takes into account neuropsychiatric theories of psychosis, stress-vulnerability models and cognitive theories of psychotic symptomatology (Fowler, Garety and Kuipers, 1995). CBT for psychosis concentrates on positive psychotic symptoms and their meaning to the individual. Its main aims are to reduce the distress and disability associated with these symptoms, to reduce emotional disturbance such as anxiety and depression associated with the symptoms and to help the individual arrive at their own formulation of their difficulties (Garety, Fowler and Kuipers, 2000). This explanation should be normalising, remove guilt and blame for the

psychosis and be a comfortable explanation in order to reduce distress (for example 'the voices are caused by faulty wiring in my brain' rather than 'the voices are a punishment from God because I am a bad person.'). The individual's formulation should also aim to reduce chance of relapse and reduce disability by providing understanding and the ability to recognise factors that may improve or exacerbate symptoms. CBT for psychosis is a long-term individual therapy; psychologists have recognised the gentle engagement procedure that is needed when working with often very disturbed and distressed psychotic patients. It is suggested that at least six assessment sessions are required followed by a median of twenty therapy sessions (Garety et al, 2000).

A number of randomised controlled trials (RCT's) of cognitive behavioural therapy for psychosis have now been carried out. A meta-analysis of studies (Rector and Beck, 2001) concluded that cognitive approaches produce large clinical effects and are effective in reducing or eliminating positive and negative psychotic symptoms. However, a detailed examination of the data has found that the effect was much greater for delusions than hallucinations. The most common finding from a number of recent RCT's (Tarrier et al., 1993, Garety, Kuipers, Fowler et al., 1994; Kuipers, Garety, Fowler et al., 1997; Fowler, Garety, Chisolm et al.1998; Tarrier et al. 1998) is a greater reduction in general psychotic symptomatology than that occurring as the result of standard care or control treatment conditions. Only one of these studies

(Kuipers et al., 1998) reported a positive change on a measure of auditory hallucinations, and this was a significant reduction in frequency at an 18 month follow-up, changes in distress and intensity did not reach significant levels. The other studies reported no significant change on measures of hallucinations, in fact, it has been suggested that hallucinations are more difficult to change than delusions and that CBT for psychosis may not be an effective treatment for voices (Tarrier et al, 1998). Psychologists have had to search elsewhere for approaches that help to relieve some of the distress associated with these symptoms. A symptom approach has been taken by a number of psychologists which has been more informative with regard to the underlying processes involved in cause and maintenance of auditory hallucinations (Morrison, 1998).

Increasingly, the experience of auditory hallucinations is being understood in terms of ordinary psychological principles, in particular with reference to cognitive models (Chadwick, Birchwood and Trower, 1996). As yet, no comprehensive model of auditory hallucinations has been described, although several have been proposed (e.g. Frith, 1992; David, 1994; Hoffman, 1986). The models proposed by Bentall (1990), Chadwick and Birchwood (1996) and Morrison (1998) will be reviewed here, as these are the main theories that have driven advances in psychological treatment for auditory hallucinations over recent years.

Models of auditory hallucinations and their treatment implications

Bentall's model (1990) views auditory hallucinations as a failure to monitor internal events, which means that they are mis-attributed to external sources. He suggests that this process is influenced by top-down processes which includes beliefs and expectations about what people believe is likely to occur such as the existence of spirits, aliens or telepathy (Bentall, Haddock and Slade, 1994). Evidence for this model comes from a variety of sources. For example, experiments have demonstrated that covert movements of the speech musculature accompany normal thinking or inner speech occur when people hear voices (Gould, 1950). Sub-vocalisation tasks inhibit the occurrence of auditory hallucinations (James, 1983) and anthropological studies have shown that the content of voices is often culturally specific (Bourguignon, 1970).

Bentall argues that anxiety is reduced when internal events that are distressing to the individual (e.g. worries, negative thoughts about the self and feared intentions) are attributed to external sources. This reduction of anxiety then facilitates and reinforces the misclassification process maintaining the experience and making it more likely that future internally generated experiences will be interpreted as external i.e. voices. There is some evidence to support Bentall's theory for example patients that hallucinate are more likely to attribute their own speech to external sources (Bentall and Slade, 1985). Source monitoring is also affected by the content of what is being said therefore as would be predicted by the model, more

external attributions are made by people with auditory hallucinations when the content of the material that they hear is negative rather than positive (Bentall, Baker and Havers 1991).

Bentall (1994) argues that this theory can account for why treatments such as occlusion or distraction are only short lasting as they are not able to address the underlying cognitive disorder. Based on his model he has proposed a new psychological therapy called 'Focusing'. The aim of focusing is to reduce frequency of voices and associated distress by gradual reattribution of a voice to an internal source. The treatment combines self-monitoring, reattribution techniques and systematic de-sensitisation to the anxiety caused by voices. It requires the voice hearer to concentrate on the phenomenology of the voices beginning with the least anxiety provoking aspects (such as their sex and loudness) and progressing to more anxiety provoking aspects (such as content). The aim of the treatment is to consider differences and similarities between the voices and the voice hearer's own thinking and worries, with the aim of deriving a personal formulation of the meaning and function of the voices which accepts them as self-generated. Research has shown this approach to be useful for half of those receiving treatment. Focusing was not significantly better than a coping strategy enhancement, both improved distress and symptom severity post-treatment but improvements were not maintained at a two-year follow-up. However, patients were more likely to make internal-attributions for the voices at

follow-up if they had had focusing treatment and this also led to significantly improved self-esteem (Bentall et al, 1994; Haddock, Slade, Bentall et al., 1998). One of the problems with the approach is that it requires the patient to attribute negative or hostile hallucinations to the self. In clinical practice patients often explain their disregard for the medical explanation as due to the impossibility that evil voices (e.g. 'Kill your mother') could come from themselves. Bentall (1994) suggests that focusing may be more successful if utilised with less chronically ill patients whose beliefs are not as well established or ingrained.

Chadwick and Birchwood (1996) describe an ABC model of voices. This cognitive formulation was inspired by Beck's cognitive model of depression (1979) which proposes that behavioural and affective symptoms are consequences of negative beliefs. The model of auditory hallucinations views voices as activating events (A's), to which the individual attributes a meaning (B) and these experiences are associated with behavioural consequences and emotional reactions (C). This approach positions the person's beliefs about voices (secondary delusions) as directly responsible for the way that the person feels and behaves, rather than the voice itself. Therefore, C's differ depending on whether the voice is believed to be malevolent or benevolent. (See examples A (benevolent) and B (malevolent) below). Whereas Spencer's reaction to the voice is negative, Alison is not distressed by her experience.

EXAMPLE A - BENEVOLENT

A - Alison hears a voice saying 'steal that watch'

B- She believes that this message is from God and is sent to test to see how good she is

C- She does not steal the watch, proves she is a good person and feels happy

EXAMPLE B - MALEVOLENT

A - Spencer hears a voice saying 'I'm watching you'

B- He believes that the voice is the Devil who wants to take him to hell

C- He is terrified and locks himself in his room

The content of the voice does not directly predict associated beliefs. For example, Spencer believes the voice saying 'I'm watching you' to be the devil and is frightened but, another person may interpret it to be their dead aunt communicating that they are looking after them and may have a positive reaction to a voice with the same content. Thus, the degree of fear, acceptance and compliance with the voices is mediated by the individual's beliefs about voices.

Chadwick and Birchwood developed a questionnaire to investigate people's beliefs about voices (the BAVQ). By using this they found that distress and coping were strongly related to perceptions of the voice's identity, its intent

to harm or help, its power and omnipotence and beliefs about the consequences of obedience or disobedience. Those people who believed their voices to be extremely powerful or omnipotent suffered from higher levels of depression and distress and this was related to a sense of powerlessness and helplessness to control the experiences (Chadwick and Birchwood, 1996). Responses on the BAVQ also suggested that coping behaviour was connected to beliefs about voices rather than the voice's content, people who perceived their voices to be benevolent engaged with the voices and those who believed their voices to be malevolent coped by resisting them (Chadwick and Birchwood, 1995). However, this has not been completely supported by other studies (e.g. Close and Garety, 1998) who found that many people are distressed by and resist voices which are perceived to be benevolent.

The psychological intervention based on this model relies on disrupting and testing beliefs about voices in order to weaken those associated with negative consequences (Chadwick and Birchwood, 1994). This approach requires slow engagement with clients because the experience of voices is emotive and the individual may find it threatening to disengage from the voices. The treatment process begins by considering the advantages and disadvantages of beliefs about the voices being false, and by normalising and de-stigmatising the experience of voices by using a video of other voice hearers. Changing beliefs utilises some of the techniques used in CBT for depression

(Beck, 1979) such as guided discovery, hypothetical contradiction and verbal challenge to disrupt beliefs, investigation of plausible alternatives and testing beliefs by using behavioural experiments. For example asking the participant to try different coping strategies at home, which allow them to control the experience, which would test the belief 'I cannot control my voices'. Therapy utilising this approach has been demonstrated to produce large reductions in belief conviction and distress as well as reducing the frequency of auditory hallucinations (Chadwick and Birchwood, 1994).

Morrison, Haddock and Tarrier (1998) have built on both Bentall's and Chadwick et al's models by integrating them with ideas taken from cognitive models of anxiety and panic (Clark, 1986; Salkovskis, 1991). They argue that broadening the model to incorporate the idea that auditory hallucinations are similar to cognitive intrusions, (unacceptable or unwanted repetitive thoughts or images), could solve some of the difficulties encountered in focusing treatment. Practitioners have found that patients are reluctant to make an internal attribution for the voices as their content is egodystonic and inconsistent with the person's belief system. For example (as above), a patient who hears a voice saying 'Kill your mother' is highly unlikely to accept that the voice came from them as they would never want to do such a thing. Integrating the idea of intrusive thoughts - as thoughts that everyone gets and may be unpleasant but that people are unable to control- into cognitive treatments could overcome this difficulty. Morrison's model

proposes that in people with auditory hallucinations, internal egodystonic experiences are attributed to an external source thus removing personal responsibility. Because this reduces the anxiety associated with the experience it maintains and reinforces the hallucinations (as in Bentall's model). This model has the advantage of being able to explain why benevolent voices can be experienced by the hearer as unpleasant (Close and Garety, 1998). These too, may be inconsistent with the person's belief system for example, in the case of a person with a poor self-image and low confidence who hears a voice which they believe to be God, telling them that they are an angel and should do good deeds.

This theory explains why distraction techniques used for suppression of the voices may be unsuccessful or short-lived. They liken distraction to safety behaviours in panic or anxiety, which increase intrusive thoughts and prevent the individual from finding dis-confirmatory evidence or new ways of coping with the experience, leading to a vicious cycle which maintains the process (Hatton and Wells, 1997). The model also highlights the importance of beliefs about voices (as does Chadwick et al., 1996) in particular beliefs that voices threaten psychological or physical integrity. To illustrate this point an auditory hallucination saying 'You will die' may be interpreted to mean that the person is in physical danger (a threat to physical integrity). On the other hand, if a person interprets the voice as a sign of madness rather than impending danger this may pose a threat to their psychological

integrity. Particularly, if the person links the phenomena of hearing voices to stigmatised and frightening media portrayals and societal perceptions of mental illness. This moves away from the ideas of Chadwick, who suggested that voices needed to be interpreted as threats to physical integrity in order to be malevolent. Negative emotions and physiological reactions associated with catastrophic mis-interpretations of threats to both physical and psychological integrity will contribute to the maintenance of hallucinations by causing high psychophysiological arousal which increases the occurrence of voices, which cause high psychophysiological arousal because of misinterpretations and so on in a vicious circle.

Morrison et al. (1998) conclude that cognitive approaches to auditory hallucinations should place emphasis on normalising and de-stigmatising the experience and on education about the occurrence of everyday intrusive thoughts and the normal continuum of psychotic experience in order to reduce misinterpreted threats to physical and psychological integrity.

Recently group psychological interventions for auditory hallucinations have been evaluated. These have combined treatment strategies from CSE, CBT and focusing but at their core lies the belief that group therapy also provides additional benefits to the individual. In the case of auditory hallucinations where de-stigmatisation and normalisation are now viewed as central parts of cognitive therapy, groups provide a naturalistic, in vivo, opportunity for doing such work with other voice hearers present rather than relying on

therapist tales or use of a video. Group processes may also contribute to reality testing and re-framing of experiences and to coping strategy enhancement as similarities and differences between people's voices can be investigated and shared within the group. Groups therapy has been found to instil hope, facilitate the dissemination of information and stimulate social and interpersonal learning (Yalom, 1985). In psychosis, group therapy has been demonstrated to capitalise on the support of group members to counter wide-spread social isolation as well as reducing symptoms (Baker, 1995). Kibel (1981) in a meta-analysis of group work for people with psychosis found the following elements to be key to success: focus on the present; setting concrete limited treatment goals; fostering group cohesiveness; reality-centred behavioural interventions (e.g. sharing coping strategies) and effective facilitation. He states that facilitators should be accepting, directive, active, non-critical and supportive. A time-limited hearing voices group with the aim of reducing distress caused by auditory hallucinations, run by clinical psychologists well versed in non-critical, supportive psychological intervention should fulfil all of these criteria. However, although there is a long tradition of hearing voices groups set up by voluntary organisations (Baker, 1999) which allow members to meet, to be of mutual support and to share coping strategies only recently have formal efficacy trials of group psychological therapy for voices been carried out (Wykes et al, 1999).

These trials have been small and largely uncontrolled but preliminary research has found these to be both clinically effective and cost effective (Gledhill, Loban and Selwood, 1998; Wykes et al., 1999). Wykes et al's study found significant reductions on a measure of auditory hallucinations, which were maintained at follow-up as well as improvements in insight, distress and overall symptomatology. There was also an increase in effective coping with voices. A larger, more methodologically rigorous randomised control trial is now underway (Wykes, 2002). Anecdotal evidence suggests that consistent with Yalom's expectations participants enjoy and benefit from meeting other people who have had similar experiences to themselves but little formal qualitative research has investigated clients' experiences of therapy. This may be useful in order to illuminate therapeutic gains and to help to refine group interventions by addressing perceived strengths and weaknesses.

The literature on psychological interventions for auditory hallucinations reveals that alleviating the distress associated with hearing voices is not contingent on removing the experience of voices. Instead, cognitive theorists believe that distress and disability should be reduced by targeting patients' interpretations and cognitions about the experience of hearing voices rather than eliminating the voices themselves. This may explain in part why distraction techniques and pharmacology are not completely successful. There is now a body of evidence to support the efficacy of cognitive

behavioural psychological interventions for psychosis which target cognitions about positive symptoms (Sensky, Turkington, Kingdon et al., 2000). In particular, cognitive behavioural techniques specifically developed to target auditory hallucinations and based on theoretical models of voices have been found to reduce the distress and frequency of auditory hallucinations in patients who have had medication resistant symptoms for many years. Recently, group therapies which combine several approaches and provide additional benefits, for example in aiding normalisation and de-stigmatisation, have been proven to reduce symptoms and unlike gains made from other treatments (e.g. focusing) improvements have been maintained at a three month follow-up. All of the interventions with auditory hallucinations reviewed above have only included patients over the age of 18. Several psychologists have suggested that a proactive approach offering psychological intervention for auditory hallucinations in earlier psychotic episodes should be considered in order to reduce distress which may get worse after a longer history of hearing voices, and to tackle beliefs at a stage when they are less ingrained and may be more malleable to cognitive techniques (e.g. Bentall, 1990; Birchwood, McGorry and Jackson, 1997).

Patients' experiences of psychological therapy for psychosis

Qualitative research can be understood as research about meaning in people's lives, stories, actions, organisational skills, social movements or interactional relationships. This type of research is particularly well suited to uncovering aspects of people's experiences, such as illness, addiction and

spirituality (Strauss and Corbin, 1990). It should therefore be an ideal tool for helping us to understand people's experiences of hearing voices and of psychological therapy.

Unfortunately, qualitative research has rarely been used to investigate the experiences of people with psychosis (for exceptions see Krudson and Coyle, 2002; Rhodes and Jakes, 2000), even less the experience of treatment for psychotic illness. In general, people's subjective experience of psychotic illness has been overlooked or disregarded by society (Strauss, 1969). People with psychosis report feeling stigmatised and not being taken seriously after receiving a psychiatric label (Leete, 1989). This can be likened to the experiences of other oppressed groups such as those with learning disabilities. The 'excluded voice theory' (Harber and Sherry, 1993) proposes that traditional positivist research fails to allow minority or stigmatised groups to have their voices heard, thus adding to their oppression, but states that qualitative research methods can provide access to their perspectives and experiences.

Recently, there has been an increase in qualitative research with clinical populations who have been historically without a voice for example, those with learning disability (Yates, 2002) and those with dementia (Clare, 2002). It has been noted that in doing qualitative research with people with learning disabilities methodological problems need to be confronted which may

require the researcher to break away from traditional qualitative protocol. Traditionally, qualitative researchers have preferred interviewees that are able to take control of the interview and to talk freely, who are articulate, and who are able to tell good stories (see Willig, 2000). This leads to a paradox: those who most need to be heard are least able to tell their stories and are therefore the least likely to be asked to do so by researchers (Baron, 1991).

People with psychosis undoubtedly have interesting and important stories to tell. However, due to their inarticulacy, unresponsiveness and sometimes bizarre speech, little qualitative research has been conducted with this population. In interviewing people with psychosis, particularly young people, we would anticipate some similar methodological problems to those encountered when interviewing people with learning difficulties. Booth and Booth (1996) state firmly that these difficulties do not amount 'to an insuperable barrier to people telling their story' (p57). They recommend a number of practical strategies which can be adopted to overcome them, such as using more direct questioning, use of simple language, reframing questions, interpretation of silences, short but more frequent interviews and using menus of suggestions from which the participant can choose their answer. In utilising these techniques it is noted that the interviewer will have to do most of the work and that there is a danger of interrogation or of incorrect interpretations being made, 'putting words into the mouths' of

informants' (p 65). However, they frame this as a risk worth taking if it allows excluded groups to share their experiences.

A literature review of qualitative research relating to the experience of psychological treatment for psychosis currently yields little. In one unpublished study of therapists' and clients' experiences of CBT for psychosis (Messari, 2000), clients described sessions as meetings between two equals who respected and accepted each other. They talked about their enjoyment of being listened to and taken seriously, often for the first time, and valued the opportunity to reflect critically on their experiences, which sometimes led to a change in their understanding and story (Messari, 2000). Personal accounts of people who have been treated for psychotic illness are consistent with these findings (e.g. Blaska, 1995; Chadwick, 1995). They affirm the value of stable therapeutic relationships with professionals willing to take their beliefs and experiences seriously. In narrative accounts of recovery from psychosis (e.g. Ridgeway, 2001; Smith, 2000) participants again describe the role of caring and supportive mental health professionals, including therapists, as crucial for successful recovery (Sullivan, 1994). A narrative analysis of ten people's descriptions of recovery from psychosis reveals that meeting other recovering individuals is a source of hope, and provides much needed social contact and support. People report that they feel more comfortable socialising with people who have had similar experiences and interests (Leete, 1989). In particular, peer self-help groups are mentioned as forums in which service-users are positioned as experts and are able to

provide valuable insights, support and practical advice to others (Ridgeway,2001).

Two studies to date have investigated the experiences of people participating in hearing voices groups. Jones, Hughes and Ormrod, (2001) reported results from a focus group in which participants discussed their experience of attending a hearing voices group. This group was organised by the voluntary Hearing Voices Movement, it was described as client directed and informally facilitated. The authors report that two main themes emerged. These were 'safety' - that the group provided a safe place to talk about voices and 'sharing' - the utility of sharing experiences with others. The group appeared to provide an environment in which the experience of hearing voices was normalised and the participants no longer felt 'alone' or 'crazy'. Few critical comments about the group are reported in the study by Jones et al. (2001), however; it is unclear whether the researcher facilitating the discussion was independent of the professionals involved in the voices group itself. Several participants did disclose that it was difficult to attend a group when their voices told them not to. Others mentioned worrying about other group members and expressed concern about confidentiality. One criticism of using a focus group is that this format doesn't allow people to be as open as they might like to be with the researcher because other group members are present.

Chadwick et al. (2000) invited an independent researcher to discuss the helpful and unhelpful aspects of a voices group following a structured, seven week, cognitive behavioural intervention. Content analysis was used to analyse interview data. People said that they found the group helpful and mentioned its role in belief change (for example in helping them to consider new explanations for the origin of the voices). They also discussed the helpful role of the group in providing a place to discuss voices without fear of criticism, judgement or hospitalisation. Several group members mentioned new ways of coping that they had learned. Most people did not volunteer any unhelpful aspects of the group but some mentioned aspects of others' behaviour.

These two studies, in asking participants about their experiences of voices groups have shed light on some of their therapeutic benefits, and less so, on unhelpful aspects of the groups. However, the two studies have employed methodologies that are not ideal for exploring in detail the participants' views of the voices groups or of their experiences pertaining to them. For example, Jones et al. (2001) used a focus group that may have curtailed the participants' freedom to speak openly. Although Chadwick et al. (2000) used an independent researcher to ask participants questions in a one-to-one situation, they did not use a semi-structured interviewing technique. This may have limited the interviewees' response rather than allowing them to give their own opinions and views about those aspects of the group which

they judged to be important. In addition, the data were analysed using content analysis, which reduces qualitative data to quantitative data, in this case by ranking how many people rated different aspects of the group. This produces less rich information about participants' views than other qualitative methodologies. In content analysis, rich data are reduced to a series of short, ranked themes which to a large extent disregard specifics of meaning and context and individual experience. This may also give a false impression of what is important. For example, in Chadwick's study, the theme rated 'least helpful' was the *role of the therapist* but it is clearly essential to have a therapist in order to aid *belief change*- and belief change was rated as the 'most helpful' aspect of the group.

Interpretative Phenomenological Analysis (IPA) is increasingly being used to explore participants' views, particularly in the areas of health and clinical psychology (e.g. Smith, 1999; Clare, 2002). The approach is phenomenological because it examines people's perceptions of an object or event, but is also interpretative in that it recognises that the researcher, in looking at interview data, interprets the personal accounts of others in relation to their own conceptual frameworks. It has been used in studies which have sought to look at the accounts of groups of patients with the same illness e.g. kidney disease. By looking for similarities, difference and tensions between the accounts of different individuals with the same illness the subjective perceptual processes by which individuals make sense of their

illness can be illuminated (Smith, 1996). Unlike discourse analysts (Potter and Wetherell, 1987) IPA researchers are willing to permit that links can be made between verbal reports and cognitive and emotional states (what people say, what they think and how they feel). Therefore, IPA appears to be ideally placed to investigate the experiences of young people attending a cognitively orientated voices group that aims to modify cognitions, reduce emotional distress and impact on the experience of hearing voices.

The two, small, qualitative studies (Jones et al., 2001; Chadwick et al., 2000) that have been carried out support the anecdotal reports of Gledhill (1998) and Wykes (1999), which suggest that people benefit from discussing their experiences with other voice hearers. They provide important additional information about voices groups that is lost in quantitative studies. They highlight aspects of the group which group members appreciate. For example, that the group provides a space where people can talk openly to people with similar experiences. The qualitative data also provide useful insight into the therapeutic process itself (e.g. the process of belief change) from participants' points of view. In this respect, the participants are the experts and have a unique knowledge of what does and doesn't work (Jones et al., 2001). The understanding gained from interviewing participants in therapy can contribute to a more complete conceptual understanding of treatment which may inform both theory and practice.

Psychological treatments for young people with psychosis

Outcome in young people with schizophrenia has been found to be affected by the adequacy of therapeutic resources (AACAP, 2001). Remschmidt et al. (1994) suggested that the treatment of EOS requires five essential elements to be integrated 1) antipsychotic treatment during acute episodes, 2) pharmacological prevention of relapses, 3) psychotherapy, 4) family intervention (e.g. psycho-education and reduction of expressed emotion) and 5) rehabilitation for example reintegration into education or training. In recently published clinical guidelines for treatment of EOS, the American Association of Child and Adolescent Psychiatry recognised psychosocial intervention as an integral part of the treatment of young people with psychosis (AACAP, 2001). However, studies documenting the outcome of pharmacological, psychotherapeutic or integrated treatment programs for schizophrenia in youth are rare.

A few studies have measured outcome following integrated treatment programs for example Pelkonen et al. (1998). They found that hospital treatment of more than 3 months which included individual or family therapy (defined as therapy by a trained professional at least once a week during an inpatient stay or more than nine family sessions) was associated with improved level of functioning at a 7 year follow-up. Because such a broad definition of a psychological intervention was used it is unclear which psychological approaches had utility. There has only been one study

addressing the efficacy of a psychosocial intervention with young people with schizophrenia (Rund, Moe and Sollien, 1994). This small study (ten patients in each group) compared psychological treatment with standard community care. In the treatment condition several psychotherapeutic interventions including parent seminars, problem solving, milieu therapy and social network reintegration were combined which again makes it difficult to untangle outcome effects. At a two-year follow-up significantly lower rates of hospitalisation were found in the intervention group and improved psychosocial adjustment was found in those who had poor premorbid adjustment. It has been concluded that adolescents with schizophrenia benefit from a combination of group, individual and family therapies as well as medication and that specialised adolescent treatment programs contribute to favourable outcomes (Well and Faragher, 1993). Unfortunately as yet the data from which to draw these conclusions is sparse, based on small numbers of participants and has not related specific treatments to changes at outcome.

To date there is no published research documenting the outcome of specific psychological therapies for young people with EOS, independent of integrated treatment programs. Preliminary reports of CBT and family therapy for EOS and cognitive remediation therapy for cognitive difficulties in EOS have been presented at conferences and show promising results (Corrigal and Browning, 2002; Wykes, Newton, Landau et al., 2001).

Treatments such as CBT and family therapy are used regularly with young people with psychosis in current clinical practice; one must therefore suppose that clinicians believe them to have efficacy but the use of such therapies with this client group does not have a strong evidence base.

The need for specific therapies to treat positive and negative symptoms in schizophrenia in children and adolescents is recognised by the AACAP (2001); Escher et al. (2002) support this view. Because the course of voices is associated with factors such as mood, appraisals and cognitions about voices and a lack of identifiable triggers, rather than to whether the child had a diagnosis of EOS, they suggest that auditory hallucinations in youth need to be targeted by a specifically designed intervention. Such an intervention would aim to change these factors (i.e. the experience of voices) rather than a broad intervention aimed at targeting a particular diagnosis (i.e. EOS), which would clearly have missed many of the young people who were distressed by the experience of auditory hallucinations.

The Handbook of Child and Adolescent Clinical Psychology says in the schizophrenia treatment section ' Unfortunately, most of the research on treatment... has been conducted with adults.....Until trials with children and adolescents have been reported , treatment of younger cases is guided by the results of studies of adults.' (Carr, 1999, p733). This may not always be appropriate, for example, children and adolescents with schizophrenia have a different symptom pattern to adults, they frequently do not have a

diagnosis early on in their illness but still suffer from distressing positive symptoms. In addition, treatments designed for adults may not be developmentally appropriate for young people, particularly given the fact that the early onset of psychosis is extremely disruptive to education and social relationships and has a worse prognosis than adult-onset schizophrenia. It may be that treatments for young people require different intervention goals to adult interventions, for example, to facilitate reintegration into education and peer social networks. Treatments also need to take developmental and educational level into account when using traditional psychological therapies such as CBT which rely on cognitive ideas and on tools such as homework and diaries, this may be beyond the capability of the young person in treatment. The AACAP (2001) practice parameters recognise that in order for adult treatments to be successful with young people clinicians should be prepared to make clinical adjustments to tune therapies to patients developmental needs. It may be that when efficacy trials are carried out adult treatments cannot be translated into clinical practice with young people as easily as is anticipated. In the meantime it is possible that the treatment programs currently being implemented with young people with schizophrenia are unsuitable and a waste of valuable therapeutic resources.

Conclusion and aims of the current study

A significant proportion of people with psychosis have a first episode during adolescence. Young people have described psychotic symptoms as confusing, debilitating and frightening and unfortunately, these symptoms frequently remain following treatment with anti-psychotic medication. Auditory hallucinations are viewed as one of the most distressing psychotic symptoms, and are instrumental in causing and maintaining psychological difficulties. It has been suggested that the longer these symptoms persist the more severe the associated disabilities (Birchwood, Fowler and Jackson, 2000). EOS is associated with a poorer prognosis and outcome and a more chronic course than adult-onset schizophrenia. Some of this associated disability is believed to be attributable to the developmental disruption caused by onset of psychosis during adolescence which curtails education, affects relationships and friendships and disrupts the process of becoming autonomous from the family.

Psychological therapy is frequently used to treat medication resistant symptoms in adults with psychosis. Cognitive behavioural treatments designed to target the symptom of auditory hallucinations have been found to significantly reduce distress and frequency on measures of auditory hallucinations but these improvements in symptoms have not always been long lasting. A recent efficacy trial of group therapy for auditory hallucinations has shown reduction in symptoms and improvement in

effective coping that was maintained at a three month follow-up (Wykes et al., 1999). This group intervention combined many elements of CBT but also had additional group benefits. For example, it allowed a space for open discussion of experiences, was normalising and de-stigmatising and allowed the participants, who were experts in voices, to share their knowledge and coping strategies with each other. Anecdotal evidence suggested that the participants valued the opportunity to meet others who had suffered from similar experiences to themselves. In addition, group treatments are cost and resource effective, as there are currently few psychologists available to do long-term individual CBT with psychosis in the NHS.

However, the current psychological treatments for auditory hallucinations have been designed to treat adults with psychosis, few efficacy trials of psychological therapy of any kind have been undertaken with people with EOS. This is despite research that has suggested that psychological treatment of auditory hallucinations may be better carried out soon after their onset when beliefs are less rigidly held and at a time when they are more startling and distressing to the individual. Soon after onset may also provide a 'critical-period' for intervention during which time intervention can change long-term outcome and prevent secondary disability occurring. For young people who may face a long course of illness this has high face validity, a group may also help to build social support networks and new friendships to

replace those that have been lost through illness and hospitalisation at such an early age.

With any new intervention, it is important to get the views of those who receive it. This helps in the understanding of the treatment particularly those elements that are perceived to be beneficial and unhelpful in order that the treatment can be refined for use in future clinical practice. Historically, people with psychosis have not been given a voice or a say in their treatment planning and their views have frequently been disregarded.

The current study has two aims and therefore takes a mixed method approach. Firstly, it aims to address the gap in the literature by conducting an efficacy trial of group psychological treatment for young people with auditory hallucinations. The main focus of the intervention is to reduce the symptom of auditory hallucinations and therefore the main outcome measure is the PSYRATS auditory hallucinations scale (Haddock, McCarron, Tarrier et al., 1999) . Secondary and clinical measures have been chosen that have been utilised and have been affected by treatment in previous trials of CBT for psychosis. These measure - beliefs about voices, depression, anxiety, insight, self-esteem, general psychopathology, activity level and coping of the scales used have proven reliability and validity and are easy and quick to complete.

The quantitative hypotheses are: -

- That a significant, positive change in auditory hallucinations will occur over the treatment period.
- The treatment will lead to significant change in beliefs and secondary disability.

An investigation of the relationship between characteristics of and beliefs about voices, depression and distress will allow a test of the therapeutic process together with the qualitative data described below.

Secondly, the qualitative part of the study will use a semi-structured interview and interpretative phenomenological analysis to investigate the young people's experience of participating in the therapy group. The aims of the qualitative part of the study are: -

- To illuminate our understanding of the treatment by asking the young people about their experiences of the group and of their auditory hallucinations.
- To allow us to reflect on the therapy protocol's effectiveness for use with young people.

The current study will take a symptom rather than a diagnostic approach when including people in treatment, focusing on the symptom of auditory hallucinations rather than a diagnosis of schizophrenia. It can be argued that a symptom led approach is more applicable when carrying out psychological

interventions and research with young people with auditory hallucinations as diagnosis in young people is often not stable and does not predict the course of auditory hallucinations. All participants, are distressed by their experience of auditory hallucinations, are under the age of 21 at time of referral and have had an onset of symptoms during adolescence.

CHAPTER 2 - METHOD

METHOD

Quantitative Methodology

Design

A waiting list control design with repeated measures within subjects was used. Participants were assessed on four occasions in order to evaluate the efficacy of the treatment. The first assessment was carried out six weeks prior to the group beginning (baseline - week 0) and the second immediately before the first treatment session (pre-treatment - week 6), this provided a six week waiting period when the young people were receiving treatment as usual from their local service and enabled us to compare change over the waiting period with change over the treatment period. Three therapy groups were run, each with five or six participants, these met for seven, one hour, weekly sessions. The main outcome measure and ancillary measures were repeated immediately post-intervention (post-treatment - week 12) and at a 3 month follow-up appointment (follow-up - approximately week 24).

Ten measures were administered on four occasions (with the exception of the activity scale which was introduced at week 6). The main outcome measure, the PSYRATS Auditory Hallucinations Rating Scale was used to measure treatment effect. In addition six additional measures of symptoms, one measure of coping and one measure of activity level were used. (See procedure for a detailed description of these measures).

Clinicians involved in the young person's voices group

Therapy was provided by two clinical psychologists who were blind to the main and secondary outcome data. One, a female psychologist, had been involved in the design of the treatment protocol and had facilitated the program on numerous occasions with adult clients. The second was a male clinical psychologist who specialises in the treatment of adolescents with mental health problems. A third psychologist (myself) attended therapy sessions in an observer's capacity and undertook an organisational role which included responsibilities such as booking transport for participants and co-ordinating the voices team. I recruited the participants, and administered all assessment measures with the exception of the Positive and Negative Symptoms Scale. This semi-structured interview schedule, was administered by one of two psychiatrists trained in the administration of this psychiatric measure in order to provide an independent rating of symptoms from a rater not directly involved in the treatment program.

Participants

A prior power calculation, based on the results of the previous group treatment study by Wykes et al. (1999) indicated that a trial with 11 participants would have 90% power to detect a change of 4.63 in mean PSYRATS score, the main outcome measure. This calculation assumed a standard deviation of differences of 4.114, using a paired t-test with a 0.05 two-tailed significance level.

Participants were recruited by contacting psychiatric services known to be treating young people with psychosis in South London. Ethical approval was obtained from the area covered by the NHS trust (see Appendix A for details). Mental health professionals working in these services were invited to refer young people who were currently experiencing distressing auditory hallucinations that had not responded significantly to treatment with neuroleptic medication. All participants fulfilled the following criteria:-

- They were aged between 15 and 21 at time of referral.
- They had been suffering from distressing auditory hallucinations within the last month.
- They were on a stable dose of medication at the time of referral.
- Their auditory hallucinations were not due to any organic disorder
- They did not have a primary diagnosis of substance misuse.

No diagnosis was specified in the selection criteria for two reasons. Firstly because it has been argued that the concept of 'schizophrenia' has low validity and reliability (e.g. Boyle, 1990), many psychologists, both clinicians and researchers, have found a symptom approach to be superior (e.g. Chadwick, Birchwood and Trower, 1996). Secondly, because the young people who participated in this research had recent onset psychosis (time since first contact with psychiatric services ranged from four months to four years) and diagnosis was frequently tentative or absent in this group.

With RMO approval, referred participants and their parents (where involved in their care) were approached by the researcher who discussed the voices group with them. Their key worker was given a staff information leaflet and

the young person was provided with a participant information leaflet (Appendix B). The young person was included in the study if they agreed to be a part of a group following this initial meeting. The purpose of the informed consent form was explained to the young person. After reading it and ensuring that they understood that they could withdraw their consent at any time during the four assessments or the treatment sessions the consent form was signed by the participant and a witness. (For Consent Form see Appendix C)

Procedure

The study was run over a 21 month period from June 2000 until March 2002. During this time dates for three, seven-week treatment groups were allocated by the two psychologists who co-ran the groups. We aimed to have between six and eight participants in each group but due to time constraints each group differed slightly in number. (Group 1- n=6 – November 2000 , Group 2 -n=5 – April 2001, Group 3 – n=6 - November 2001)

Intervention

Sessions were based on a cognitive behavioural approach, following a semi-structured format. Sessions lasted for one hour a week for seven weeks, each session dealt with a particular theme:-

Week 0- 6 - Waiting period

Week 6 – The sharing of information about voices

Week 7 – Models of Psychosis

Week 8 – Models of hallucinations

Week 9 – Effective coping strategies

Week 10 – Stigma and labelling

Week 11 – Improving self-esteem

Week 12 – Overall model of coping with voices

Each session followed a detailed protocol containing the aims of the session, examples of interventions and model responses for the therapist (see Appendix D). This treatment protocol was designed to treat groups of adults suffering from auditory hallucinations (Wykes et al., 1999). Following each session I produced a brief summary of the discussion that had been held. This acted as an aide memoire for participant and therapists and was given out as a hand-out at the beginning of the next session. At the end of the seven groups each participant was given a copy of all hand-outs to take away with them.

Sessions were held in an outpatient psychology department, separate from any of the services that the young people regularly attended. Transport to and from the group was arranged by taxi by the researcher to ensure the safety of the participants involved.

Assessments

Participants were assessed at weeks 0, 6, 12 and 24 using the following measures :-

Main Outcome Measure

Auditory Hallucinations Rating Scale (PSYRATS; Haddock, McCarron, Tarrier and Faragher, 1999).

This is a structured interview designed to measure severity on three different dimensions of hallucinations: the emotional content, physical characteristics of the voices and the person's cognitive interpretation of them. This was specifically designed to be easy to administer in clinical practice and to measure symptom change over time during psychological therapy.

The scale has eleven items which enquire about frequency, duration, severity and intensity of distress, controllability, loudness, negative content, degree of negative content, beliefs about the origin of the voices and the disruption that they cause to the person's life. Each answer given by the participant is rated using a five point ordinal scale from 0 to 4.

SAMPLE ITEM

1. Frequency

Interviewer: How often do you experience voices? For example every day, all day long?

Responses

Voices not present or present less than once a week	0
Voices occur at least once a week	1
Voices occur at least once a day	2
Voices occur at least once an hour	3
Voices occur continuously or almost continually (stop only for a few seconds or minutes)	4

The scale has been found to have good inter-rater reliability for each of the eleven items (reliability co-efficients ranged from 0.79 to 0.9). The construct validity of the scale was explored by exploring its relationship with the auditory hallucination items taken from the KGV Psychiatric Assessment Scale (Krawiecka et al., 1977). Significant inter-item relationships were found demonstrating good convergent validity but results also suggested that the PSYRATS provided independent information giving a fuller picture of an individual's psychotic symptoms.

Secondary Outcome Measures

Positive and Negative Symptoms Scale (PANSS; Kay, Fiszbein and Opler, 1987)

This structured interview scale provides a measure of overall psychopathology in adults with psychotic disorders. In particular it investigates the theoretical constructs of positive and negative symptoms. The PANSS was specifically designed to improve on previous rating scales

e.g. the Brief Psychiatric Rating Scale (Ventura , Green and Shaner, 1993) by including additional, clinically relevant, symptom items and also by including a comprehensive anchor-system in order to provide high levels of inter-rater reliability. The PANSS is frequently used to evaluate treatment outcome.

The scale has thirty items in total, a seven-item Positive Scale, which includes items such as delusions and hallucinations, a seven-item Negative Scale, which includes items such as blunted affect, and emotional withdrawal and a sixteen item General Psychopathology Scale which includes items such as somatic concern, guilt and anxiety. A seven point Likert scale is used to rate the answers given by the interviewee.

A large normative sample is described and the scale's reliability and validity have been widely researched. It has been found to have high levels of inter-rater reliability and the sub-scales have high internal consistency. Construct validity has been tested by comparison with other similar scales (e.g. BPRS) and studies have consistently found good concurrent validity (e.g. Kay et al.,1987).

The revised Beliefs About Voices Questionnaire (BAVQ-R; Chadwick, Lees and Birchwood, 2000)

This self-report questionnaire was designed to measure cognitive, behavioural and affective responses to voices. Within the scale there are three

sub-scales relating to a person's beliefs about the voices which they hear: malevolence (e.g. My voice is punishing me for something that I have done), benevolence (e.g. My voice wants to protect me) and omnipotence (e.g. My voice is very powerful). There are also two further subscales, one measuring a person's engagement with the voices (e.g. My voice reassures me) and one measuring their resistance to them (e.g. I tell it to leave me alone). In total there are thirty-five items each with a choice of four responses (disagree, unsure, slightly agree or strongly agree).

The reliability and validity of the BAVQ-R has been established by its authors (Chadwick et al, 2000). Reliability co-efficients for each of the subscales are high suggesting that it measures clear and stable dimensions of a person's beliefs about the voices that they hear and of their relationship with auditory hallucinations. When construct validity was examined, a high correlation was demonstrated between malevolence and resistance, and between benevolence and engagement, with all other correlations between sub-scales being in a negative direction. This was consistent with theoretical expectations.

Coping Strategies (CS; Wykes, 1999)

This is a self-report scale listing twenty five different coping strategies that clinical observation has suggested that people frequently use in order to respond to auditory hallucinations. For each item the respondent is asked to indicate whether they have tried this particular coping strategy (e.g. talking

back to the voices, listening to music) and if so, whether it doesn't work (score 0) , whether it is partly successful (score 1), or completely successful (score 2). The outcome used was total success score at each time point.

No systematic evaluation of the CS's reliability and validity has been undertaken. However the scale has high face validity and been used in a number of previous clinical trials (e.g. Wykes et al, 1999).

Additional Clinical Outcome Measures

Beck Depression Inventory II (BDI-II; Beck, Steer and Brown, 1996)

This twenty-one-item, self-report questionnaire measures the severity of depression and is widely used in clinical practice. The items cover different behavioural manifestations of depression, for example change in sleep pattern, loss of interest, and feelings of failure and guilt. Each area is represented by four possible response statements which allow the participant to choose the response that most closely describes how they have been feeling over the past two weeks.

The BDI-II was specifically designed to aid diagnosis of depressive disorder as described by DSM-IV, because it is based on these criteria it has high content validity. Its reliability and validity are well established in both clinical and non-clinical populations (e.g. Beck , Steer and Garbin, 1986; Rudd and Rajab, 1995). The BDI-II has been demonstrated to show a high level of internal consistency (co-efficient alphas over 0.9 for both clinical and non-

clinical samples) and high test-retest reliability. It has been correlated with a number of other psychological measures and shows evidence of convergent validity (e.g. when correlated with measures such as the Beck Hopelessness Scale), criterion validity (when correlated with other measures of depression such as the Hamilton Psychiatric Rating Scale for Depression) and discriminant validity (when correlated with scales such as the Hamilton Rating Scale For Anxiety) (see Beck et al,1996). The BDI is frequently used to measure change over time in treatment studies. However, for the purpose of the current study it is important to note that both people with a diagnosis of schizophrenia, and adolescents in general tend to show elevated scores.

Beck Anxiety Inventory (BAI; Beck, Epstein, Brown and Steer, 1988)

The BAI is a self-report questionnaire widely used in clinical settings as it is very sensitive to change with treatment. This twenty-one-item questionnaire measures the severity of somatic symptoms related to anxiety for example, nervousness, dizziness and heart palpitations. Participants are asked to mark on a four point Likert scale the extent to which they have been troubled by each symptom over the past week.

There have been numerous studies reporting the reliability and validity of this measure (e.g. Beck et al, 1988; Fydrich, Dowdall and Chambless, 1992). It has been demonstrated to have high internal consistency (alpha 0.9) and test-retest reliability (alpha 0.75) It has also been shown to have high correlations with other anxiety rating scales e.g. the Hamilton Anxiety Rating

scale and therefore good convergent validity (e.g. Spielberger, Gorsuch and Luchene, 1970). Although it has some correlations with measures of depression e.g. the BDI the BAI has been demonstrated to distinguish more accurately than other self report measures between anxiety and depression. Discriminant validity has also been demonstrated, the BAI can discriminate clinical and non-clinical samples and can discriminate people suffering from depression from those with anxiety. Of particular relevance to the current study the BAI has been demonstrated to have utility in evaluating self-reported anxiety in adolescent psychiatric inpatients and outpatients (Steer, Kumar, Ranieri and Beck ,1996; Kumar, Steer and Beck,1994).

Activities Scale (AS; Reeder, 2001)

This self-report scale was developed in order to collect information about the social activities (e.g. meeting friends, going to parties, playing a sport), daily-living activities (e.g. shopping, washing clothes, taking care of personal appearance), individual/creative activities (e.g. computer games, artistic activity, playing an instrument), and going-out activities (e.g. eating out, going to the cinema, going for a walk) that participants were currently engaged in. It provides a check list of sixty-two items and asks the participant to tick which activities they have participated in within the last month. The scale's reliability and validity have not yet been investigated.

Rosenberg Self Esteem Scale (SES; Rosenberg, 1965)

This is a self-report scale which measures overall self-esteem as well as providing separate measures of esteem and depreciation. It has been described as the 'instrument of choice with adolescents' in Canadian and American research studies because it has proven reliability and is easy to understand and administer (Bagley and Mallick, 2001). The scale contains ten statements, five relating to esteem (e.g. 'On the whole I am satisfied with myself') and five relating to depreciation (e.g. 'I feel I do not have much to be proud of'). Participants are asked to rate their attitude towards each statement on a five point Likert scale ranging from disagree strongly to agree strongly.

A recent study by Bagley et al, 2001 demonstrated that the Rosenberg measure is a potentially reliable and valid scale for use with British secondary school children up to the age of seventeen. The scale has a high level of internal consistency ($\text{Alpha} > 0.8$ for all age groups) and criterion validity is indicated by lower self-esteem scores being found in schools in areas of lower socio-economic status as was predicted by the researchers. Negative correlations were found between the SES and sub-scales measuring emotional and behavioural disorders thus demonstrating construct validity. The authors conclude that the SES is a good measure to use in mental health screening and in assessment of change following therapy with British adolescents.

Self-Report Insight Scale For Psychosis (IS; Birchwood, Smith, Drury, Healy, Macmillan and Slade, 1994).

This is a self report questionnaire, which provides measures of insight on three different factors; symptom attribution, awareness of illness and acceptance of the need for treatment. The scores are combined for an overall measure of insight. The IS was designed to provide a quick and acceptable measure for use in evaluating treatment outcome and to augment clinical judgements on insight. It is made up from eight short statements (e.g. I am mentally well) and the respondent is asked to tick the answer on a three point scale (agree, disagree or unsure) which they feel best applies to them.

The validity and reliability of the scale have been investigated by the authors. It was demonstrated to have high internal consistency and good test-retest reliability. An investigation of the scale's construct validity supported the hypothesis that the items of the scale measured one underlying construct, the construct of insight. The IS was also able to discriminate between patients shown to have different levels of insight in a clinical interview and to correlate with other clinical measures of insight (criterion validity). Of relevance to the current study the scale was found to be sensitive and able to detect changes in insight in psychotic patients during recovery from a psychotic relapse.

Administration of the measures

The self-report measures were given to the participant by the researcher. They took approximately thirty minutes to complete on each occasion. At baseline and follow-up the participant was usually visited at home or in hospital. Assessment at pre and post treatment took place at the treatment centre immediately before or after a therapy session unless the participant requested otherwise, in which case they were visited in their place of residence. The researcher remained present whilst they completed the questionnaires and was therefore able to give assistance with any questions with which they had difficulty. In some cases participants had difficulty with reading or concentration, in these cases the researcher read the questions out to the participant.

The PANSS was administered by one of two psychiatrists who had not been involved in the group treatment program in order to give an independent rating of symptoms. The first ten ratings were done by both psychiatrists. There was a highly acceptable level of inter-rater reliability (Cohen's Kappa 0.9).

Statistical analysis

The sample size for this study was small ($n=17$) and excluding all participants from the analysis who had data missing on any measure at one of the four time points would reduce the sample size further to an n as low as

10 on some measures (see Table 4). This affected the way that the statistical analysis was undertaken in order that this difficulty be minimised.

- For the analysis of main outcome and ancillary measures, a series of unbalanced repeated-measures models (assuming an unstructured covariance matrix) were employed to estimate missing observations so that *n* remained at 17 for all analyses. For each outcome measure, the effect of time was tested using the Wald statistic (by entering data from all four time points into the analysis).

This method is recommended by Everitt (1998) for dealing with treatment trial data, because, when taking measures from a number of participants at multiple time points, it is likely that the data set will be incomplete (e.g. due to participant drop out, refusal to complete a particular questionnaire, lost data or participant illness/unavailability on the day of sampling). Statistical packages such as BMDP (Dixon,1992) use the method of 'restricted maximum likelihood' to estimate a missing score for a particular participant, based upon the overall pattern of associations over time (covariance matrix). Therefore this takes into account both the overall pattern of scores (for example, a pattern of decrease on a measure may be predicted from all available observations) and a particular participant's scores at those time points which *are* available, and uses this information to generate

a score estimate for that participant's missing time point. For example, if participant 1's BDI score was high in comparison to the group at times 1, 2 and 3, it is likely to be high at time 4 (even if this score is missing). However, if the overall pattern demonstrated by the rest of the group tends towards a decrease in score at time 4, then the estimate for participant 1 will still be lower than the score for that participant at time 3.

In addition, 'expectation maximisation' is used to reduce the likelihood of overestimates. This is an iterative process which improves the prediction of missing values by taking into account how many missing values there are in the analysis (See Acock,1997). This method of analysis and missing value estimation is superior to MANOVA (often used for longitudinal data analysis), which, by default, analyses only complete cases. Reliance on complete cases has serious drawbacks for clinical trials, such as significantly reducing sample size and power of the test, and biasing results when data is not missing at random (Little and Rubin, 1987).

The method of maximum likelihood is also a more effective means of estimating missing values than the most common method, 'mean substitution.' Mean substitution neglects important information, such as a participant's previous score on that measure, which can lead to

biased results. For example, a person with a high depression score may improve following intervention at time 2, but is likely to still have a high score when compared to the rest of the group. Therefore substituting their score at time 2 with the mean for the entire group is likely to be an overestimation of their improvement and may lead to a type 1 error.

- Where there was a significant effect of time on an outcome measure, further Wald tests were carried to find out whether significant change occurred over the waiting period (change between weeks 0 and 6), treatment period (change between weeks 6 and 12) or total treatment period (change between weeks 6 and 24), or whether significant change occurred during more than one of these time periods. All tests were two-tailed taking a conservative approach.
- Partial correlations were used to investigate associations between characteristics of auditory hallucinations (malevolence, benevolence, engagement, resistance, omnipotence, frequency, control and intensity and amount of distress) and outcome rating on measures that changed significantly over time (PSYRATS, activity level and coping success). The partial correlation allowed us to control for initial score on the outcome measure.

- In addition, correlations were performed in order to investigate the relationship between distress caused by auditory hallucinations, depression and perceived power of the voices.

Qualitative Methodology

Design

This part of the study used qualitative methodology to provide a measure of the effectiveness of the group treatment program, by viewing the group members as experts in the utility of the voices group and asking them about their experiences. This was done by intensive examination of the accounts of eight of the young people who had completed the intervention. These eight cases were interviewed using a semi-structured interview schedule, to allow them to talk as freely as possible about their experiences and perceptions of the group. Data were analysed by employing interpretive phenomenological analysis (see Smith, 1996).

Participants

Eight participants were interviewed. This sample comprised of all of the eight young people from groups two (April 2001) and three (November 2001) who completed the seven-week therapy program and were present at the final (7th) assessment session. Group one (November 2000) was not included as only a sub-sample of the original seventeen participants were required to provide enough interview data for a qualitative analysis to be undertaken (see Smith, Jarman and Osborn, 1999). Brief background information about each participant and their experience of auditory hallucinations is given in Table 1 (below). The names of all participants and

any information which may lead to them being identified has been changed in order to maintain confidentiality

Table 1- Participants

Harinder	Harinder is 17 years old. He was born in the UK, his parents moved from India prior to his birth. He lives at home with his parents and siblings. Five months ago Harinder described hearing the voices of his neighbours coming through the wall. He became very distressed by this and angry with his neighbours' as at first he believed the voices to be real. He no longer identifies the voices as his neighbours but perhaps a djinn in the form of his neighbours voices. He was admitted to hospital but has recently returned home following a short admission. He spends his days at home. He continues to hear voices every day but does not always find them distressing.
Chidi	Chidi is 17 years old. She lives at home with her mother who describes herself as African. Chidi was born in the UK. She became unwell four years ago whilst at secondary school and began hearing the voices of her peers and teachers. Many of these voices are critical although she finds some entertaining. Chidi hears voices almost continuously. She has been in hospital for the majority of the past four years but was discharged approximately one month before the group began , in the day time she attends the school at a local hospital.
Angelo	Angelo, who is 17, moved from Italy to the UK in his early childhood. Angelo is a Catholic. He reports feeling different from other people at secondary school because of his religious convictions and he became gradually more isolated. Two and a half months ago he was admitted to a local adolescent unit. He finds the voices very distressing, he describes them as demons .The voices have commanded him to destroy his belongings and he has acted on this in the past , they also tell him to kill himself but he has resisted doing this.
Leonie	Leonie is of mixed African/Indian origin. Leonie was born in the UK and is 17 years old. She grew up under the care of the local authority and was admitted to hospital aged 15 following an attempted suicide. She has been an inpatient since this time. Leonie describes feeling very lonely in the home where she lived and describes the first voice that she heard as 'an imaginary friend'. However, the voices that she heard became upsetting in their content often threatening to harm her or asking her to self-harm. Leonie hears voices every day for much of the time.

Table 1 continued

Tracey	Tracey 's family are white and are from the UK. She is 15 and lives with her mother , step-father and sibling. Five months ago she was admitted to hospital for the first time, she was discharged during the group therapy program but continued to attend day-hospital and the voices groups. Tracey did not give much information about the voices that she has heard, she reports that she stopped hearing them before the group began . She says that she can no longer remember what they were like but they sounded as if they were coming from behind her head or from her pillow.
Jocasta	Jocasta is 18, she began to hear voices two years ago. She has never been admitted to hospital but is in touch with the local community mental health team . Jocasta lives with her mother, father and siblings and describes herself as Jamaican although she was born in the UK. In the daytime she attends college and has a part time job. Jocasta says that she hears voices that sound like they are from 'a horror movie' at night although they used to occur more frequently. She used to find these experiences very distressing, particularly as the voices often threatened to hurt her or asked her to harm others. However, she reports that she has many coping strategies that she was eager to share with other group members.
Patience	Patience is 17, she was born in the UK but is of Caribbean origin. She lives with her mother. She became unwell one year ago and was admitted to hospital under section for a short period of time. Since this time she has remained at home, she stays at home during the day time but says that she would like to go to college, she was unable to finish school. Patience used to hear the voices of people that she knew saying that they were coming to hurt her or talking about very personal information. Patience says that until she realised that the voices were 'only in her mind' she was very frightened. The voices stopped just before Patience began coming to the group but she was keen to come to meet other young people who heard voices .
Mark	Mark is seventeen years old, he comes from an African family with strong religious convictions. He was admitted to hospital one year ago following a suicide attempt and has been an inpatient since this time. He hears voices which he believes to be god and the devil daily. Mark is very distressed by these experiences, the auditory hallucinations frequently tell him that he is evil and that he should end his own life. He reports that he can not see any alternative to suicide unless someone can take the voices away.

Procedure

As a part of their post-treatment assessment at week 12, in addition to completing the quantitative outcome measures the young people were asked by an independent researcher if they would participate in an interview about their experience of the young persons' voices group. Participants were told that interview data would later be transcribed and that transcripts would not contain any identifying information. It was explained that the data collected would be used in order to help clinicians understand, from the young person's perspective, both the positive and negative aspects of the treatment program so that it could be adapted for future use.

Interviews

The participants were interviewed immediately following the seventh treatment session. The interview was conducted by an independent researcher (Ruth), with a background in music therapy. She had not attended any of the treatment sessions. It was made clear to participants that the researcher was not employed by the trust or in any way connected with the clinicians who co-facilitated the voices group. This measure was taken in order to reduce social desirability although we recognise that this cannot be entirely avoided. (i.e. if one of the clinicians involved had asked the questions the participant may have answered the questions in a way that they felt would be acceptable to the clinician and may not have felt able to raise any points critical of the intervention.)

A semi-structured interview schedule was designed in order to explore the participants' views of the young person's voices group which they had attended (Appendix E). The interview schedule was reviewed in conjunction with a psychologist who was experienced in qualitative research methods. It was also given to three members of the general population who were not psychologists for their comments. Ambiguous questions were revised.

The order of questioning during the interviews was fluid in order to enable the interviewer to follow the participants' leads. Open questioning was deliberately employed to encourage the young people to talk freely about experiences which they felt were relevant. However, the researcher's clinical experience suggested that probing in a semi-structured way may not provide the depth of material required as participants were both adolescent and suffering from a psychotic illness. Adolescent participants are frequently found to be reticent in answering questions and the symptoms of psychotic illness may also include, poverty of speech and flattened affect. Therefore, a series of more concrete prompts was used to guide the interviewer where necessary.

All interviews were taped, with the participant's permission, and interviews were transcribed verbatim. (A sample transcript is provided in Appendix F). To improve the interviewing technique and quality of transcripts, supervision was sought from two outside sources – both with experience in interpretive phenomenological analysis. They critiqued the initial four

interviews and suggested some changes in interviewing style. These changes were adopted by the interviewer prior to the second group of interviews so that a higher quality of information could be yielded from the participants.

Analysis

Step 1- Interpretive phenomenological analysis was used to examine the data collected (Smith,1995;1996). The transcript produced from each adolescent's account was read a number of times and emergent themes were elicited and noted . Care was taken at this stage to draw themes entirely in the text rather than imposing any structure from external sources e.g. theory or clinical practice.

Step 2- From examination of the themes elicited from each individual case emergent super-ordinate common or related themes (between cases) were put together. Verbatim extracts were used to illustrate and support each theme drawn from the transcripts. At this point interpretation was introduced. Verbatim extracts illustrating and supporting each theme were used to anchor interview data to the themes produced.

Step 3 - A colleague with extensive experience of using IPA was asked to look over the analysis and emerging themes and their interpretation. He suggested corrections and new interpretations of some of the original data. Changes were made in view of these recommendations.

Step 4 - A narrative account was constructed around the final list of super-ordinate themes. This account was illustrated with verbatim extracts from the transcripts. These should allow the experiences of the young people to remain transparent to the reader and also ensure that the interpretation of the researcher, unavoidable in any analysis, is visible to the reader.

CHAPTER 3 - QUANTITATIVE RESULTS **AND DISCUSSION**

RESULTS

Quantitative Results

Description of participant sample

Twenty-seven participants fulfilling the required criteria were referred to the study. They were all approached by the researcher and seventeen agreed to participate in a group. Twelve of these participants were female and five male. Nine described their ethnic origin as white UK, one as Indian, one as Italian, one as mixed race, two as African UK and three as West Indies UK. Their ages ranged from 15 – 21 years with the mean age at time of referral being 17 years. At time of referral nine were living with their family whilst the remaining eight were inpatients. Two of the participants had lived in a house share or independent flat but fifteen had never lived independently.

Of the nine participants living with their families two attended day hospital, two attended colleges of further education and five had no structured occupation during the day. Eight of the nine participants had regular outpatients appointments with only two receiving additional support, for example from a community psychiatric nurse or a social worker.

The following summary of data collected at base-line includes sixteen of the seventeen participants as one participant did not receive a full base-line assessment as they were not stable on medication at week 0.

The mean time since first contact with psychiatric services was eighteen months (range 4 months – 60 months) and fifteen of the participants had been admitted to hospital under section at least once since the onset of their illness. Sixteen participants were taking atypical antipsychotic medication at time of referral (Table 2 below), the seventeenth was not yet stable on a dose of medication but had also been prescribed an atypical antipsychotic. Ten of the participants were taking solely antipsychotic medication. The other six participants were taking a combination of other medications in addition to antipsychotics, which included anti-depressants (3 people), medication to counteract side-effects (2 people), anti-anxiolytics (4 people), mood stabilizers (2 people) and sleeping tablets (1 person).

Table 2 – Antipsychotic medication

	Number of participants taking this antipsychotic medication	Mean dose per day / Range of doses
Risperidone	3	4.3mg 3-5mg
Clozapine	3	433.3mg 300-650mg
Amisulpiride	3	466.7mg 400-600mg
Quetiapine	1	300mg 300mg
Olanzapine	4	11.25mg 5-20mg

At the beginning of the study the young people had a 'below average' mean general psychopathology (mean raw score 28 range 14-48 S.D. 10 mean T

score 38) and mean positive symptom score (mean raw score 12 range 7-20 S.D. 4 mean T score 37) when compared to normative data for the PANSS (sample of 240 people with a diagnosis of schizophrenia taking neuroleptic medication). The mean negative symptoms score fell within the average range (mean raw score 20 range 7- 42 S.D. 9 mean T score 47). The young people had high levels of depression, with the mean score falling into the moderate depression category on the BDI (mean 20 range 8-42 S.D. 11). The mean score for anxiety level as measured by the BAI fell into the moderate to severe anxiety range (mean 24 range 0-63 S.D. 19). The mean self-esteem score of the group fell within the average range for this age group (mean 32 range 24-45 S.D. 6), none of the individuals' scores were below 21 which would indicate very low self-esteem. The normative values for these scales are widely available and can be seen below.¹

Forty-one per cent of the group (n=7) reported that they found their auditory hallucinations extremely distressing but could imagine them being worse. Twenty-one percent (n=3) reported that the voices that they heard were so distressing that they could not possibly get worse. In contrast only six percent (n=1) reported that the voices were not distressing, fourteen

¹ Normative and category values for comparison purposes:

BDI-II - total score 0-13 minimal depression, 14-19 mild depression, 20-28 moderate depression, 29-63 severe depression (Beck et al.,1996)

BAI - total score 0-9 minimal anxiety, 10-18 mild anxiety, 19-29 moderate anxiety, 30-63 severe anxiety (Beck et al.,1988)

PANSS - 50th centile: Positive raw score 20 Negative raw score 22 and General psychopathology 40 T-score interpretive guidelines 70+ very much above average, 66-70 much above average, 61-65 above average, 56-60 slightly above average, 45-55 average, 40-44 slightly below average, 35-39 below average, 30-34 much below average, below 30 very much below average. (Sample 240 medicated schizophrenic patients, Kay et al. 1987)

Rosenberg Self Esteem Scale - age 12-19 years male mean 31 (S.D. 5.4) female mean 28 (S.D. 5.35) (Sample 1330 UK adolescents, Raithel, 2001).

percent (n= 2) slightly distressing and six percent (n= 1) distressing to a moderate degree. Sixty percent of the group (n= 10) had recently experienced voices making personal threats or commanding them to harm themselves or someone else. Forty eight percent of the group (n= 8) were hearing voices daily, thirty five (n= 6) percent at least once a week and twelve percent (n= 2) less frequently than this.

Table 3 below, shows the mean scores of the group of young people on a number of ratings of characteristics of auditory hallucinations, these were collected at base-line. The table compares these scores to those of a sample of adult patients collected by Wykes et al. (1999).

Table 3 - Comparison with Wykes et al's (1999) adult sample on mean ratings for characteristics of auditory hallucinations.

Clinical Measure	Young People (mean age 17yrs)	Adults (mean age 40yrs)	Sig. Difference
Ownership of voices	3.1	2.3	NS
Control over voices	3.1	3.6	NS
Amount of distress	2.1	3.0	NS
Severity of distress	2.6	2.8	NS
Physical characteristics (duration,loudness,frequency,location)	9.2	10.3	NS
Disruption caused by voices	2.9	2.1	NS

There were no significant differences between the characteristics of auditory hallucinations when the ratings of the young people were compared to the

ratings of the adult sample. Both report suffering equivalent amounts of distress and disruption from the voices and both groups felt that they could control their experiences to a similar degree. Both samples also rated the physical presence and characteristics of the voices as being very similar, auditory hallucinations occurred at a similar frequency, were of an equivalent volume and lasted for similar periods of time.

Intervention : Completion and Drop-out Rate

Four people did not complete the treatment program: one person from group one, two people from group two and one person from group three (two males and two females). This group of four young people were compared with the group that completed the treatment program (n=13) on all outcome variables by using independent sample t-tests. No significant differences were found and therefore their data were entered into the final analysis, an intention to treat approach was taken. For the number of observations made on each measures at the four time-points please refer to table 4 overleaf. Of the thirteen participants who completed treatment the mean number of treatment sessions attended was six (range 5 to 7).

Table 4 – Available number of observations at the four assessment times for main outcome and ancillary measures (out of 17 participants)

Measure	Number of observations made at:-			
	Baseline	Pre-treatment	Post-treatment	Follow-up
PSYRATS	16	17	14	14
PANSS	14	17	14	11
BAVQ	16	17	15	14
Coping Strategies	16	17	13	14
BDI	16	17	14	14
Rosenberg Self-Esteem Scale	16	17	14	14
Insight Scale	16	17	15	14
BAI	16	17	15	14
Activities	N/A	16	15	14

Analysis of change in measures of outcome and clinical ratings over total assessment period.

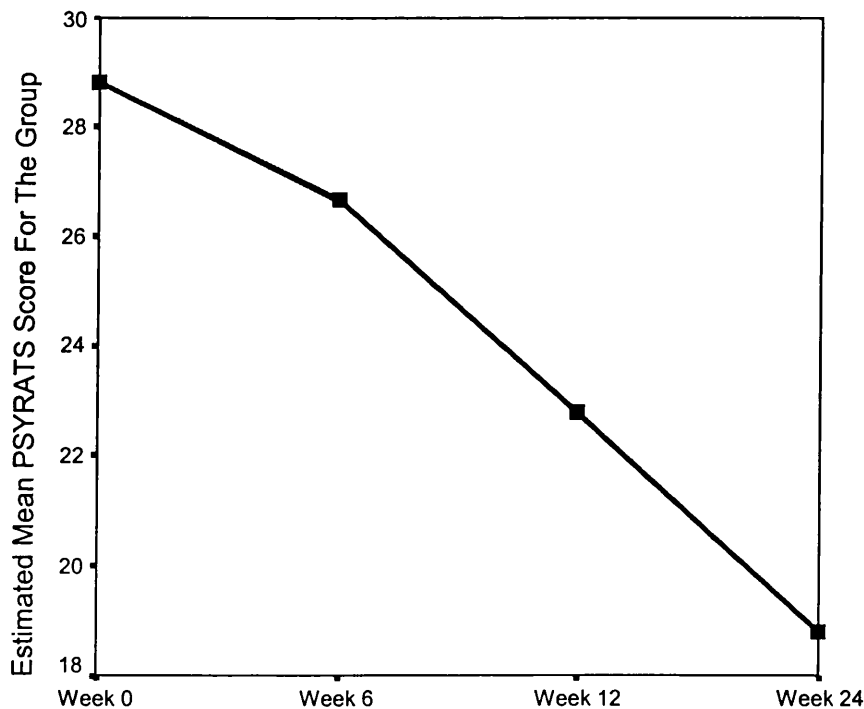
MAIN OUTCOME MEASURE

PSYRATS Auditory Hallucinations Rating Scale

Figure 1 shows the estimated mean PSYRATS score at each of the four time points (baseline = week 0, pre-treatment = week 6, post treatment = week 12, and follow-up = week 24). A reduction in score indicates an improvement in the experience of auditory hallucinations. The mean PSYRATS score changed significantly over the total assessment time (Wald test $\chi^2 = 13.01$, d.f. =3, $p =$

0.046). Further investigation of these changes using pair-wise comparisons showed no significant change over the control period (week 0-6), nor over the treatment period (week 6-12) but a significant reduction in symptoms occurred over the total treatment period, between the pre-treatment and follow-up assessments (week 6 and 24) (Wald test $\chi^2 = 8.71$, d.f. = 2, $p = 0.0032$). The estimated mean score of the group fell by 7.86 points over this time period (95% confidence interval (CI) 2.5 to 13.2).

FIGURE 1 – Estimated Mean PSYRATS Auditory Hallucination Rating Scale Score For The Group At Each Time Point.



SECONDARY OUTCOME MEASURES*Positive and Negative Symptoms Scale*

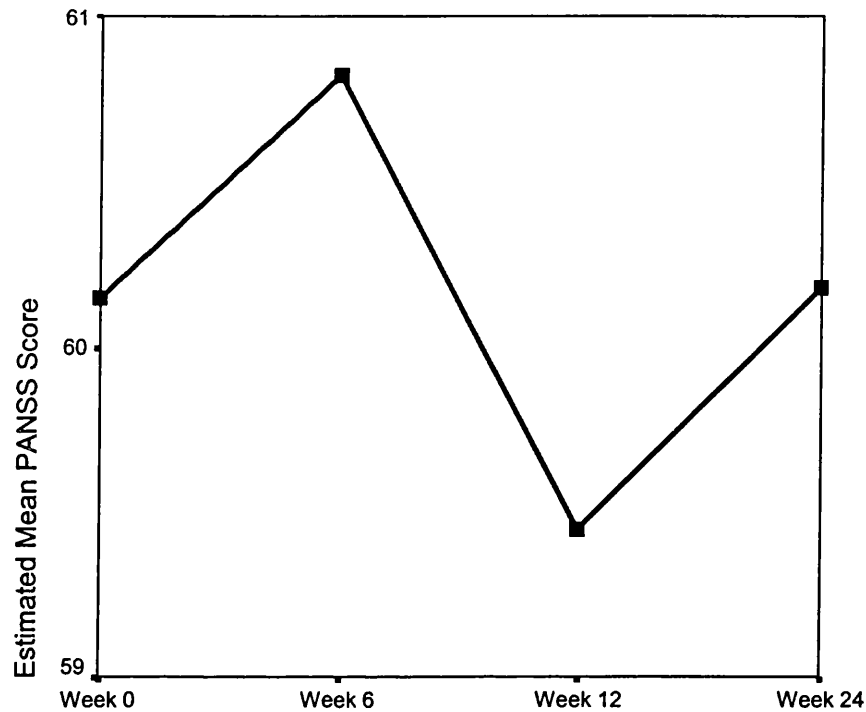
Figure 2 shows the estimated mean PANSS score for the group at each of the four time-points, with a reduction in mean PANSS score indicating a reduction in overall level of psychopathology. Although the graph shows that the mean PANSS score reduced over time, this change was not significant.

The scores of each individual on the PANSS was examined to see in what direction they had changed between the base-line assessment (week 0) and the end of treatment (week 12). (See Table 5, n = 12 , participants with scores at both time points). Twice as many participants fell into the improvement in psychopathology category (n=8) as fell in to the higher psychopathology category (n=4) . There were no relapses during this time.

Table 5 – Direction of change in PANSS score between base-line and post-treatment assessments.

Direction of change	Number of participants
Increase in score (higher level of psychopathology)	4
Decrease in score (improvement in psychopathology)	8
No change	0

FIGURE 2 – Estimated Mean Positive and Negative Symptoms Scale Scores
For The Group At Each Time Point.



Beliefs About Voices Questionnaire-R

Figure 3 shows change in estimated mean total BAVQ score over the assessment period. The graph shows that this score decreases over the treatment period indicating a general increase in adaptive responses to auditory hallucinations. However, the change in estimated mean BAVQ total score over the assessment period is not significant.

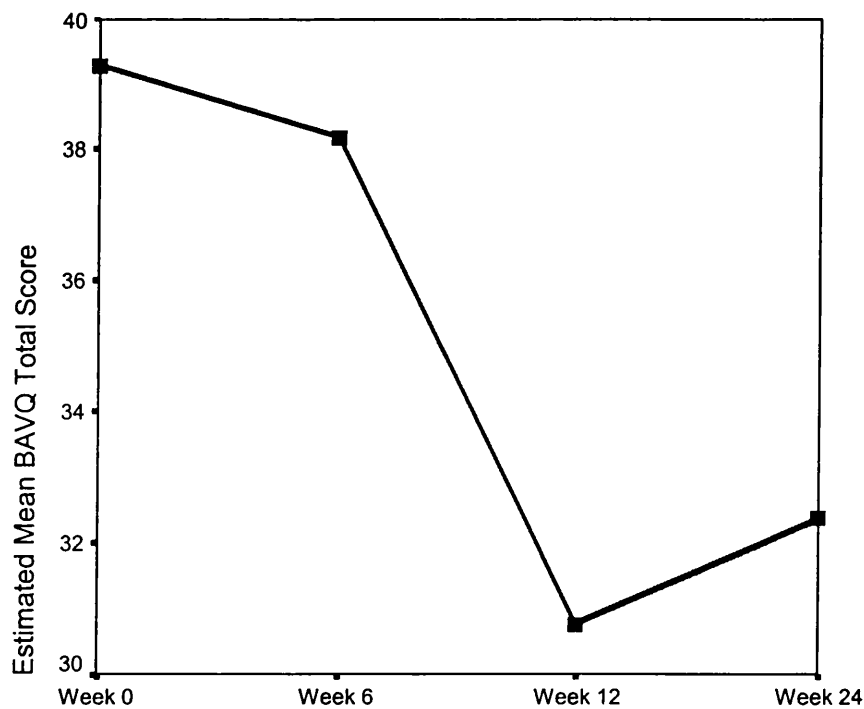
Again, the scores of each individual were examined in more detail to find out in which direction people's scores had changed between week 0 and week 12. See Table 6 below. (n = 14, participants with scores at both time points).

Ten participants increased in their adaptive beliefs about voices whilst four held less adaptive beliefs following treatment than prior to treatment.

Table 6 – Direction of change in BAVQ score between base-line and post-treatment assessments.

Direction of change	Number of participants
Increase in score (decrease in adaptive beliefs about voices)	4
Decrease in score (increase in adaptive beliefs about voices)	10
No change	0

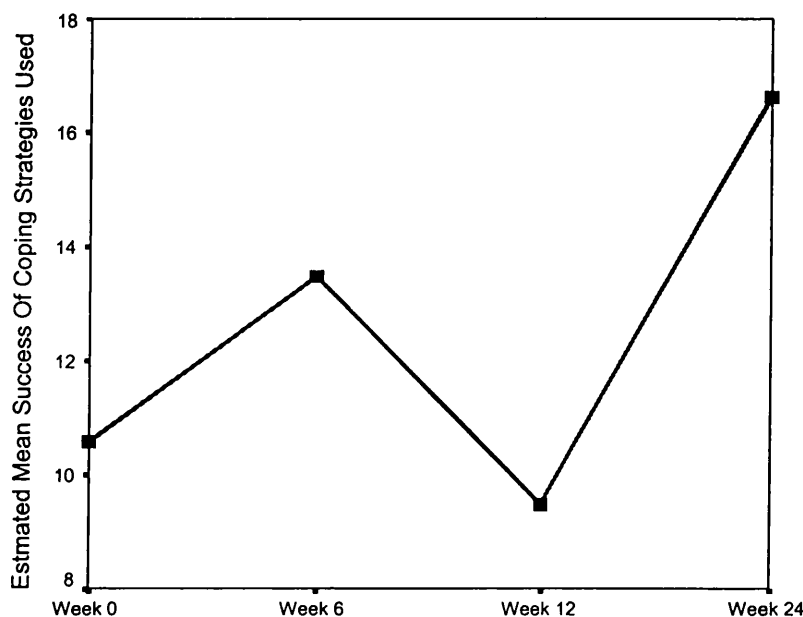
FIGURE 3 – Estimated Mean Total Beliefs About Voices Questionnaire (revised) Score For The Group At Each Time Point.



Coping Strategies

Figure 4 shows the estimated mean success rating given for the coping strategies used by participants at each time point. There was a significant change in success of coping strategies over the total assessment period (Wald test $\chi^2 = 10.940$, d.f. = 3, $p = 0.012$). When investigated further using pair-wise comparisons a significant increase in success of coping strategies was found over the waiting period (Wald test $\chi^2 = 4.666$, d.f. = 1, $p = 0.031$) and over the total treatment time (week 6- week 24) (Wald test $\chi^2 = 4.2998$, d.f. = 1, $p = 0.039$) with the estimated mean score for the group rising by 2.9 (95% CI 0.2 to 5.6) over the baseline period and 3.15 between pre-treatment and follow-up (95% CI 0.11 to 6.19). Although there was a decrease in score over the treatment period (week 6-12) this was not significant.

FIGURE 4 – Estimated Mean Rating of Success of Coping Strategies At Each Time Point.



ADDITIONAL CLINICAL OUTCOME MEASURES

Few significant changes were found on the additional clinical outcome measures. No significant changes were found in estimated mean depression scores over the total assessment time, as measured by the Beck Depression Inventory II (Figure 5), in estimated mean total self-esteem score, as measured by the Rosenberg Self-Esteem Scale (Figure 6), or in estimated mean insight as measured by the Insight Scale (Figure 7).

FIGURE 5 - Estimated Mean Beck Depression Inventory Scores For The Group At Each Time Point.

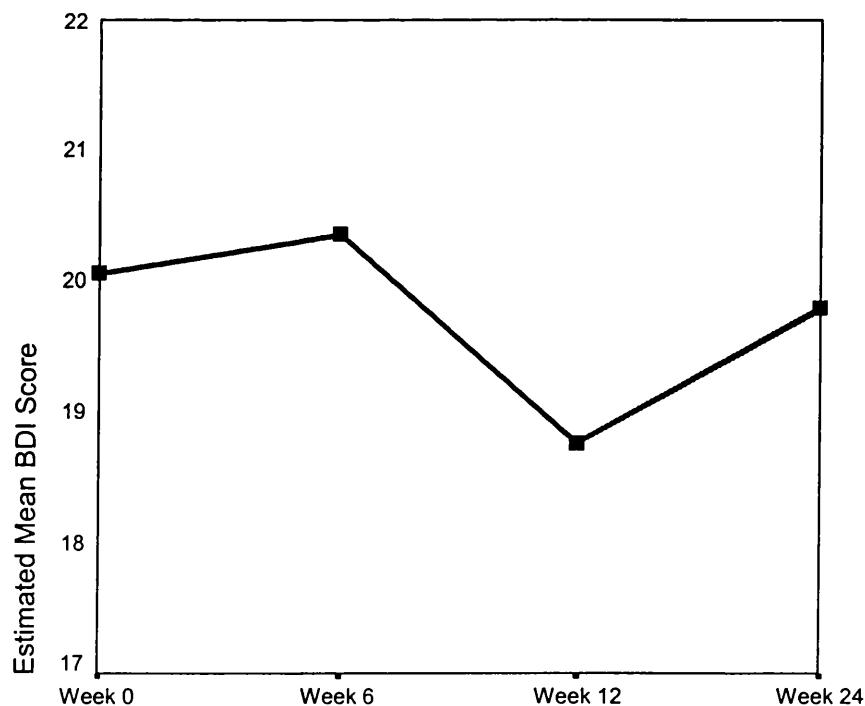


FIGURE 6 – Estimated Mean Self-Esteem Score For The Group At Each Time Point.

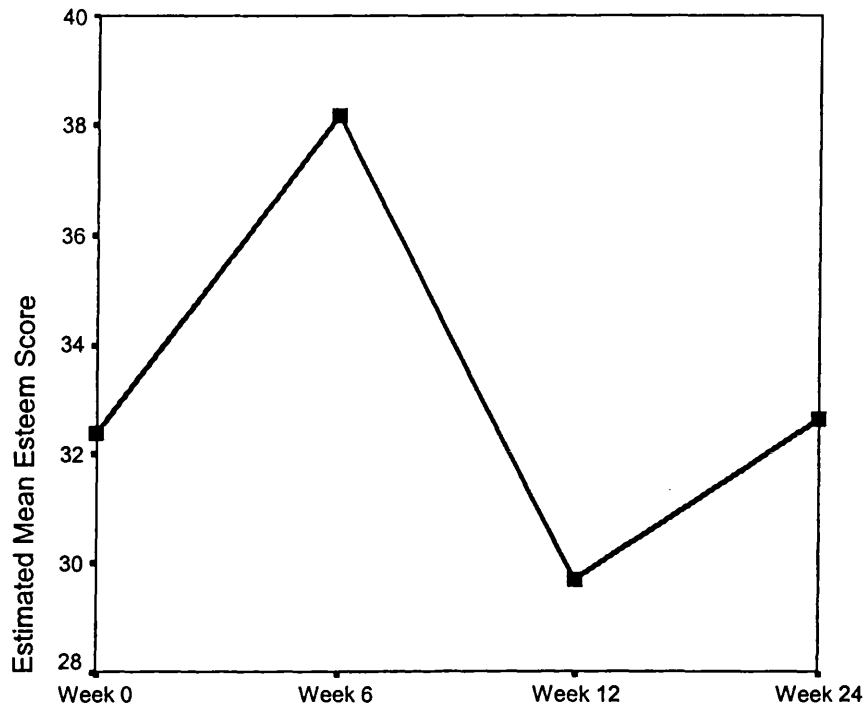
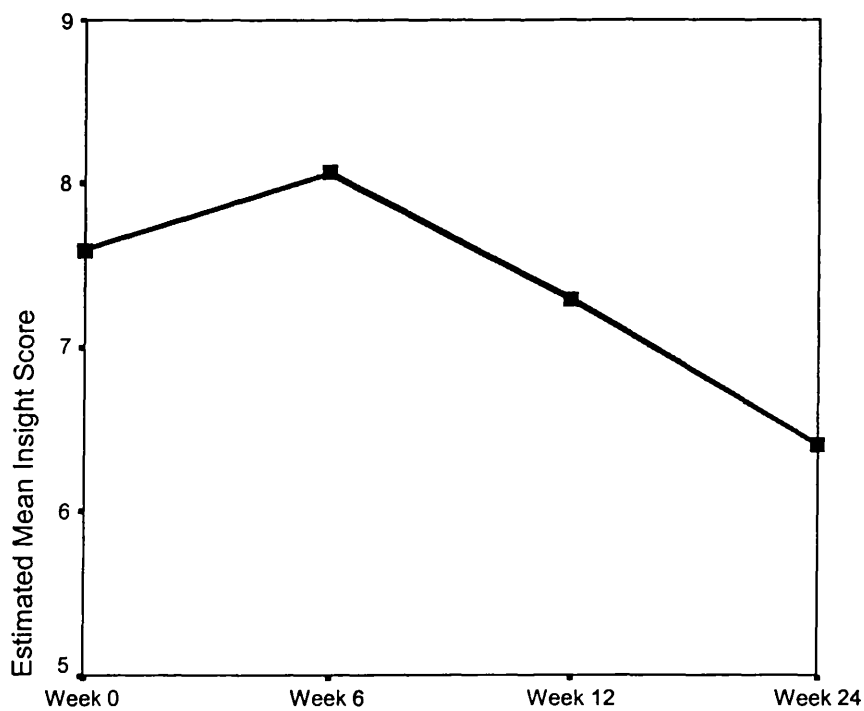
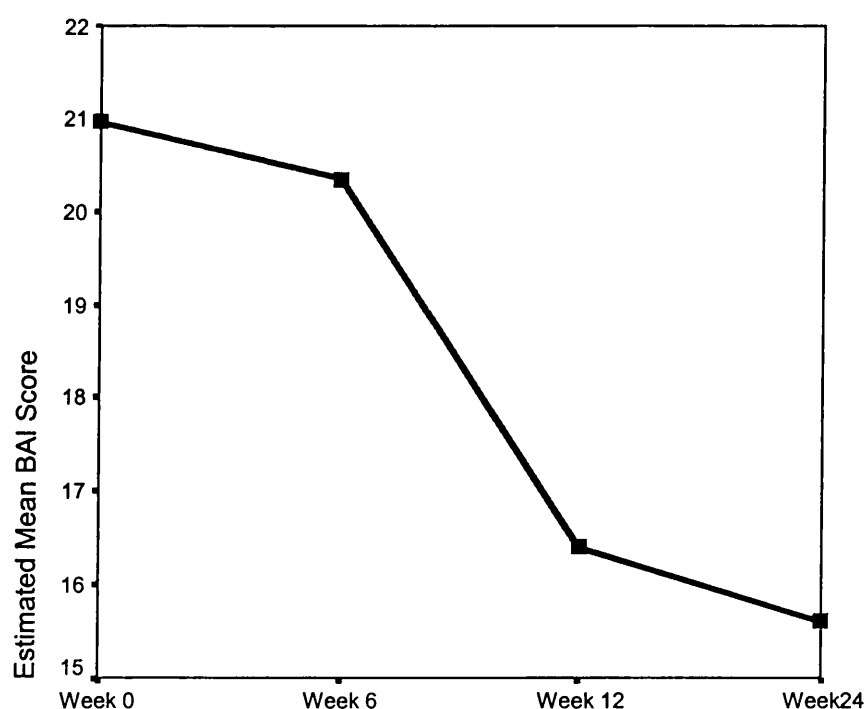


FIGURE 7 – Estimated Mean Insight Score At Each Time Point.



There was no significant change in reported level of anxiety but a trend over time which approaches significance can be observed. (Figure 8) (Wald test $\chi^2 = 3.33$, d.f. =1, $p = 0.068$). The estimated mean score fell from 20 (CI 95% 16 to 24) at Week 6 to 16 at Weeks 12 and 24 (CI 95% 12 to 20 Week 12 and 24).

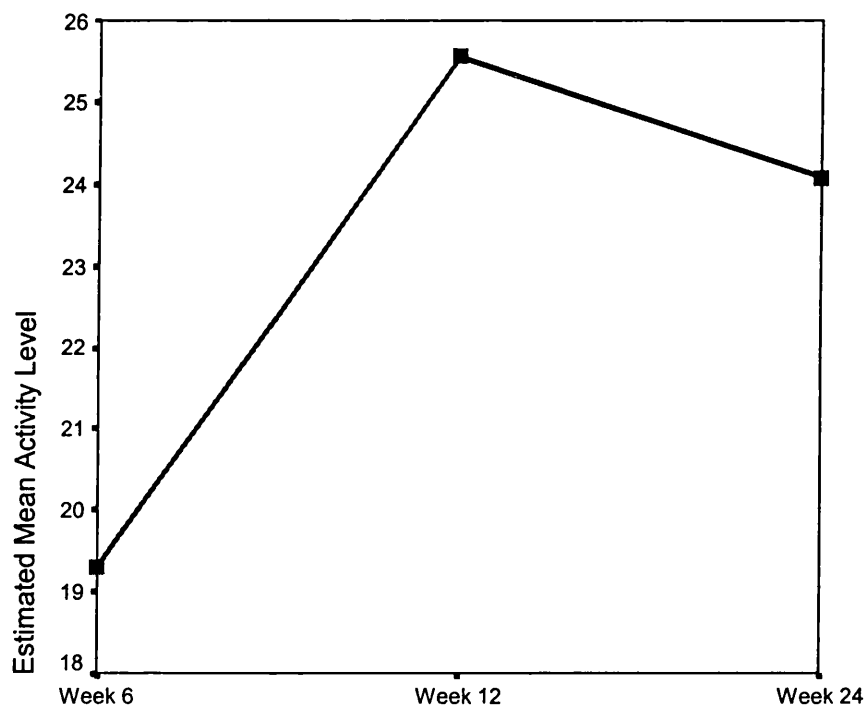
FIGURE 8 - Estimated Mean Beck Anxiety Inventory Scores For The Group At Each Time Point.



A measure of activity level was introduced at the pre-treatment assessment, there was a significant increase in the amount of activities participated in over the total treatment period (Wald test $\chi^2 = 7.94$, d.f. =2, $p = 0.019$). The estimated mean number of activities participated in increased from an

estimated mean of 19 (CI 95% 15 to 24) to 26 over the treatment phase (CI 95% 15 to 24; Wald test $\chi^2 = 5.57$, d.f. = 1, $p = 0.016$) this increase was maintained at follow-up (estimated mean at Week 24 = 24, CI 95% 20 to 28; Wald test $\chi^2 = 7.45$, d.f. = 1, $p = 0.006$). (see Figure 9).

FIGURE 9 – Estimated Mean Number of Activities Participated In



Associations with outcome

In order to investigate whether there were any associations between the characteristics of auditory hallucinations (malevolence, benevolence, engagement, resistance, omnipotence, frequency, control and intensity and amount of distress) and outcome in those measures where there was significant change over time (PSYRATS auditory hallucinations rating, coping success and activity level) a series of partial correlations was

performed. Initial score on each outcome measure was controlled for in the partial correlation.

There were no significant correlations between any characteristics of auditory hallucinations at base-line and outcome score as measured by the PSYRATS auditory hallucinations rating scale. Similarly there were no significant associations between the characteristics of auditory hallucinations and successful coping at follow-up. However, the intensity of distress caused by the auditory hallucinations and the frequency of these experiences at base-line was significantly associated with activity at follow-up after controlling for initial activity level as measured immediately pre-treatment (intensity of distress $r=-0.59$, $p=0.042$; frequency of auditory hallucinations $r=-0.73$, $p=0.007$). The lower the frequency of auditory hallucinations and the lower the intensity of distress caused by the auditory hallucinations the more activities a person engaged in at follow-up.

Perceived power of auditory hallucinations: associations with distress and depression

Previous studies (e.g. Birchwood and Chadwick, 1997; Close and Garety, 1998) have found that an improvement in perceived power of auditory hallucinations is associated with lower distress levels and lower levels of depression. It is therefore deemed important to weaken beliefs about the voices' power during therapy. Investigation of ratings of power found no significant reduction in mean rating of power for the group over time. However, eleven of the fourteen young people completing the therapy

rated the voices as less powerful at follow-up than at week 6 (pre-treatment).

A partial correlation between distress and change in perceived power of the voices over treatment holding initial level of distress constant found no significant correlation between change in power and level of distress. There were no significant correlations between perceived power of the voices and distress at any of the four time points but there was a significant association between power and depression at follow-up ($r=0.545$, $p=0.044$).

Changes in medication

Medication data were available for sixteen participants over the baseline period (those reported to be on a stable antipsychotic dose) and fourteen of the seventeen young people for the treatment and total treatment phases of the trial (those that did not drop out during the treatment phase of the study). There were few changes in medications given in addition to antipsychotic medication so these should not have had any effect on the results of the study. However, antipsychotic medication type and dose was changed frequently during the trial with only two people reporting no change to their antipsychotic medication type or dose between any of the four time points. Seven participants reported receiving more than one change to their antipsychotic medication during the trial and we can also assume that other changes to antipsychotic medication occurred within each phase of the study which we were unable to collect information about.

This is clearly a group of young people who are not yet on a stable medication regime. Due to the small number of participants remaining on a stable medication type and dose over the course of the trial it is not possible to compare the outcomes of those whose medication changed with those whose remained stable. This would have provided more information about the efficacy of the psychological therapy regardless of changes in medication. As this is not possible it will be important to bear the instability of neuroleptic intervention in mind when interpreting the outcome data for this study.

Changes in antipsychotic medication over the treatment phase (week 6-12) and total treatment phase (week 6-24) can be seen in Table 7 below.

Table 7 – Changes in antipsychotic medication.

Type of change in medication	Number of participants making a change in the baseline phase (N=16)	Number of participants making a change in the treatment phase (N=14)	Number of participants making this change over the whole treatment period (N=14)
No Change	10	9	4
Dose reduction	0	2	3
Taken off medication	1	0	1
Increase in dose	3	3	4
Change to typical antipsychotic medication	0	0	1
Change to different atypical antipsychotic	2	0	1

Discussion of Quantitative Results

The quantitative part of this study explored the usefulness of a group cognitively orientated psychological intervention for auditory hallucinations. It was the first time that such a treatment had been implemented with groups under the age of eighteen. The treatment was similar to those used in other intensive individual cognitive behavioural treatments for auditory hallucinations. However, presenting the treatment in a group was believed to have added value due to the group processes themselves.

Participants

Seventeen young people participated in the trial, their mean age was seventeen years at time of referral. Ethnicity of the sample was representative of the catchment area. Only five of the participants were male, this is unrepresentative of a group of young people with psychosis, usually characterised by a higher proportion of males below the age of fourteen and a slightly higher or equal ratio of females to males during adolescence. The referring agents suggested that this difference may have been because they referred only young people whom they felt would be able to contribute to and might enjoy participating in a group. Male patients tended not to want to discuss their symptoms with others. In a larger sample it may be useful to investigate gender differences in take-up of therapy and outcome.

As in other studies of young people with psychosis (e.g. Pelkonen et al, 1998) the majority of cases in our sample reported that their social and educational

development during adolescence had been disrupted by their illness. Six of the seventeen participants had left school before taking GCSE's, this is an unusual occurrence in most schools. Only two young people had gone on to further education and all except two had been hospitalised due to their psychosis. Most of those who were outpatients were not participating in any meaningful daytime activity such as work or education. Anecdotal evidence suggested that one of the reasons why they enjoyed attending the group was that they viewed it as a 'trip out'. Secondary impairments such as a fall in socio-economic status, unemployment and poverty later in life could be associated with this failure to reach developmental milestones, certainly studies (e.g. Haas and Garratt, 1998) have found better outcome in those who reached more milestones before the onset of psychosis. Our sample are similar to those who have traditionally been reported to have a poor prognosis and psychosocial outcome in adulthood (e.g. Lay, Blantz Hartman and Schmidt, 2000; Hollis, 2000).

Symptoms

The group of young people participating in the voices groups had a lower than average level of general psychopathology when compared to the norms for a chronic schizophrenia sample on the Positive and Negative Symptoms Scale. However, they continued to hear distressing voices even when treated with antipsychotic medication. Sixty-two percent (n=10) of the group rated the symptom of auditory hallucinations as extremely distressing for them. The majority of the group (60%, n=9) suffered from voices which threatened

harm to them or others or commanded them to hurt themselves or other people and 94% (n=15) rated themselves as having minimal or no control over the voices. The young people reported suffering from high levels of anxiety and depression. These descriptions of their voices are consistent with the findings in previous studies of both adults and adolescents with auditory hallucinations; people who request help from psychiatric services report that their voices have a high negative content and frequently experience command hallucinations and feel less in control of the voices (Romme et al, 1992; Escher et al, 2002). High rates of depression and anxiety are consistently reported in groups of people with auditory hallucinations (Birchwood and Jackson, 2000).

The sample of young people experienced equivalent amounts of distress to an adult sample of voice hearers participating in an efficacy trial of group psychological treatment for auditory hallucinations (Wykes et al, 1999). The characteristics of the auditory hallucinations were not significantly different from the adult sample, the mean scores for the groups suggested that the voices were similar in aspects such as volume, duration and frequency.

Missing data analysis

Three people dropped out of the treatment program and therefore did not provide any or had minimal data at times 3 and 4. In addition there was some missing data for other participants due to illness or refusal to complete measures (see table 4 for details). The minimum number of observations on

a measure at any one time point was thirteen out of a possible seventeen. As the sample size was already small it was important not to lose any more data from the analysis which would further reduce its power. An unbalanced repeated-measures models were employed to estimate the missing observations.

This method has the advantage of using all available data rather than deleting cases which do not have a full data set (as in MANOVA), and is recommended for use in treatment trials when there are often some missing observations (Everitt,1998). However, it is important to recognise the limitations of such an approach. Imputed variables are purely the best estimate of an actual score that we can make given all of the information available and are no substitution for 'the real thing'. Missing data estimation also assumes that the data missing is 'missing at random'. I feel that this is the case in the current research as the clinicians could not have predicted who would drop out or not fill in measures. However, if this were not the case the results may have been biased by using this approach to the analysis. For example, if all of the people whom the group did not help chose not to fill in the PSYRATS following treatment the BMDP package would predict from the overall patterns of associations that their scores improved at time 3 when in reality their scores stayed the same or decreased. Missing data analysis should be treated with respect and caution, it is clearly preferable to minimise missing data during the data collection stage of research so that

data estimation is used in very few cases, the power of the analysis is maximised and the risk of bias is reduced.

Outcome following intervention

Consistent with our initial hypothesis there were significant improvements on some symptom and clinical measures following the treatment. Most importantly, a significant improvement on the PSYRATS auditory hallucinations scale was demonstrated over the total treatment period whilst change occurring over the waiting period on this measure was not significant. This finding is consistent with the outcome from other group treatment studies (Wykes et al, 1999; Gledhill et al, 1998) and suggests that the group treatment has utility for young people with auditory hallucinations. We suggest that the waiting period provides a conservative estimate of change without psychological therapy as this period contains the effects of expectancy. It is important to note that the group did not significantly improve on the auditory hallucinations rating over this period which supports the idea that the change may be attributed to participation in the voices group rather than to treatment as usual.

The success of people's coping strategies for dealing with auditory hallucinations significantly increased over both waiting period and total treatment time. Although it is possible that treatment as usual improved coping a more plausible explanation is that the coping strategies presented as part of the assessment process acted as a stimulus to their use. This effect was

noted in a previous study which investigated the coping strategies of people with auditory hallucinations (Carter, Mackinnon and Copolov, 1996).

Significant improvements in auditory hallucinations and coping were found at follow-up but not immediately post-treatment. I believe that this is because by week 6 the young people have not yet had an opportunity to assimilate all of the information provided in the group or to try out different coping strategies which may have only been presented in the last weeks of therapy. In this way I suggest that the treatment is similar to other cognitive behavioural interventions for psychosis that have demonstrated that gains may occur or continue following the end of the active treatment phase (e.g. Kuipers et al, 1998).

A significant increase in activity level was found following treatment and this gain was maintained at follow-up. Both intensity of distress caused by the auditory hallucinations and the frequency of voices were negatively correlated with activity level at follow-up indicating a significant association between low frequency and distress and higher activity levels. As activity level increases significantly over treatment time but distress and frequency do not I interpret these findings as suggesting that behavioural activation can lower the distress and frequency of auditory hallucinations. In addition, encouraging people to participate in activities, as a part of the treatment protocol, may enable participants to discover that their behaviour allows

them to have some control over their experiences of auditory hallucinations.

A bigger sample would be needed in order to investigate changes that predict outcome by using path analysis.

There was a trend towards a reduction in anxiety level over the treatment period with the estimated mean score falling from 20 at Week 6 to 16 at Weeks 12 and 24. Although this reduction is not statistically significant it represents a clinically significant change in the group mean from 'moderate-severe' to 'mild-moderate' anxiety level. Eight of the twelve participants with measurements of anxiety at base-line and follow-up changed a clinically significant amount (a fall of one category or more) following treatment. Of those that did not have a clinically significant reduction only one participant's anxiety increased significantly, the others' anxiety level remained stable. Those two remaining stable had normal or mild anxiety at both assessments. It is possible that reduction in anxiety is related to factors such as the emotional consequences of being part of a group of people with similar difficulties or of developing more successful coping strategies. The small sample size makes it difficult to investigate what factors relate to change in outcome. For this a larger data sample would be needed to allow exploration such as multiple regression analyses or co-variance modelling which may elucidate the effects.

There was a trend towards a reduction in the group mean score on the BAVQ indicating more adaptive beliefs about voices following treatment. Changes in belief, particularly regarding the perceived power of the voices have been demonstrated to be associated with reductions in distress and depression (Chadwick and Birchwood, 1994). Although reduction in perceived power was not significant for the group eleven of the fourteen participants rated the voices as less powerful following treatment. Perceived power at follow-up was significantly associated with level of depression but not level of distress. Depression for the group as a whole did not significantly reduce over time which was consistent with the findings from the adult study (Wykes et al., 1999).

No significant reductions were found on other symptom or clinical measures. On the PANSS, measure of general symptomatology, this result is not surprising since young people with psychosis have been found to under-report psychotic symptoms (McGorry et al., 1996). Even if our results are an accurate reflection of symptomatology, the result may represent a ceiling effect. Similarly, the group had normal rather than low self-esteem and therefore an improvement would not have been expected. A significant improvement in insight was found in a previous trial of group therapy for auditory hallucinations with an adult sample and we hypothesised that a similar improvement in insight would be found but there was no significant change in insight following the young people's voices groups.

All seventeen participants were taking atypical anti-psychotic medication at week 0 as well as a combination of other medicines including drugs to reduce anxiety, depression and side-effects. Many of the responsible medical officers made changes to the young people's medication regimes during the treatment trial, although all those completing the trial continued to be prescribed some form of antipsychotic medication. The group of young people were clearly not yet on stable medication regimes, this point needs to be taken into account when interpreting the findings of the study. In order to be sure that the treatment effect is over and above those caused by medication change and treatment as usual the treatment group would need to be compared with a non-treatment group who were also not yet stable on medication. However, as a preliminary study of the efficacy of group psychological treatment for auditory hallucinations for young people, the result that no significant reduction in auditory hallucinations rating was found over the waiting period but occurred over the total treatment phase suggests that this may indeed be the case. In order to find more conclusive evidence that group therapy for young people with voices is an effective adjunct to treatment as usual a larger, randomised controlled trial will be necessary.

CHAPTER 4 – QUALITATIVE ANALYSIS AND DISCUSSION

QUALITATIVE RESULTS

Analysis of qualitative data

Introduction to analysis : The themes emerging from the data

Two main themes emerged from the analysis of the qualitative data. The first super-ordinate theme, *'The Voices Group As A Place To Explore Shared Experiences,'* is primarily phenomenological and includes four sub-themes, 1. *a safe place to talk*, 2. *normalising and de-stigmatising*, 3. *learning from and helping others*, 4. *the role of the facilitators* . These are all very grounded in the data, and provide experiential accounts of the hearing voices group and reflections made by the participants on the process of group therapy. The second theme is more interpretative and somewhat speculative. This theme, *'A Heuristic Model of Auditory Hallucinations,'* explores the cyclical relationship between the content of the voices, the participants' explanations for, and emotional reactions to, these experiences, and thus their ability to cope with them. It considers the ability of the intervention to target each part of this cycle. Both themes will now be examined in detail, using verbatim extracts from the interview data collected. The convention ... is used to illustrate a pause in speech and (...) to illustrate where a piece of text has been omitted.

Theme 1 - The Voices Group As A Place To Explore Shared Experiences

All eight participants viewed the primary utility of the group as providing a forum in which they could share similar experiences:

Ruth: *'Are you glad that you came along to the group?'*

Mark: 'Yeah.'

Ruth: *'Yeah? Why's that?'*

Mark: 'Cos I met people who had been through the same thing as me.'

Ruth: *'and was that a good thing?'*

Mark: 'That was encouraging.'

(And later)

Mark: '....I was talking to people who have similar experiences to myself, so it was quite helpful to understand and see the similarities between cases, which was quite remarkable how similar it was and how the voices started ...'

Mark expressed enormous surprise that other people's voices had begun in the same way and were very similar in content to his own. Other participants echoed his surprise, possibly because the majority of the group (six out of eight), had never met anyone else who heard voices before joining the group. The participants' accounts suggest that they understand the process of talking about voices to other voice-hearers as more beneficial than talking to non-voice-hearers, for example, family members or friends:

Ruth: *'Did you have anyone that you could talk to?'*

Jocasta: 'Yeah, my Mum but she didn't....she didn't hear voices before.'

Ruth: *'So she didn't understand?'*

Jocasta: 'She understand, but she didn't.'

From this comment we can see that Jocasta found it more useful to talk to people in the group about voices than to her Mum. Participants appeared to believe that their peers were more able to understand and empathise with their difficulties, and therefore provide them with better support than people who have not heard voices. The age of the other group members, and other shared characteristics, may also have been important:

Ruth: *'And what about in the group, talking to people in the group, did that help?'*

Patience: 'Yeah that helped a lot, cos you got to know people who was, who had the same problems as you and you can just, like Jocasta, I have made a friend like, who's, like who's been through the same thing as me and she's just cool with it.'

So for example, Patience talked about the importance of making a friend who understood what she had been through. As an observer, I felt that other perceived similarities between Jocasta and Patience which included, age, gender, ethnicity and interests such as music and the opposite sex (both of their boyfriends accompanied them to the sessions) were also factors in encouraging this friendship. The two participants continued their relationship after the intervention was completed. This increased level of social-support can be interpreted as a positive outcome of the group.

A safe place to talk

Although stigma is not explicitly mentioned in any of the transcripts, it is implicit within the young people's descriptions. The participants clearly discriminated between safe people (such as close family members, friends and nursing staff) and unsafe people (for example neighbours, people at college or potential employers) in terms of disclosing their experiences of auditory hallucinations:

Ruth : '*Did it help to talk to people in the group?*'

Chidi: 'Because if you talk to someone they don't know what it's all about so.'

Ruth : '*Can you say a bit more?*'

Chidi: 'Like people take the mickey around my area so.'

(And later)

Chidi: 'Other people find it weird.'

We can see here that Chidi valued the stigma-free-space provided by the group. This obviously allowed auditory hallucinations to be discussed freely,

and appears to have helped Chidi to share her often difficult and painful experiences with others. She spoke about the importance of being able to talk about voices without being seen as 'weird' or taunted by others. In both the group and the interview, Chidi spoke about her experiences of prejudice and stigmatisation in the community, which included her neighbours calling her 'the girl who talks to herself'. Similarly, in her interview, Patience observed that the experience of hearing voices caused her to fear for her sanity ('like you start to question yourself'), and then went on to reflect upon the identity implications of this:

Ruth: 'Was there anything that you learned from the group that you didn't know before, do you think?'

Patience: 'Just that there are more people ... of my age group have this problem. I'm not the only person that's got this problem, so I don't have to feel like I'm crazy or anything like that.'

Ruth: 'Is that how you felt before?'

Patience: 'Yeah a bit ... yeah, other people's got my problem its not just ...'

Ruth: 'Yeah. Its not just something that you, its not just you, it's other people and other people of your age as well.'

Patience: 'Yeah.'

Patience implies here that 'crazy' was not a concept which she wished to be identified with, and that the group helped her with this ('I don't have to feel like I'm crazy or anything like that'). Many in the general population would associate 'hearing voices' with 'madness,' and obviously 'madness' has many negative connotations. In particular, there are many popular myths associated with the label schizophrenia. For example, people with schizophrenia are often thought to have a split personality, to be unaware of what they are doing, to be violent, and to be dirty and unkempt. It is not hard to see how young people who hear voices would not wish to be identified in this way.

Normalising and de-stigmatising

One of the primary aims of the group was to normalise and de-stigmatise the experience of hearing voices. The group did this in two ways. Firstly, it facilitated a meeting with other people who hear voices. Secondly, it attempted to modify the young people's misconceptions and to reduce the fear associated with 'schizophrenia' or 'psychosis,' by providing accurate information to the participants about what these terms mean, and more importantly, do not mean. The themes of normalisation and de-stigmatisation can be seen throughout all eight transcripts and are clearly illustrated by all verbatim extracts given above, therefore we can assume that the group went some way towards meeting this aim. For example, Patience described a change in her interpretation of the meaning of hearing voices from 'hearing voices means that I am crazy' (prior to the group), to 'I am one of a number of people of my age who have the experience of hearing voices' (following the intervention). She directly related this change to the experience of meeting with peers who shared her experiences. By providing a safe environment in which experiences could be explored, the group allowed each of the young people to learn that he or she is not the only young person who hears voices. This 'normalising' experience is linked by group members to changes in their thinking about, and understanding of, voices. This has emotional consequences, such as feeling 'relieved' and 'encouraged,' and reducing negative emotions such as 'fear', 'loneliness' and 'isolation.'

Learning from and helping others

Although all of the participants claimed that they benefited from meeting other young people with auditory hallucinations, different participants appear to have taken different things away from the experience. Mark referred to the experience of meeting other voice-hearers as 'encouraging', and as providing hope for the future. This comment may be interpreted with reference to the group's composition, in terms of its members' stages of recovery from psychotic illness. Mark attended the voices group during his first admission to hospital, having become unwell four months previously. Consequently, he felt optimistic when he met others who had learned to cope with experiences similar to those currently causing him extreme distress.

In contrast, Jocasta had been in touch with psychiatric services for two years, and although she reported being initially very depressed and frightened when she heard voices she had recently returned to full time further education. Thus, Jocasta did not describe the group as providing encouragement. Instead, she suggested that meeting other voice-hearers provided a sense of relief:

Ruth: 'Had you not met many people who heard voices like you?'

Jocasta: 'No, never.'

Ruth: 'Never, really? Was that the first time?'

Jocasta: 'Yeah.'

Ruth: 'So, I was just wondering how it felt before when you didn't know people who heard voices?'

Jocasta: 'It felt lonely and ... different.'

Jocasta's experience of meeting other voice hearers was different to Mark's but appeared to be equally valid and valuable to her. She described the

emotional impact of the group as enabling her to feel less isolated and lonely. In addition, the role of 'helping others' was expressed by a subset of participants who had reached a point of recovery where they were currently functioning in the community with minimal support. These more experienced participants had developed a more extensive coping repertoire, as illustrated by Jocasta and Patience:

Jocasta: 'It was good because you got to meet people like yourself... and that's it, and you went over your strategies and stuff like that and you could help each other and stuff like that.'

Patience: 'Um, well, um, I talked about um, cos like Mark was saying about how he felt like killing himself, he felt that there was nothing to live for and I tried to explain to him that you shouldn't let the voices ruin your life. You shouldn't let the voices affect your life in a way where you can't deal with things or go places or have a normal life, just live like everybody else. Cos you should just try and just ignore them or just think of it as if you have an illness like cancer or some thing and that you should just try your best to overcome it and just aim to do as much as you can with your life.'

It appeared that this sub-set of participants valued the positive emotional impact of meeting other young people who hear voices, and the normalising and de-stigmatising effect of the group. However, they also perceived their role within the group as to help those understood to be 'more unwell' than themselves. This may have had a positive impact on their self-esteem by positioning them as higher status within the group. It must be noted here, that this 'higher-status position' also benefited other group members by providing positive role-models, suggestions for coping, and hope for the future, as first-hand evidence that voices could be overcome.

The extracts above demonstrate the clinical importance of having a mixture of young people in the group - some inpatients and some outpatients. A

more homogeneous group (e.g. all inpatients) would not have provided the same breadth of experience to draw upon, and would not have been able to capitalise on these two polarised, yet complementary, group roles. The extracts also suggest, tentatively, that what a participant gained from the group was partially dependent upon the length of their illness, admission-status and recovery-stage.

The role of the facilitators

With all of the participants stating that the most important part of the group was the opportunity to be able to meet and talk to other young people who heard voices, an important question is 'what role, if any, did the facilitators of the groups play?' Firstly, it seems that, within the group, participants were positioned by the facilitators as 'experts in voices' and this empowered them to use their expertise to help other people within the group, by sharing their own experiences. For some, this meant occupying the 'helping' role described above, but for most participants, this meant sharing their coping strategies with others:

Angelo: 'Yeah, it was interesting and it was also about um, we were discussing about what we were going through and how we could cope with our voices.'

Ruth: '*What was it like talking to other people who hear voices, finding out how they cope?*'

Angelo: 'They put up informations on what they could do to cope with the voices and we shared each other's ideas.'

Ruth: '*So did you feel that you learnt anything from talking and sharing experiences?*'

Angelo: 'A lot of the time I felt like what they were saying I knew about it already, cos we were talking about hobbies and interests and how many voices we hear, and what were the voices saying, um but I also learnt more things than what I came in with.'

Ruth: '*What things did you learn, can you remember any of them?*'

Angelo: 'That um, that um, how to cope with the voices like social support and (interruption)'

Ruth: '*Sorry Angelo can you remember what you were saying?*'

Angelo: 'Yeah um, that I learnt, um, that's it, about how to cope with the voices, hobbies and interests and talking about it.'

Sharing coping strategies was mentioned by all eight participants. Although not everyone said that they learned new strategies from the group, and others reported that the things that they had tried out at home in between groups were not successful, most participants listed a number of successful ways of coping with voices. The range of strategies identified by the participants is illustrated in the following three extracts:

Ruth: *'What kind of things did people say about how they avoided the voices?'*

Chidi: 'Watching TV, playing football.'

Ruth: *'And what things did you say?'*

Chidi: 'Watching TV.'

Ruth: *'But not playing football!'*

Chidi: 'No.'

Ruth: *'Is there anything else that you do?'*

Chidi: 'Listen to some music.'

Ruth: *'Does that make the voices go away?'*

Chidi: 'Watching TV does.'

Ruth: *'Does that make them go away completely?'*

Chidi: 'Yeah.'

Ruth: *'And what about listening to music?'*

Chidi: 'Yeah, that works.'

Ruth: *'Do you have any other ways?'*

Chidi: 'No.'

Ruth: *'Maybe you learnt, did you learn from the group any new ways of helping the voices to go away?'*

Chidi: 'No.'

Ruth: *'And did you learn ways of sort of coping with the voices?'*

Jocasta: 'Yeah, well I knew them already.'

Ruth: *'Right what kind of things did you know already?'*

Jocasta : 'To (inaudible) or to read a book or watch telly or listen to music, I knew to do that stuff already.'

Ruth: *'Did you sort of try things at home?'*

Mark: 'Yeah, I tried singing.'

Ruth: *'Singing?'*

Mark: 'And um...'

Ruth: *'Did that work?'*

Mark: 'Not really.'

The comments of the young people indicated that, at worst, the group reinforced the use of successful strategies, and at best, taught more effective

ways of coping to the participants. The facilitators' role was not purely to facilitate the sharing of experiences and coping strategies, but also to use psychotherapeutic skills to bring about positive change. Harinder illustrated this, by talking about the psychological questioning techniques used by the therapists:

Ruth: *'And what about the people that ran the group, what were they like?'*

Harinder: 'Yeah, they were all right, yeah.'

Ruth: *'What kind of things did they say?'*

Harinder: 'Good things.'

Ruth: *'Good things? What good things?'*

Harinder: 'Well questions, like, like I said, about the voices.'

Ruth: *'So they were good questions were they? Why?'*

Harinder: 'Because, I mean, I could see what helped me and what didn't.'

Ruth: 'In terms of?'

Harinder: 'What made the voices, what made me stop hearing voices and what didn't stop me from hearing voices.'

Ruth: *'Right'*

Harinder: 'so now I can see why playing football, watching TV, going out, helps, but if I just sit alone and keep listening to my voices its not going to help.'

These questions enabled him to see what useful coping strategies he could employ, for example 'playing football' and 'watching TV', and what behaviours exacerbated the distress caused by auditory hallucinations, for example 'sitting at home and listening to the voices'. Changes in Harinder's behaviour, and a reduction in the distress caused by auditory hallucinations, may be a result of the therapists' highlighting Harinder's coping resources and his ability to control the voices.

Jocasta, Tracey and Patience all discussed the role of the facilitators in encouraging turn-taking, allowing quieter group members to be heard and preventing those with a tendency to speak continuously from dominating conversations:

Patience: 'They (the facilitators) made sure like everyone like had a chance to speak and everyone got their point across.'

Ruth: '*Do you think that was important?*'

Patience: 'Yeah.'

Ruth: '*That everyone had a chance to talk?*'

Patience: 'Yeah.'

Jocasta: ' (The facilitators) made us all get our voice heard and stuff like that, made us all feel important.'

Ruth: '*Are you someone who is quite good at talking in groups?*'

Jocasta: 'Um, yeah, I'm quiet most times but I like to talk because I want to talk about it so I did talk a lot about it (voices).'

Ruth: '*And they gave you the opportunity to do that' (...) 'How did they make you feel special?*'

Jocasta: 'Like we all got to say our views.'

Ruth: '*And they listened?*'

Jocasta: 'And they wrote it down on the board, stuff like that.'

Ruth: '*Did other people in the group listen to each other as well?*'

Jocasta: 'Yeah.'

Ruth: '*Was that something that the leaders had to help you with sometimes?*'

Jocasta: 'Yeah.'

Ruth: '*Why do you think you needed help with that?*'

Jocasta: 'Cos some people just talk over other people, cos they don't know any better but the leaders will help.'

Both Jocasta and Tracey felt that the way that the therapists had facilitated the group not only gave everyone the chance to speak, but had a positive impact on the participants' self-esteem by making them feel 'better about themselves' and 'special':

Ruth: '*You think that coming to the group has helped you to feel better about yourself?*'

Tracey: 'Yeah, and every time I leave here I feel good about myself.'

Ruth: '*Do you know why that is?*'

Tracey: 'Because you're doctors and you help us.'

Ruth: '*Because of the doctors?*'

Tracey: 'Yeah'

(And later)

Ruth: '*Is it hard for you to talk sometimes?*'

Tracey: 'Yeah, because I had a breakdown, a breakdown.'

Ruth: '*Yeah? What happened when you had a breakdown?*'

Tracey: 'I stopped talking for a long time.'

Ruth: '*Completely?*'

Tracey: 'Completely, and I still feel its hard now...I felt talkative when I walk away (from the group)'

Ruth: '*Mm is that a big difference?*'

Tracey: 'It was good meeting in the groups because you talk to them and you get to commu- like communicate with them and meeting with them and communicating with them and its good.'

Ruth: *'And did you feel that the doctors listened to you as well and'*

Tracey (interrupts): 'Yeah, they listened to me.'

This may have been the first time that the young people had discussed their difficulties with mental-health professionals, who valued their opinions about their experiences and their treatment. The participants stated that the opportunity to discuss their difficulties with mental health professionals and other young people with similar experiences was highly valued. As we have seen, their interviews suggest that providing this opportunity has a number of positive cognitive, emotional and behavioural consequences.

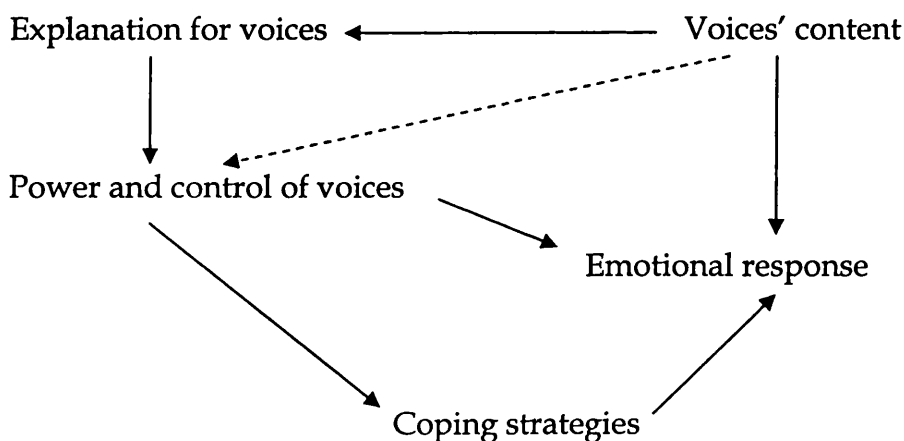
Theme 2 – A Heuristic Model Of Auditory Hallucinations

In addition to talking about their experiences of attending the group, the young people talked to Ruth about what the experience of hearing voices was like. With this second theme, I have taken a more interpretive stance in relation to the data, than previously I have done with theme one. In doing so, I have attempted to understand the participants' experiences of hearing voices within a psychological and cognitive behavioural framework.

The detailed descriptions of hallucinations that were offered by participants revealed many differences in phenomenology. However, *the way* in which the voices were described in each case revealed striking commonalities. Each individual clearly described a pattern of interactions between the content of the voices, their personal explanations and beliefs about voices, their emotional reaction to these experiences, and their coping repertoire. I have

developed an interpretation of these patterns in the data by utilising a clinical psychological perspective. In order to illustrate this interpretation, a heuristic model is plotted below, showing the inferred relationships between the shared features of the participants' accounts. This *heuristic model of auditory hallucinations* (Figure 10) is intended to simplify and clarify the relationships between hallucinations, beliefs, and emotional and coping responses, as described by the participants, for the purpose of analysis and discussion of the data collected.

Figure 10 – A Heuristic Model of Auditory Hallucinations



Within the model developed here, the type of explanation which participants utilised for their experiences is extremely important. The participants' own explanations for their voices can be understood to affect their strategies for coping with them, and also their emotional reactions to them. This mediating function of the participants' various explanations for hearing voices occurs primarily via the perceived power and control of the voices, with far less

influence coming from what the voices actually say (dashed line). 'Explanation' appeared to divide the participants into one of two categories: those who have adopted an 'external' explanation for their voices (e.g. a conviction that the voices are caused by other people, supernatural forces, or spiritual entities), and those who had adopted an 'internal' explanations for their voices (e.g. a belief that the voices are an illness, a brain dysfunction or caused by a sensitivity to stress). This is best illustrated by using two examples, one from a participant utilising an external explanation, and one from a participant offering an internal explanation.

Harinder gave an external explanation of the voices that he heard, and believed that these were caused by his neighbours - or if not, then possibly by a djinn:

Harinder : 'No the voices aren't inside me, but well, its not inside me but its talking through me, so when I stop talking, when I'm just breathing, I can hear it there on my breath.'

Ruth: 'And what does it feel like?'

Harinder: 'Well, there was a time I felt really scared. I didn't go to sleep that night. I stayed awake all night, then it was morning, I was tired, I couldn't lay down on the bed, I was so ... the anxiety. I was feeling so, so mad, the anxiety was getting really worse and so I had to get up and go downstairs and watch T.V. So I did that and my sister came downstairs and she went to work and the T.V. wasn't on and I was just sitting down and looking at the garden and I could feel something behind me and it was one of those voices that came and actually put his fingers on my back, right next to me.'

Ruth: 'Touching you?'

Harinder: 'Yeah, and telling me, say that thing to her, say that thing to her, say that thing to her, say that thing to her.'

This excerpt shows how Harinder links the voices to his emotional responses. Harinder described being anxious, scared and feeling 'mad'. This emotional reaction to the voices can be seen to have behavioural consequences; Harinder attempted to cope with the experience by

distraction, going downstairs and watching TV. Unfortunately, these behavioural coping strategies were not successful because the voices followed him. Harinder related the failure of his attempt to shut out the voices to his explanation and beliefs about the voices:

Ruth: 'Right and what was it that they wanted you to say?'

Harinder: 'I don't know, that's all they said, that's all. Well, the voice that I was hearing sounded like my next door neighbours, next door neighbour boy. I was thinking he was doing (inaudible) so I was thinking of doing something to him like ... but I didn't because my mother stopped me, because I kept on going to the house and knocking on the door to try and get them out to tell them 'Look, I'm hearing your voices!' but my mum stopped me, she said 'Just go in.'

Harinder held a firm conviction that his voices were caused by something external to himself. Later in the interview he explains them as a 'djinn' which is able to appear in the form of his neighbour's voice:

Ruth: 'What's a djinn?'

Harinder: 'It's a spirit.'

Ruth: 'A spirit?'

Harinder: 'Yeah, so I was thinking that's my voices that's how they are, I was talking about that (in the group) . I was talking, talking, talking (laughs).'

Ruth: 'Right, can you say a bit more about that? Can you talk about it now, that's OK?'

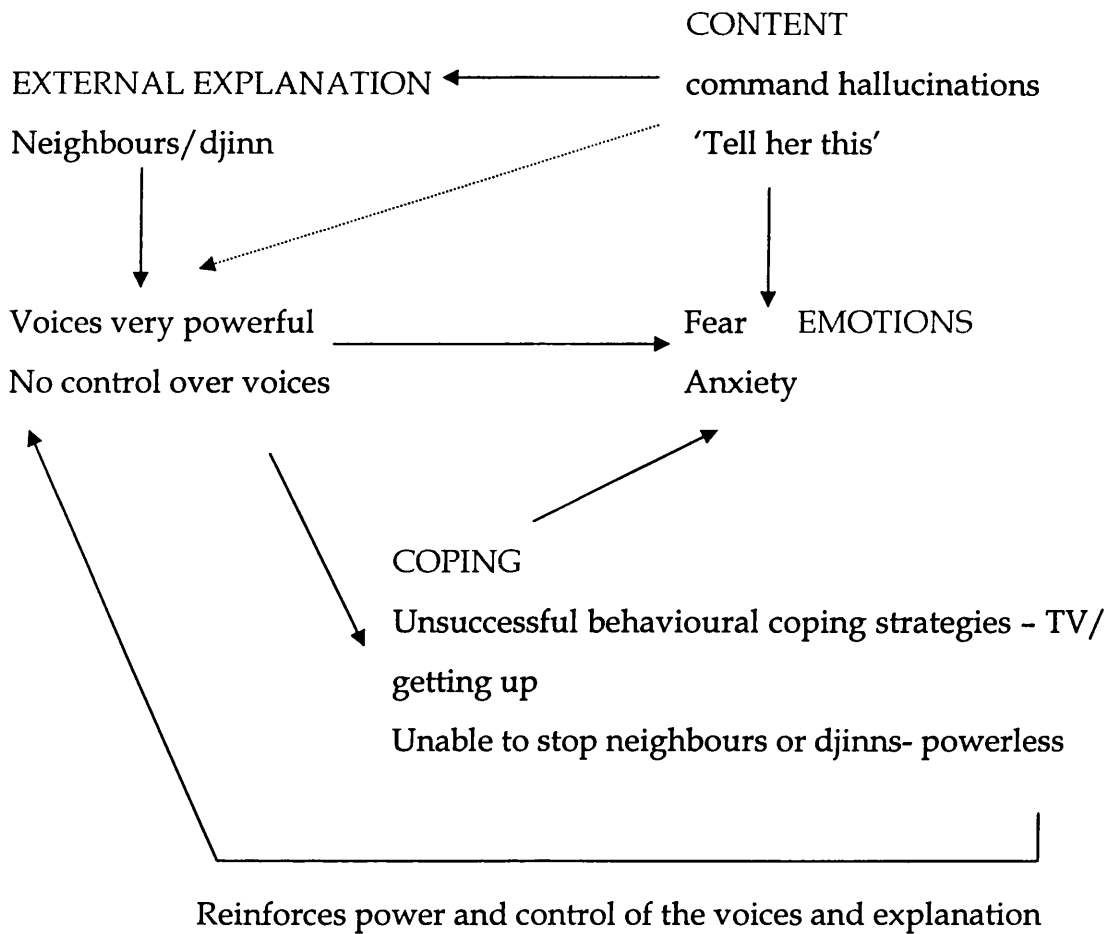
Harinder: 'It's made out of fire, the spirit and it's a belief of Islam and that's what I thought my voices are. That's how they try and get a connection with me maybe, that's only a thought. Maybe its not, maybe it is ...'

Harinder's two explanations for the voices (either neighbours or a spiritual force), both position him as being unable to control them. The voices are understood to be omnipotent, and thus Harinder sees himself as powerless to do anything to stop them. In this context, it is perhaps unsurprising that his coping strategies are unsuccessful. From a clinical perspective, we can surmise that Harinder's preferred explanation is also likely to have reduced the amount of coping strategies that he has attempted (why play, if you can never win?). Similarly, we can reasonably speculate that Harinder's inability

to control or cope with these experiences will have contributed to his emotional distress. In turn, Harinder's lack of coping resources could also be expected to have reinforced both the omnipotence of the voices, and his external explanation for them. Harinder's beliefs about voices, his inability to cope, and his experience of auditory hallucinations themselves, led to emotional distress and anxiety. A vicious cycle is thus created and then maintained.

A personalised model of Harinder's voices is presented in Figure 11, which uses the general model of auditory hallucinations, outlined previously, to map the cyclical relationship between Harinder's explanations for the voices that he heard, his coping strategies, and emotional reactions.

Figure 11 – Heuristic model of Harinder's voices



In contrast to Harinder, Patience believed that the voices were caused by an illness, 'like cancer'. She explained that she had not always thought that way and attributed successful coping to a change in her explanation from external to internal:

Ruth: 'So how did you used to cope when you heard voices?'

Patience: 'Well at first I was a bit quiet, I was just, I used to hear them, they used to scare me, I used to get frightened of them. I thought they were going to hurt me or kill me or something, and then afterwards, I just thought, especially when I started taking medication, when I started taking medication they started getting quieter.'

Ruth: 'Right.'

Patience: 'So it was easier to ignore them, and just to get on and try and ignore them.'

Patience modified her explanation of the voices from people 'going to hurt' or 'kill her' to a medical explanation:

Patience: ' I thought at first that people were talking to me and wanted to hurt me, then afterwards spoke to the doctors ... they said I'm hearing voices and especially taking medication started making them quieter I started to believe it's voices. I'm just hearing voices and not people actually talking to me and wanting to hurt me.'

She suggests that this change in explanation has enabled her to 'ignore' the voices, and to cope more successfully. Prior to the change in belief, it is clear that Patience was very frightened by the experiences of voices and believed that people were out to 'kill' her or 'beat her up'. Interestingly, although she reported that the voices had become quieter since taking medication, the content of the voices remained the same. Thus, we might suggest that it is a cognitive shift in her own explanation which allows Patience to 'get on,' rather than any change in the symptoms themselves:

Patience: ' Not at first, not when you start hearing voices cos you're not sure what's going on or how to deal with it or, like you start to question yourself. Like whether or not you're going mad or if, well just what's going on basically. But after a while, especially after you've seen like, like doctors and stuff and they've reassured you that it's voices that you're hearing, then it's nothing really to be scared of, they can't hurt you. They may say horrible things to you but they can't hurt you.'

Ruth: *'Mmm and do your voices say horrible things to you?'*

Patience: 'Yeah.'

Ruth: *'And how did you learn what you were just telling me about? How did you learn to take that, to take that attitude?'*

Patience: 'I just started to have it, because, speaking to my boyfriend, he used to tell me to just, just ignore them and don't worry about it and things like that.'

Ruth: *'So, you used to talk to your boyfriend about it?'*

Patience: 'Yeah.'

Ruth: *'And how did he react?'*

Patience: 'He didn't react badly. He just, cos at first we didn't know what was going on, I thought people were around me, I thought people were talking to me, I didn't know I was hearing voices. I thought I was hearing people's voices I knew, I thought they, like they wanted to come and beat me up or something, so, then, sorry, what were we saying?'

Ruth: *'I was just saying did- what was his reaction?'*

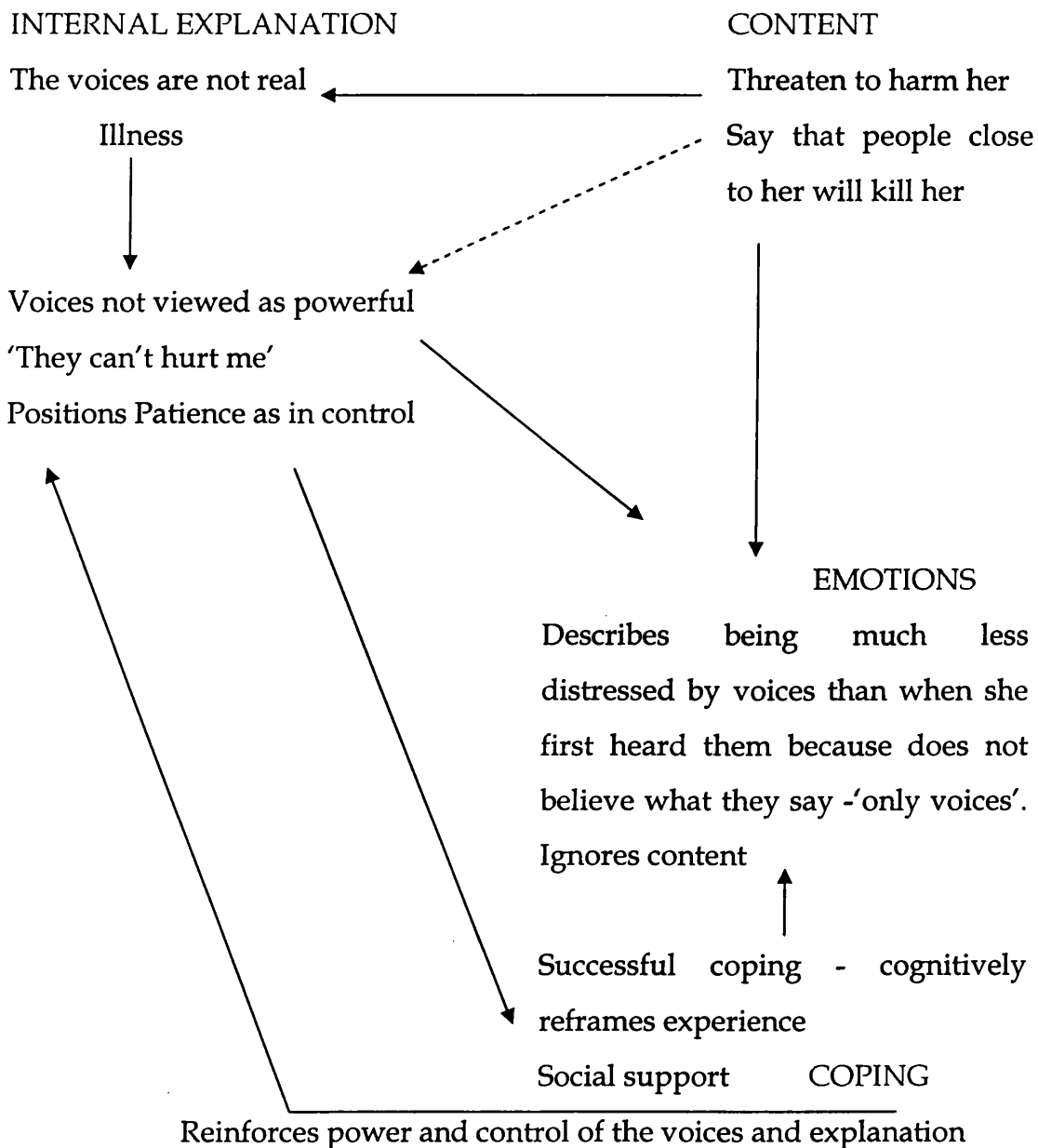
Patience: 'Yeah, he was, like he was just trying to help me get through.'

We can see here that Patience used cognitive strategies and social support as her methods of coping with auditory hallucinations. She was able to reassure herself, when she heard voices, that their content was untrue. She did this by using logical reasoning, some of which can be seen in the extracts given above. Going beyond what Patience says, we might guess that her reasoning process may have looked something like this:

It is voices that I am hearing. They are part of an illness. I have evidence for this because the doctors have said so, and the voices got quieter when I took my medication. Only real people can hurt you: the voices are not real people and therefore they can not do me harm. I will therefore ignore the voices.

Patience talks in the excerpts above and elsewhere in the interview about her social-support network. It appeared that both her boyfriend and close family endorsed an external medical explanation for the voices, and provided support for Patience when she was distressed. A personalised heuristic model of Patience's voices can be seen in Figure 12.

Figure 12 – A heuristic model of Patience's voices



So, we have seen that Patience's experience of hearing voices, and of coping with them, was understood in very different terms to Harinder's. To an external observer, the content of Patience's voices would probably be rated as more distressing than that of Harinder's. However, it appears that Patience's 'internal' beliefs about the origin and power of her voices make their content irrelevant. Patience viewed the voices as 'not real', unable to do

her harm, and therefore was able to cope with them successfully, thus reducing her emotional distress. She reported that previously, when she did not 'know what was going on,' she was extremely distressed and frightened by the auditory hallucinations. The wider social context also appeared to be important for Patience, in that her family and partner were very supportive and reinforced the explanation that the voices are caused by a medical condition. In contrast, Harinder's external explanation actually seems to exacerbate the impact of the content of his voices.

Although I have only presented two personalised models of voices, other participants were observed to fit into these two categories. For example, the following extract from Mark's interview firmly places him in the 'external' explanation category, despite the fact that he 'hears' the voices as *inside* his head:

Mark: 'I think it's a spirit of suicide.'

Ruth: '*A spirit of suicide?*'

Mark: 'Yeah.'

Ruth: '*Can you say a bit more about that?*'

Mark: 'I think it's a spirit that's related to death.'

Ruth: '*What do spirits mean to you?*'

Mark: 'Not real things ... like if there's a spirit in my brain, in my head that speaks to me.'

Ruth: '*Is that how you understand where the voices are coming from?*'

Mark: 'Yeah.'

Ruth: '*A spirit inside you?*'

Mark: 'Yeah.'

Ruth: '*Is it inside or outside you?*'

Mark: 'Inside my head.'

Mark explained the voices as 'a spirit of suicide' which he felt had come to him as a punishment for 'prophesising against the church.' This made him feel guilty, hopeless and depressed. Mark believed that he deserved to hear

the voices, and perceived them as very powerful. Although he understands the voices to be inside his head, they have an external source.

As the interview develops, it emerges that the only coping strategy that Mark is able to describe is to commit suicide. He says 'either I goes or they go and I think that its going to be me'. It appears that Mark viewed both the group and his doctors as failing to remove the voices, which left suicide as his only remaining option. These comments were made by Mark immediately following the treatment session; his depression and desperation appeared unchanged by the therapy, thus highlighting an important limitation of the group. Although Mark reported being 'encouraged' by others who reported learning to cope with voices, his preferred explanation of his own voices and perceptions of their power and control remained unchanged by the group. We can see here that the group's benefits may be limited for young people who have already adopted strong, inflexible and external explanations for their voices. Such explanations may well be connected to the social and cultural context in which onset occurs – as is illustrated by the religious nature of Mark's explanations.

In contrast to Patience's family, Mark's family accept his 'spirit of suicide' explanation and hold a firm conviction that the voices can be understood within a religious - as opposed to medical - framework. This places Mark in a difficult situation, because accepting the internal, medical explanation

offered by the group could help him to cope more successfully with the content, control and power of the voices. However, this explanation would *not* be endorsed within the wider system of his day-to-day life, and would therefore be difficult to maintain outside of the group. It may even be a cause of conflict with his family and church.

During the interviews there were other examples of the need to consider and involve the wider social system surrounding the young person in their treatment. For example, Jocasta suggests that this would be useful for her :

Ruth: 'Is there anything that other people can do to help you? It sounds like you've found a lot of ways of helping yourself, what about is there anything that other people can do? '

Jocasta ' No...well actually, because I go to college I think they should help me cos I can't take too much stress. That's why I will take days out and.... 90% attendance and I think I can't handle doing, things like that right. If a doctor could write me a letter saying what's the problem and stuff like that, that's one of the ways ...'

She recognises that hearing voices, and her inability to tolerate 'stress,' may affect her performance at college, and that liaison between the mental health service and her teachers may be useful in helping them to understand, and be more tolerant of, her problems. At the moment, Jocasta takes control of this situation by taking days off, but she recognises that it would be better if the college was informed of the reasons for this, rather than viewing her as a 'poor attender'. The role of the wider system in therapy will be considered in more detail in the qualitative discussion.

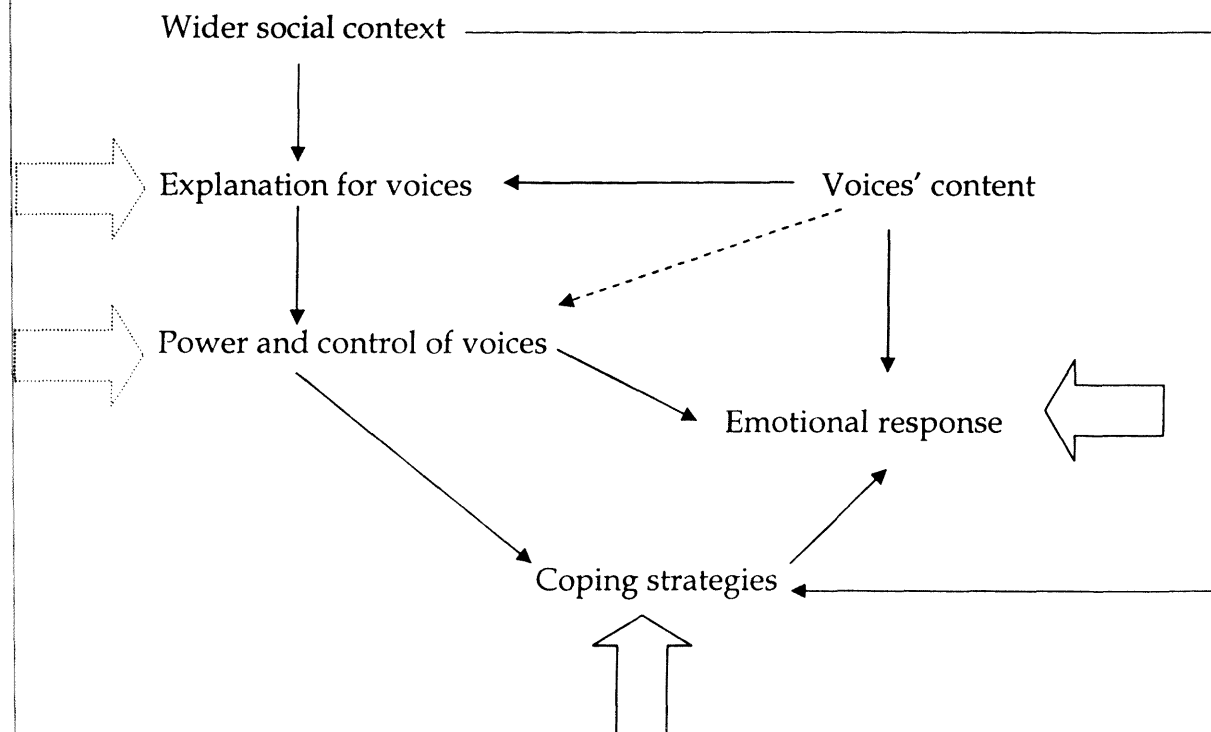
Linking the qualitative data to the treatment protocol

From theme one, we can see that participants report the following benefits from the group:-

- Normalising and de-stigmatising the experience of hearing voices
- Emotional benefits of the above and of 'hope' for the future
- Sharing coping strategies
- Understanding what made voices better and worse
- Thinking about and discussing different explanations

If we plot these perceived benefits onto our model of auditory hallucinations (the block arrows) we can see the areas that participants say the group is effective in targeting (Figure 13). In figure 13 the role of wider social context as described in Theme 2 has also been added.

Figure 13 – Intervention targets



Although explanations for the voices are discussed in the group, this can not be done on a highly individualised basis. This may mean that participants who have a high level of conviction in powerful and malevolent explanations for their auditory hallucinations may not be able to modify them (therefore dotted block arrows are used). This may be particularly problematic if a person's wider support system (for example, family, friends and church) endorses and reinforces their beliefs. The group does not currently target the system surrounding the young person. This may be a limitation, because failure to modify those explanations which are associated with poor coping and negative emotions may limit the effectiveness of those aspects of the group process which aimed to target other issues (i.e. increasing coping and reducing negative emotions). This is clearly illustrated by Mark, who claimed that none of the new coping strategies worked for him, and who remained as distressed as before the group had begun. We might reasonably suppose this to be a result of his strong conviction that the voices are so powerful and uncontrollable that he personally cannot influence their negative impact upon him in any way.

For those with less rigid convictions in an external explanation, there is a greater likelihood of change during the group process, because both beliefs and explanations *are* tackled in the group - even though this does not take place on an individualised basis. All participants should also benefit from the discussions around coping strategies and emotional connections and

responses to auditory hallucinations held within the group. Its success in doing this is clearly illustrated by the accounts of the participants, who list the coping strategies that they have used since beginning the group, and who talk about the group having positive emotional consequences. For example: reducing distress via improving coping, and by normalising and destigmatising the experience of hearing voices, and consequently reducing negative emotions, such as loneliness, isolation and anxiety.

Discussion of Qualitative Data

The qualitative part of this study aimed to explore the young people's experience of the voices group, and to explore its possible effects on their experience of auditory hallucinations. It was hoped that their verbal reports would allow us to reflect on the clinical intervention. A semi-structured interview was undertaken by an independent researcher immediately following the final treatment session, whilst the therapy was still fresh in participants' memories, and the data were analysed using IPA.

Two super-ordinate themes emerged from this analysis. Theme 1, '*The Voices Group As A Place To Explored Shared Experiences*,' was primarily phenomenological, and was grounded firmly in the participants' descriptions of attending the voices group. This theme drew attention to the experiential aspects of therapeutic group, such as its ability to provide an environment in which it was safe to discuss the experience of hearing voices, the emotional and psychological impact of meeting other young people who

also heard voices, the differing roles of participants within the group, and the perceived benefits of the therapy.

In contrast to theme 1, theme 2 took a more interpretive approach to the data. Looking closely at the young people's descriptions of their experiences of auditory hallucinations, relationships were observed between the content of the voices, the participants' preferred explanations for and beliefs about the voices, and their coping strategies and emotional reactions to the voices. These patterns of interaction were interpreted with reference to a psychological, cognitive behavioural framework and a '*Heuristic Model Of Auditory Hallucinations*' was developed. This model was then utilised to look at the differences between the young people's experiences of voices in terms of their explanations for them, and to examine the consequence of this explanation on coping success and emotional distress.

Theme 1 – The Voices Group As A Place To Explore Shared Experiences

A safe place to talk

Phenomenological accounts suggested that the voices group successfully provided a safe place to talk about the very personal experience of hearing voices and that this was something that all eight participants valued. This was a theme that emerged in both of the other previously-cited qualitative investigations of voices groups; with participants stating that they could talk openly without fear of stigma, hospitalisation or rebuke (Chadwick et al., 2000; Jones et al 2002).

De-stigmatisation

In the past, talking about voices was associated with negative consequences for some participants, while others described having to choose their confidants carefully, for fear of stigmatisation. Stigma has been described by service-users as one of the most significant barriers to recovery from mental illness (Smith, 2000). This is because stigma may be internalised by people with mental health problems, and have negative effects on their self-image and coping (Link, Mirotznik and Cullen, 1991). Reduction of the stigma attached to hearing voices, both by psychoeducation provided in the group, and by exposure to peers with auditory hallucinations, can be viewed as a positive effect of the group. This effect appears in the narratives of those attending the group, although this was not tested explicitly by any of the quantitative measures. Stigma has been found to be reduced by exposure to people with mental illness (e.g. Link and Cullen, 1986), and therefore it is likely that exposure to others who hear voices reduces stigmatisation and the extent to which negative-self views are held. In turn, this may have a positive effect on coping and self-esteem. This relationship needs to be explored further, by including quantitative measures of stigma, and exploring their associations with treatment outcomes, in future research.

Normalisation

The young people emphasised the normalising aspect of the group; most of them had never before met a peer who shared their experiences. This can be

related to the primary therapeutic factors of universality, as described by Yalom (1985). Many patients enter therapy thinking that they are the only person with a particular problem. Group-work can quickly reassure them that this is not the case, and patients generally benefit from the catharsis and acceptance which accompanies this universality (Yalom, 1985). Chadwick et al. (2000) suggest that the normalising aspect of groups provides the opportunity to bypass the slow process of normalising and de-stigmatising mental illness that is necessary in individual approaches. Instead the therapist can focus almost immediately on the distressing aspects of the voices. On the basis of the data discussed here, I would agree with this view.

In accordance with other narrative accounts of recovery from psychosis (e.g. Ridgway, 2001), the young people state that they prefer to talk to people who have had similar experiences to themselves, rather than to those who have not. This finding is consistent with reports from previous evaluations of therapeutic groups for people suffering with psychosis. For example, Gledhill et al. (1998) who reports that all clients said that they benefited from discussing their experiences with others and felt less isolated and different following the group. 'Sharing' was also one of the themes that emerged from Jones et al.'s focus group evaluation of a hearing voices group (2001). The comments of the participants in the Jones study resonate with those from our group. For example, Jones et al. quote one participant as saying that, 'It's nice to know someone else is suffering with the same thing as me as though I'm

not alone' (p37). Similarly, the young people in the current study reported that meeting others with similar experiences had positive emotional consequences: for example, reducing 'isolation' and 'loneliness', which are some of the secondary emotional consequences of psychotic illness.

In addition, meeting other people with voices may lead to a change in beliefs about voices. This was illustrated by Patience, for example, who said that she no-longer felt 'crazy' now that she knew that other people had the same problem. This change reduces the threat to psychological integrity (Morrison et al,1998). This should result in a reduction in the distress caused by voices, and may also reduce their frequency by discontinuing the maintenance cycle, in accordance with Morrison et al's model (1998).

Learning from and helping others

The group inevitably contains individuals at different stages of the 'coping-collapse' continuum (Yalom,1985) and participants also benefit from observing the improvement of others. Participants in the current group drew attention to this by suggesting that meeting other people who were less distressed by voices provided them with hope and encouragement. It appears from our data that the mix of inpatients and outpatients, at different stages of recovery, facilitated this aspect of the group.

People who had recovered 'more' also benefited from the group perhaps by being reminded how far they had come. They clearly stated that they enjoyed

the role of being able to share their experiences to help others. All of the young people appeared to value the role, ascribed to them within the group, of 'expert in voices,' which facilitated the process of sharing information on issues such as coping strategies. In therapy groups, the process of giving is as important as receiving. In groups of psychiatric patients, who may feel that they have nothing of value to offer, the opportunity to be of some help to others may serve to boost morale and self-esteem (Yalom, 1985). This certainly seems true of this group of young people. Even those who may be described as 'least well' were able to give positive contributions to the group: for example, in sharing their coping strategies or similar experiences with others, and by being empathic.

Re-integration and socialisation with peers

The group may also help by encouraging a gradual and general re-introduction to peer-socialisation. In the group, this is enabled initially via socialisation with an immediate peer-group of other young people who have had common, life-changing experiences. Psychotic illness is often accompanied by a period of extreme social withdrawal, both because people actively isolate themselves, and because hospitalisation may be required (Ridway, 2001). In addition, it is common for young people who experience psychotic illness to lose contact with their pre-onset social-networks (for example, people at school or college; see Hafner and Nowonty, 1995). The increased level of social support provided by the group is important because social-support has been found to be a predictor of long-term outcome in

psychosis. Often one of the main targets of early intervention is to re-establish social-networks (Browning and Corrigan, 2002). It is particularly promising that some of the young people involved in this project remained in contact with each other after the group-work was completed. In this context, it is obviously important to provide group support to young people, and to do so with peers of a similar age.

The role of the facilitators

As in the study conducted by Chadwick et al. (2000), the participants here commented upon the important role played by the group's facilitators. In particular, the young people recognised the importance of strategies used to let 'everyone have a say' and 'to make everyone feel special'. This appears to have contributed to the young people's developing sense of self-worth. It may also have helped them to (re) develop social skills which may have been disrupted during their initial period of illness, through the use of behavioural techniques, such as reinforcement and modelling, that are useful in preparing the young person for future social situations.

The participants also described the facilitators' use of therapeutic skills, such as socratic questioning and guided discovery, to enable them to try new coping strategies and to think about their experiences in different, more adaptive ways. For example Harinder realises that if he is active he does not hear voices, but that if he sits in a room doing nothing he is distressed by them. As in other studies of individual and group CBT aimed at targeting the

omnipotence of voices, success in modifying beliefs and in asserting a participant's ability to control their experiences is likely to be related to an improvement in mastery and coping with auditory hallucinations, and to reductions in beliefs about the power and control of the voices (Chadwick et al., 1996; Chadwick et al, 2000).

Theme 2 – A heuristic model of auditory hallucinations

Theme 2 moves away from the primary experiential focus of IPA, but does not abandon it. Instead this theme draws upon my contextual, clinical knowledge-base to formulate a series of links between key themes (i.e. explanation, content, coping). These links are first developed within, rather than across transcripts, in order to develop interpretations which are meaningful for each participant. Larkin (2001) suggests that the first stage of an IPA analysis requires a phenomenological emphasis upon experience (which is what I have aimed to achieve with Theme 1), but that a second level of analysis may allow the analyst to draw upon a number of interpretative frameworks. This is both a reflection and a development of Smith's (1996) initial position statement on IPA.

Larkin's work (2001) deals with the experiences of inpatients in a 12-Step group therapy program. He illustrates this interpretive mode of IPA in an extended example which draws together a number of epistemologically-diverse frameworks to produce a unified account of a single interview extract. Among these frameworks is an approach which he terms 'pragmatic

idealism.’ This is driven by “a specific, practical interest in the participant’s account” and the necessity of attempts “to identify the needs of a certain kind of person.” (p. 197) This is the approach which I have taken in developing an account of Theme 2, draws upon relevant theory from clinical and research psychology in an attempt to ‘make sense’ of the participants’ accounts for future, pragmatic and clinical purposes.

From the data in theme two, it is suggested that an ‘internal/external explanation’ dichotomy is useful in helping us to understand both the ability of young people to cope with their experiences, and the intensity of emotional distress caused by the voices. Those with a high conviction that the voices are caused by powerful and uncontrollable external forces may be more distressed and have fewer successful coping strategies than those who believe the voices to be internally generated (by their brain or by an illness, for example). Romme and Escher (1992) state that having an explanatory theory is essential to the development of coping strategies. They recognise that explanations that discourage the individual from seeking mastery over the voices are least useful and are unlikely to enable successful coping (e.g. that the voices are caused by electronic forces, or by a biological problem which can only be cured by medication). On the basis of the data discussed here, it seems fair to propose that those with external interpretations may gain less benefit from the treatment group, because they have little or no belief that they can influence their experiences. They may therefore be less

likely to try to influence the voices, or to succeed in doing so, when encouraged to do so by the group. There is a need for further exploration of those frames of reference which seem to be more and less successful in this respect, as the current research only describes the experiences of eight young people, and therefore may not be generalisable to a larger group.

These findings point to a potential role for individual therapy to follow the group-work, especially when strong external explanations are held, because these do not appear to be successfully modified during the group. However, the group does provide some possible alternative explanations for hearing voices, and also helps to de-stigmatise and normalise the experience. A group prior to individual CBT would facilitate engagement (if the participant is seen by a facilitator) and speed up the process of therapy, which clearly has cost-benefits in services where psychologists and their time are limited. For others with less rigid 'external' beliefs about the source of their voices, it may be that the group itself is enough to modify beliefs and to reduce the distress associated with some beliefs about voices.

The findings of the current study agree with Bentall's (1990) suggestion that an external explanation for voices may reduce distress, whilst recognising that an internal explanation over which a person has no control (e.g. voices are an illness and can only be cured by medicine) may also be maladaptive. In order to reduce the distress caused by voices, the findings reinforce the

necessity of taking beliefs and interpretations into account (Chadwick and Birchwood, 1996) On the basis of the data discussed here, I would have to agree that it is beliefs about the experience of auditory hallucination - rather than the hallucination itself - that is most responsible for the way a person feels or acts in response to hearing voices. However, these beliefs do not seem to be purely about the benevolence or malevolence of the source of the voice, as suggested by Chadwick et al. (1996). They also include beliefs about what it means to hear voices for the individual - such as that they are 'crazy,' or that their 'future is going down the drain'. Beliefs about malevolence, egodystonic benevolence, and about threats to physical and psychological integrity all appear to affect coping capacity and psycho-physiological arousal. This can, in turn, maintain the vicious cycle of auditory hallucinations, according to the reports of the young people in the current study. These data thus provide support for the model proposed by Morrison et al. (1998).

In addition to the explanation held by the young person, the beliefs of those in the young person's immediate social network need to be considered. The data described in the second theme suggest that family members and partners may influence the explanation and beliefs held by the young person, therefore may reinforce either an adaptive or maladaptive explanation. In response to this, a role for systemic work, alongside the young people's voices group is proposed. Family intervention, in conjunction with treatment

as usual, has been demonstrated to significantly decrease relapse rate (APA, 1997). Systemic work in conjunction with the voices group may be necessary to reinforce and maintain the benefits of the group when the young person returns from the group to their family and community. This would be particularly useful in the case of any contexts which may increase distress, by endorsing powerful, uncontrollable explanations for the young person's experiences (as in the cases of Mark and Harinder whose parents believed that voices could be understood in a religious context). However, it may also be useful to consider group sessions for carers, teachers and partners of the young people, as a normal part of the program, to be held in parallel with the young person's voices group (as illustrated by Jocasta who suggested that it would be beneficial to educate her teachers at college about voices).

Many of the young people's parents were keen for their children to attend the groups and expressed great curiosity as to its content. It was clear from meetings with them that they had received little support or information from mental health services about their child's illness. It was also noted that the boyfriends of two participants came along and sat talking in the waiting room whilst the group was held, thus providing informal support for one another. A formal psycho-educational group for members of the young people's social network could easily be run in parallel with the existing group. This may further benefit the young people by enhancing understanding of their difficulties and by reinforcing ways of helping them

to cope. These meetings may also reduce some of the distress and anxiety suffered by carers and partners of young people who suffer from auditory hallucinations.

Theme 2 allows us to reflect on the clinical intervention by mapping the perceived benefits of the group as described by the young people onto the model, thus allowing us examine both the positive aspects and possible shortfalls of the protocol used. In addition to revealing information about the effect of explanation on the process of therapy, it highlights the positive effects that the group has on coping and emotions. It also illuminates the importance of the social context outside of the group, in which the participants' understandings of hearing voices have to be negotiated.

Reflections on the process of qualitative data collection and analysis

The interviews undertaken lasted between twenty and forty minutes. The transcripts were short and it was clear from these that the interviewer had to work hard in order to encourage participants to talk about the therapy group. She used many prompts, and on occasions had to reframe questions in several different ways before getting an answer. Often, only brief or one-word answers were offered. Ruth's persistence in pursuing the research question is clearly visible (see examples of quotes appendix F), and she draws on her clinical and therapeutic skills to gently engage participants in conversation about the group. She is also able to use her knowledge of the voices group to encourage them to say more, by making suggestions. Many

of the techniques used by Ruth are similar to those recommended for use with 'unresponsive and inarticulate' participants by Booth and Booth (1996). Useful questioning techniques from this project, which might complement Booth and Booth's strategies, were documented by Ruth and myself, and are presented in Appendix G.

One serious criticism of qualitative research to date is its tendency to rely on articulate participants, thus limiting the populations with whom it can be effectively used. This is at odds with one of the main aims of qualitative research, which is to allow participants to present their own perspective upon the phenomena being studied (Elliot et al, 1999). In particular, this applies to participants who rarely have the opportunity to be heard. The style of interviewing utilised in the current study deviates substantially from guidelines given in qualitative research texts (e.g. Willig, 2001; Smith et al, 1999) which neglect to include information on data collection methods for use with clinical populations in which communication and comprehension are affected. These text books clearly state that the interviewer's questions should *only* act as triggers to encourage the participant to talk, and that interviews should contain a *small number* of open-ended questions (Willig, 2001). Interviewers are also generally advised to take the stance of a naïve observer, in order to encourage the participant to give as full a description as possible. In the current study, Booth and Booth's advice (1996), that interviewing style must be adapted to the participants' levels of

comprehension and articulation, has proved pertinent. However, I would also agree with Booth and Booth on a further point: such adaptations need not be a barrier to undertaking qualitative research with clinical populations, who may be inarticulate, but still have important things to say.

The data were analysed by myself - a researcher with previous experience of working with young people with psychosis, and a background in clinical psychology. I also had a dual perspective on the data, because I had observed all of the therapy groups. It is important to note that some of my clinical knowledge of the participants, and my observations of the interaction that occurred within the intervention have been utilised in the analysis. In particular this is true for theme two, which is clearly more speculative and interpretive than theme one, and less directly grounded in the interview data. This might be seen as an advantage, because it enabled me to draw upon my 'insider's perspective,' with knowledge of the situation being described by participants, and to incorporate some clinical insights, where relevant. However, this also represents a shift away from the transparency demanded by IPA, and so might also be seen as a disadvantage, in that it does not always allow the reader to see how an interpretation was made. The analyst may also have interpreted interactions during therapy in a different way to the participants themselves.

However, in order to ensure that the analysis of the data was credible and meaningful the analysis was reviewed by a colleague with experience of IPA, who made suggestions and corrections. Minor changes to the analysis were made following these discussions. Verbatim extracts have also been utilised throughout the analysis section, and a representative sample of quotes under each theme and sub-theme are provided in Appendix F, to allow the reader to draw their own conclusions about the meaningfulness of the analysis and the interpretations that have been made.

Comparison with both quantitative and qualitative studies of people with auditory hallucinations suggests that the current analysis has many commonalities with previous research. This suggests that, although this is an in-depth analysis of interview data from a small number of participants, that the findings may be considered - with some caution - to be relevant to other groups of young people with auditory hallucinations.

Conclusion

The opportunity for the young people to have their voices heard and discuss their treatment options is rare, possibly because the young people face 'double exclusion,' in that they may be identified negatively as 'mentally ill,' and also perceived to be 'too young to have a valid opinion and/or know what is good for them'. Currently, little emphasis is placed on psychotherapeutic and psychosocial interventions with this client group. This is unfortunate, because in theme 1 the participants clearly state that the

opportunity to discuss their difficulties with mental health professionals and other young people with similar experiences was highly valued. As we have seen, their interviews suggest a number of positive cognitive, emotional and behavioural consequences resulted from the intervention. The *'Heuristic Model Of Auditory Hallucinations'* developed in theme 2 may be useful in helping us to understand the benefits and the limitations of the treatment. Some additions to the current protocol have been suggested for its future use. These are:

- a group for people in the immediate social network of the young person to be run in parallel to the voices group
- a period of individual therapy immediately following the group for participants with strong convictions in external explanations

In addition, reflections on the process of undertaking qualitative research with young people with psychosis have revealed many differences in comparison to conducting qualitative research with non-clinical populations. It is hoped that the suggestions made here about this process (Appendix G) may be useful to others undertaking qualitative research with similar populations.

CHAPTER 5 – GENERAL DISCUSSION

GENERAL DISCUSSION

Summary and conclusions drawn from both the quantitative and the qualitative data

In the introduction to this project, it was noted that the treatment of young people with recent onset psychosis has been criticised for its over-reliance on a medical-model of treatment. This medical-model is generally 'reactive.' Neuroleptic medication forms the basis of treatment in this model, and crises (such as suicide attempts) typically lead to hospital admissions, which can be very distressing (Birchwood et al, 2000). The early phase of psychosis (i.e. the first three years after onset) is viewed by Eaton et al. (1995) as the 'critical period' for intervention, when the long-term trajectory of psychosis can most successfully be influenced. Those who have criticised the medical-model have therefore suggested that this 'critical period' should be a primary target for more proactive treatment of young people with psychosis. Birchwood et al (2000) argue that this kind of proactive approach should utilise psychotherapeutic methods to reduce the distress caused by psychotic symptoms and to prevent the development of secondary impairments. However, the number of efficacy trials of psychological interventions for treatment of specific psychotic symptoms in adolescence is negligible.

Furthermore, research into psychological therapy for positive psychotic symptoms - and auditory hallucinations, in particular - has suggested that proactive interventions should be made as soon as possible after the initial onset of symptoms, when they may be less treatment-resistant (e.g. Bentall, 1990). Recent research investigating the experiences of children and

adolescents who hear voices has stipulated the necessity of symptom specific, age-appropriate treatment to reduce the distress caused by voices and to prevent the maintenance and exacerbation of these symptoms (Esher and Romme, 2002).

The current study attempted to address the paucity of treatment literature available on psychological interventions for young people with psychosis, by conducting an efficacy trial of group psychological treatment for young people under the age of twenty-one with distressing auditory hallucinations. The activities of the group were structured, in that they followed a seven-week protocol, written with reference to cognitive theories of auditory hallucinations, and drawing upon previously tested adult psychological interventions. In this study, there were two aims. The first was to investigate the utility of the group treatment, and the second was to gain more understanding of the therapy process from the perspective of the participants, in order to reflect on the treatment protocol. A mixed-method approach was taken in order to achieve these aims.

Both the quantitative and qualitative data suggest that the 'young person's voices group' had efficacy and clinical utility. Significant improvements in the experience of auditory hallucinations were demonstrated over the total treatment phase. When interviewed, the young people did not specifically link the experience of being a participant in the group with changes in

symptoms. However, they did clearly articulate the role of the group in helping them to consider their coping strategies (both what was successful, and what made the voices worse). The quantitative data support this by demonstrating a significant increase in coping success over time.

The respondents also talked about the role of the group in normalising and de-stigmatising the experience of hearing voices. Before attending the group, few of the young people had met anyone else who heard voices. They described their pre-group experiences as 'lonely', 'frightening,' and as leading them to question their sanity. The negative emotional consequences of their isolated position were expressed, and it is possible that the opportunity to share experiences within the group accounts for some of the reductions which were observed in anxiety scores.

Morrison (1998) has stressed that the cognitive behavioural treatment of auditory hallucinations must aim to normalise and de-stigmatise the experience as much as possible. In an attempt to put this into practice, the voices group presented an in vivo therapeutic opportunity to discuss issues pertaining to stigma and the normal occurrence of hallucinations. It also created a group of peers, as proof that other 'normal' young people shared this experience. This is intended to reduce the psychological threat of 'hearing voices' (e.g. that it is perceived to be a sign of irrecoverable madness). A perceived threat to psychological integrity may cause emotional

distress, and emotional distress has been found to exacerbate the symptom of auditory hallucinations (Morrison et al, 1998). On this basis, our data suggest that the group can play a role in breaking the vicious circle, which appears to maintain the auditory hallucinations by reducing threat to psychological integrity via normalisation and de-stigmatisation facilitated by group processes.

Following the group treatment, the data show that the young people were engaged in significantly more activities than before the group began. This can be viewed as a positive outcome, particularly as increased activity level appeared to be associated with decreased frequency of auditory hallucinations and distress. The therapists encouraged the young people to try out activities as 'homework' between the groups. These 'behavioural experiments' were encouraged in order to expand the young people's coping repertoires, and to help them to modify their beliefs about their voices. Within the group itself, the therapists utilised psychological questioning techniques to further promote changes in the young people's beliefs about the power and control of their voices. In Harinder's interview, for example, he clearly expresses his appreciation of the therapists' contributions. He understands the therapists' questions to have led him to a change in his own understanding, and thus to have illuminated his own control over the voices, rather than their control over him (i.e. he didn't hear voices when playing football, but he did if he just sat at home listening to them).

The treatment program was based on a number of cognitive behavioural approaches to auditory hallucinations which all aim to change the negative appraisals and beliefs associated with the experience of voices. The quantitative analysis employed here did not find a significant decrease on the BAVQ questionnaire following therapy. However, there was a trend towards a reduction in scores on this scale, and the majority of participants (11/14) described their voices as less powerful following the group intervention. The qualitative data supported this, suggesting that the treatment allowed the young people a valued opportunity to consider their beliefs about voices.

Most importantly, the qualitative data illustrate the critical importance of people's beliefs and explanations for their voices, and this has implications for future therapeutic interventions. It appeared that the voices group had less utility for those people with a strong conviction that the voices were caused by external entities beyond their control (e.g. spirits or electronic forces). These explanations may also have been reinforced by the cultural and religious beliefs of these participants, and by the wider social systems in which they live. Such participants appeared to be less likely to attempt to influence their experience of voices when asked to do so in the group. This finding is consistent with those of Romme and Escher (1993), and with Bentall's model of auditory hallucinations (1990). Both sources suggest that an internal explanation for voices should enhance people's capacity for

coping with them because this offers people the potential to influence their experience of voices. This view appears to be supported by the models developed from the data in this project. The clinical implications of this finding are discussed in the *clinical utility* section below.

The current study supports the view that psychological treatment is a good way of engaging young people with psychosis. All eight participants stated clearly that they valued the group and enjoyed attending. This is consistent with anecdotal reports from previous voices groups for adults with psychosis (e.g. Wykes et al, 1999). The current study proposed two quantitative hypotheses: 1) that significant positive change in auditory hallucinations would occur following treatment, and 2) that the treatment would lead to significant changes in beliefs and secondary disabilities. The quantitative findings clearly supported hypothesis one: a significant reduction in rating of auditory hallucinations occurred following the treatment. In terms of hypothesis 2, some (non- significant) changes in beliefs were found, and significant changes in some areas of secondary disability were noted (reduction in anxiety, increase in coping and activity levels). The results of the qualitative part of the study are consistent with this. The aims of the qualitative investigation were to illuminate the participants' experiences of the treatment, and thus to enable us to reflect on the utility of the therapy. I would argue that these two methodological approaches have complemented one another very effectively in this project. They have

allowed us to ask different kinds of questions of the participants. Thus, whilst the quantitative data can be viewed as operating at a macro-level, the qualitative data acts at micro level, helping us to understand when the therapy worked, and how this occurred - and when it didn't work, and why this might have occurred, also. I would argue that both sets of findings are of equal importance.

Both the qualitative and the quantitative data suggest that this model of group psychological intervention for young people may provide a successful medium for treatment of auditory hallucinations in adolescence and early adult-hood. The need for such a treatment has been identified by previous research (e.g. Escher and Romme, 2002).

Clinical utility of the young peoples' voices groups

All too often, adolescents with psychosis are placed on adult wards or treated in adult services. This can be frightening enough for adults, and we can expect that for younger people, it will only add to their feelings of desperation, isolation and hopelessness. First episodes of psychosis are described as shameful, stigmatising and frightening (Meyer et al, 1999). A current priority of the National Health Service, is to provide acceptable and accessible services for people with recent onset psychosis. The young people's voices group provided a safe environment in which the young people could share their distressing experiences of voices with peers who had similar experiences. The qualitative data clearly demonstrated that the

participants valued this. In addition, young people often lose touch with their social-networks during psychotic illnesses. Social integration is viewed as an important part of treatment of young people with psychosis because it may improve prognosis (Corrigal and Browning, 2002). I feel that the group provided a gradual re-introduction to socialising with peers, and this was illustrated by some of the comments made in the interview data (e.g. that Tracey felt much more talkative following the group).

As in any therapy group, the participants occupied different points on a 'coping-collapse' continuum (Yalom,1985). This was perhaps amplified by the mixed inpatient/outpatient nature of the current group. I would recommend that future groups draw their constituents from similarly mixed origins, because the variability of experiences and coping responses appeared to facilitate the group process. In future, I would also recommend careful consideration of the gender representation in the group. In two of the three groups in the current study, there was only one male client in the group (and the male therapist). One of these participants dropped out after two sessions and the other had a lower than average attendance rate. It may have been that the gender bias made the group more difficult, or less useful, for male participants. Future research or clinical work should aim to include a larger proportion of males in each group, where possible, or else to run all female groups.

There were a low number of participants in each of the groups. I aimed to recruit between six and eight participants per group. However, at no one time were there this many young people, with distressing auditory hallucinations, not responding to medication, in the recruitment area. The groups ran with between three and six participants (following drop out from treatment). From clinical observations made during the groups, I would suggest that groups should never reach less than four participants on any one occasion, and also that groups would need to begin with a minimum of seven participants, in order to account for illness or drop out. Although the groups were clearly beneficial for participants, there are implications for integration with existing clinical services. Perhaps in a smaller geographical area, one group a year could be facilitated, or alternatively, groups could be run across several services. The provision of transport to and from the treatment centre is likely to be a major logistical problem. In the current study, taxis were used, and this was very expensive. This was necessary, however, in order to facilitate participation and to keep the young people safe.

Few adaptations from the adult treatment protocol were necessary for the young people's group. An aide-memoire was introduced at the beginning of each session to facilitate discussion. A more child-centred approach was taken by therapists to encourage people to join in and say more (e.g. asking participants to take turns to write on the flip chart, rather than speaking, if they were shy).

One short-fall in the current protocol was that it failed to address the wider-social context of its participants, which is clearly implicated by the qualitative data collected. This is particularly important if the context to which the young person returns (and 90% of young people with psychosis continue to live with their families) reinforces beliefs about the external and uncontrollable nature of the experience of auditory hallucinations. In the future I would suggest that main members of the young person's social network (e.g. mothers, fathers, siblings, partners or teachers) are invited to attend a number of parallel group sessions. In these sessions, key topics could be discussed: psycho-education about hearing voices, stress-vulnerability models, coping, the role of expressed emotion, and the role of beliefs and appraisals of voices. A family group would also provide a forum in which carers could share their concerns and anxieties with others in a similar position.

Finally, a group therapy appears to provide additional group processes which are of benefit to participants, and which would not be provided in individual CBT. I feel that it is important to have facilitators who are clinical psychologists, or CBT-trained, because they will be more likely to pick up on moments in groups where beliefs can be modified or tested, and which may be missed by less-experienced facilitators. Even with expert therapists the group appears to have benefits in terms of cost and therapist time. For some

young people, it may be that a period of individual therapy will be necessary following the group intervention. However, the young people's group may introduce participants to a process of psychological therapy which will prepare them for individual therapy, and both reduce its duration and increase its effectiveness in doing so.

Methodological considerations and future research implications

The current study utilised a within-subject, waiting-list control design. This is not as powerful as a randomised control design. The study would clearly have benefited from a treatment-as-usual control group, particularly as the young people were not on a stable dose or type of neuroleptic medication. We suggest that this would be the case for any group of young people with psychosis and therefore, in order to conclude that there were benefits of the voices group over and above usual treatment and changes in medication, the treatment group would need to be compared with a non-therapy control of equivalent age and illness duration. The ethical implications of this would need to be carefully considered, however. For example, the control group would need to be offered therapy as soon as the trials were completed. Due to the small number of young people with auditory hallucinations in any one geographical area at any one time, such a trial would also need to be multi-centred.

A longer-term follow up would be recommended in future research, in order to investigate maintenance of treatment effects, or continued improvement.

Due to practical restrictions, a three-month period was used in the current study, which allowed only a short follow-up time. Further improvements on some measures were found at this follow-up point. A later follow-up point would have allowed us to investigate whether these improvements continued, were maintained or reduced over time.

In addition, a larger sample size should be used in future research of this type. This would enable further investigation of the therapeutic process to be undertaken, by looking at associations with outcome by using multiple regression and covariance modelling. In particular, we suggest that a future study could further investigate the role of people's beliefs and level of conviction in their explanation for the voices, and the impact that this may have on the success of therapy.

Issues of measurement also need to be taken into account. The symptom ratings made in the current study were independent (undertaken by researchers who were not directly involved in the therapy), but they were not blind to treatment status as all participants were in the treatment groups. Again, a randomised control trial would eliminate this difficulty because it would be possible to use raters who would be blind to treatment status.

The participants interviewed for the qualitative part of the current study are not typical of the articulate participants usually interviewed in qualitative research. The interviewer had to work hard, and to speak a lot more than is

usual when using a semi-structured interview, in order to prompt participants to respond. In using strategies to promote responses (such as interpretation, reflection and giving a choice of possible responses), it is possible that the interviewer 'put words into the mouths' of the participants. However, this was felt to be a risk worth taking. Certainly, the results are illuminative and clinically relevant, providing important insights into the experience of attending the voices group.

Bearing the interviewer's role in mind, and considering the relative inarticulacy of these participants, and the fact that their views of themselves and the world around them often appear to change dramatically (in some cases) from week to week, it could also be argued that it is equally 'risky' to use IPA with this data. IPA takes an epistemological position which allows it to infer links between what people say and what they experience. This position has been challenged (e.g. Willig, 2000). If the views of adolescents and people with psychosis are more-than-usually prone to change, it becomes even more difficult to infer links between discourse, cognition, emotion and action. There are, however, methodological strategies which could be used in order to reduce this risk in future qualitative research with this participant population. For example, one could meet with the participants following the analysis to present the data and receive their comments about whether it is a fair representation of their position. Alternatively, the participants could be interviewed on more than one occasion, and consistency between subsequent

accounts could be explored. Unfortunately, in this study there was simply not enough time to utilise either of these strategies.

Conclusion

The current study can be viewed as a preliminary study of the efficacy of a young people's voices group. Following a seven-week cognitive-behaviourally-orientated group intervention, significant reductions in the symptom of auditory hallucinations were found. In addition, successful coping significantly increased, anxiety was reduced, and the participants were involved in significantly more activities than before the intervention. These are indicative of good outcome, and findings from the qualitative data support this. Although the current findings are promising, I suggest that further investigation is necessary using a randomised controlled design, in order to provide further evidence that these positive results occur as a function of the psychological intervention rather than as an effect of treatment as usual. However, I am optimistic that this will be the case and propose that further investigation of this kind is warranted because auditory hallucinations did not reduce over the waiting period, only during the intervention phase.

Previous research has specified the necessity of acceptable, non-stigmatising, youth-friendly treatments which provide positive experiences of mental health care, and which increase optimism and hope for the future. Phenomenological data collected during the qualitative part of the current

investigation suggests that the young people who attended the group felt that it fulfilled all of these criteria. The qualitative data also identified important limitations of the current treatment protocol such as failure to involve the young people's close social network, and the need to consider peoples' explanations for their voices in more detail. These issues will need to be addressed in future groups. Although the process of interviewing the young people was not without difficulty, I feel strongly that this should be reframed as a limitation of the method and researcher, rather than as an 'inadequacy' of the participant. The qualitative analysis produced rich and essential information about the group, the treatment process, and its limitations. These would have been lost in a purely quantitative investigation.

The results of the current study are consistent with the view that cognitive behavioural interventions for auditory hallucinations have utility for people at an early stage in their illness. They can enhance coping and go some way towards alleviating the distressing symptom of auditory hallucinations as an adjunct to treatment as usual. A group intervention provides a practical alternative to individual CBT as it is less dependent on expert therapists' time, and it is cost-effective, in that up to eight individuals can be seen at any one time. However, in some cases, attending a group may not be sufficient to reduce distress and individual cognitive behavioural treatment may be necessary as an adjunct following participation in the group. I suggest that

the group intervention used here has additional benefits to individual CBT. For example, it can provide in vivo normalization and de-stigmatisation, it can provide access to a peer support network, and most importantly the young people state that they really enjoyed, and benefited from, meeting with peers with similar experiences to themselves.

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Appendix A- Letters of ethical approval

**Institute of
Psychiatry**

at The Maudsley

**Ethical Committee
(Research)**

Research Ethics Co-ordinator
Margaret M Chambers MSc

Room W109
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel 020 7919 2892
Fax 020 7919 3560
Email m.chambers@iop.kcl.ac.uk

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ETHICAL COMMITTEE (RESEARCH)

26 May, 2000

Prof T Wykes
Dept. of Psychology
Institute of Psychiatry

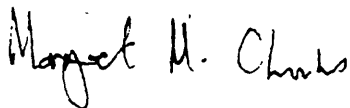
Dear Prof Wykes

**Re: Institute - Nottingham - South Manchester Investigation of Group
Hallucinations Treatment (INSIGHT) (218/98)**

At its meeting on 19 May 2000, the Ethical Committee (Research) approved the amendment to this study, to extend the age range for recruitment, from an ethical point of view.

Please quote Study No. 218/98 in all future correspondence.

Yours sincerely,



Margaret M Chambers
Research Ethics Coordinator

**Institute of
Psychiatry**

Department of Psychology

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CRISP

Centre for Rehabilitation in Severe Psychosis

17 October 2000

Ms. Caroline Tompsett
Lewisham Research Ethics Committee
1st Floor, Research Centre
University Hospital Lewisham
Lewisham High Street
London
SE13 6LH

Dear Ms. Tompsett

**Re: Institute - Nottingham - South Manchester Investigation of Group
Hallucinations Treatment (INSIGHT) (218/98)**

Following our discussion yesterday, we wish to lower the age of entry to the current study to age 15 years. We have permission for this variation from the SLAM ethics Committee (see enclosed letter).

If you require any further details regarding this matter, please do not hesitate to contact me.

Yours sincerely,

Professor Til Wykes
Professor of Psychology and Rehabilitation

Encl:

Head of D Clin Psy Course
Professor David R Hemsley
Ext 3222

Head of Clinical Psychology
Services
Dr Derek Bolton
Ext 3231/3255

PhD Tutor
Dr Richard Brown
Ext 3773/3295

Emeritus Professor of Psychology
Professor Jeffrey A Gray

Appendix B – Staff and participant information leaflets

Staff Information

Group Cognitive Behaviour Therapy for Young People with Persistent Auditory Hallucinations.

As you may be aware, a treatment trial is currently in progress organised by Elizabeth Newton, Trainee Clinical Psychologist and Professor Til Wykes, to try to reduce the distress and frequency of auditory hallucinations. The psychological treatment will be provided in a group and we are now asking clinical teams to refer patients to the trial. The trial is a waiting list control trial so all patients will receive the therapy after a waiting period of six weeks.

The current study has ethical committee permission and is an extension of previous work which has shown that group cognitive therapy can have a positive effect on mental state, insight and auditory hallucinations specifically. We now require individuals to be referred to the new trial who fulfil the following criteria:

- age 21 or under
- who suffer from distressing auditory hallucinations at least once per month
- who are not suffering from an organic disorder which may also contribute to their psychotic experiences

It does not matter what diagnosis the participants have.

In order to estimate the effects of this new psychological treatment we would also like there to be no definite plans to alter medication particularly during the treatment part of the study. However, all decisions about medication will remain with the referring team and will of course be dependent on their clinical judgement.

All participants in the trial will receive four assessments at baseline, at weeks 6 , 12 and at follow-up, week 24. The assessments will consist of insight tests, symptom and mood assessments. Group treatment will be provided for the treatment group for one hour per week for seven weeks at the Maudsley Hospital. The groups will take place in the evening so that they do not interfere with participants usual daily routines.

If you have any queries about the project, or any patients that you feel would be suitable for referral, please contact Elizabeth Newton.

Letters - Young Peoples Voices Project, Centre for Rehabilitation in Severe Psychosis (CRiSP), Clinical Treatment Centre, Maudsley Hospital, Denmark Hill SE5 8AF

Telephone- 07881 622647

Participant Information

NEW PSYCHOLOGICAL THERAPY

GROUP TREATMENT FOR YOUNG PEOPLE WHO HEAR VOICES.

What is the therapy?

Some people find that they hear voices even though they take their medication. Hearing voices can often be distressing, and this can make everyday life more difficult. If you hear voices, then group therapy may help you to learn to control your voices. The therapy is provided in a group format, there are usually six to eight people in a group that also hear voices. They will all be under the age of 21. The therapy runs for one hour per week for seven weeks on Tuesday's from 5-6pm.

How do I get involved in the study?

As this is a new therapy we need to be able to estimate its effectiveness. In order to do this the therapy offered is part of a research trial. If you decide you would like to take part we will make an appointment to see you, so that we can get some information about your experience of hearing voices. If we think we can help you, you will be invited to participate in the next group. Everyone will be asked to take part in further assessments-one just before the therapy begins, one when it ends and a final assessment three months later.

Where will this take place?

Groups will take place in the evening at the Maudsley Hospital. We may be able to help with travel arrangements and expenses.

Will I have to Take part?

No, but we would be very grateful if you did. You are free to withdraw from the therapy or the assessments at any time for any reason. If you decide to do this, this will not affect any treatment that you receive in the future.

If you have any questions or you would like to take part please contact:

Elizabeth Newton on 07881 622647. If you leave a message I will return your call as soon as possible. Send letters to the Clinical Treatment Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AF.

Project Leaders.

Professor Til Wykes
Professor in Clinical Psychology
Institute of Psychiatry.

Elizabeth Newton
Trainee Clinical Psychologist
University College London

Appendix C- Informed consent form

CONSENT FORM

New Treatment for young people who hear voices.

This project is aimed at helping young people who hear voices. The therapy is a psychological therapy provided in a group format. The therapy is for one hour per week, for seven weeks. Should you agree to participate in this study you will receive the therapy after a six week waiting period. In addition to the therapy you will also be required to complete some short assessments.

If you decide to withdraw at any time this will not affect your present or future treatment and health care in any way.

I confirm that I (full name)..... Freely agree to participate in this study. The nature and the purpose of the study have been explained to me and I have also read the information sheet. All my questions regarding this study have been answered to my satisfaction.

I understand that the information obtained through this study is strictly confidential and will be only used for research purposes by the members of the research team. I also understand that participation, non-participation or withdrawal will not affect my treatment in any way.

Date.....Participant.....

Date.....Witness 1.....

Date.....Witness 2.....

For further information contact Professor Til Wykes: 0208 848 0596 or Elizabeth Newton 07881 622647. Clinical Treatment Centre. Maudsley Hospital.

Appendix D

VOICES GROUP PROTOCOL

T. Wykes, P. Hayward and Ann-Marie Parr

Department of Psychology
Institute of Psychiatry
1998

Background

Despite high doses of medication a significant number of people with schizophrenia still experience distressing psychotic symptoms such as auditory hallucinations. These not only affect the quality of their lives but are probably instrumental in maintaining depression and low self esteem. The efficacy of psychological treatment as an adjunct to pharmacotherapy for these patients has been established in a number of randomised controlled trials (e.g. Tarrier et al, 1998; Kuipers et al, 1997). However, because of the dearth of trained therapists and the length of individual treatments these therapies are unlikely to become widely available in the health services in the near future. This manual describes an alternative mode of providing psychological therapy to alleviate the distress of auditory hallucinations which offers the likelihood of more general availability of psychological treatment at a lower cost.

Psychological approaches to the treatment for hallucinations has a long history. Slade and Bentall (1988) identified 40 published clinical studies which included such interventions as the wearing of ear plugs, operant procedures, systematic desensitisation and thought stopping. While many of these treatments have proved beneficial to voice hearers, their effects were short lived. More recently clinicians have investigated novel psychological therapies to try to reduce the disability associated with continuing symptoms. These new approaches have all been developed from Cognitive Behaviour Therapy (CBT) which was originally devised for use with patients with depression. Three recent randomised control trials in the UK have shown that individual CBT can reduce overall symptoms and reduce relapses (Kuipers et al., 1997; Tarrier et al., 1998; Kingdom and Turkington, 1997). However, all these approaches have had their main effect on general measures of psychopathology and except for Tarrier's study, have rarely shown effects on specific measures such as hallucination frequency or the distress associated with hallucinations. In fact Tarrier et al. (1998) have suggested that hallucinations may be more difficult to change than delusions.

Other modern studies have adopted a symptom based approach to treatment and have specifically focused on reducing auditory hallucinations in the long term. Two studies (Tarrier et al., 1990, 1993) have evaluated the efficacy of cognitive behavioural interventions in enhancing patients natural strategies for coping with psychotic symptoms. Coping Strategy Enhancement (CSE) is characterised by the development of coping methods which patients may already possess as well as teaching an array of new coping strategies. Haddock et al (1993) and Bentall et al. (1994) report on a focusing approach to hallucinations. In this form of therapy patients were asked to focus on their voices and to try to reattribute the voices to themselves. Half the participants showed an improvement on this individual therapy.

Group therapy capitalises on the support of all group members which can counter the widespread reports by voice hearers of social isolation (Baker, 1995). Within the group, experiences of voices can be compared allowing the commonalities between individuals to be identified which facilitates reality testing and the re-framing of the experiences. Common factors which increase the frequency and severity of the experiences can be identified which are then demystified. Finally the natural coping strategies of the group members can be shared to encourage the adoption of a wider coping repertoire.

One study has already shown that this form of treatment is feasible and potentially beneficial. Gledhill et al. (1998) in an uncontrolled study reported that all five patients said that they benefited from attending the group although only three showed any changes on the formal measures and no significance tests were carried out. A more recent waiting list controlled study (Wykes et al, 1999) showed that there were effects of group psychological therapy on symptoms, insight and distress as well as increases in the effectiveness of coping strategies adopted. Most of these improvements were still found at follow-up.

The format of the group sessions briefly described here is based on a number of different approaches which have previously been shown to be successful. It draws mainly on the coping strategy enhancement approach (Tarrier et al., 1990; 1993) but also uses therapeutic elements from the normalisation approaches of Romme and Escher (1989) and CBT as formulated by Fowler et al. (1995). The main aim is to

provide people in the group with an opportunity to learn new coping skills, to feel less isolated, and to raise self-esteem.

Introduction to therapy

The voices group is established for people who have strange experiences not shared by others and all sessions are centre around a number of basic underlying principles. From the offset, therapy will focus on what Kingdon & Turkington (1991) called the normalising rationale. It will be emphasised that hearing voices is something that many people experience and that it does not mean that somebody is mad. The idea of a continuum of experience will also be introduced to the sessions. Here, attention will be given to a variety of experiences that may be considered odd or abnormal, such as mysticism. As the course progresses it is suggested that the experience of hearing voices is best viewed as something that can be coped with, using any one of a number of coping strategies. Group members are encouraged to try out different methods of coping with their voices as exercises set as homework. Finally, there is a focus on the improvement of self-esteem, and exercises to achieve such ends are performed.

The first three sessions revolve around engaging clients in a dialogue about their voices and encouraging the exchange of information. This part is particularly important as often the voices suggest to the patients that they should not attend in the future. The therapist must be aware of this possibility and suggest it to the group if it does not get discussed explicitly. A video of the BBC's Horizon programme Hearing Voices is used as a way of presenting other people's descriptions of their voices so that it is possible to start a dialogue of how group members' voices are the same or different from the ones described in the video. The therapist should aid the group to discuss different models of voices. The vulnerability-stress model is the one most easy for group members to accept and the therapist should make sure that each member contributes to this sort of formulation i.e. by indicating instances of different types of stressor being associated with the exacerbation of the voices. Medication is always described by the therapist as providing a protective layer to a vulnerable (or sensitive person) in the context of reframing the group member's contributions.

The therapist must keep an open-minded approach and try not to appear to be supporting one type of model rather than another. Means of coping and its effectiveness is also discussed here. The therapist should take a more active role at this point in drawing together the different methods by categorising them and also suggesting new type.

Some work on coping is carried out in session 4 and homework was set so the beginning of the second phase of treatment this is reviewed and evaluated. Unsuccessful attempts discussed and evaluated but the successful coping methods should be stressed. Emphasis here is on the ability to control the experience and the effect of this mastery on mood. Sessions 4 and 5 concentrate mostly on reinforcing coping attempts and discussing self esteem and stigma. The final session reminds group members what they have discussed during the sessions and draws up a model of the psychotic experience as one which can be interpreted within the stress vulnerability context.

Confidentiality

To help promote trust between the therapist and group members issues of confidentiality should be discussed at an early stage. The therapist should emphasise that he or she will listen to what the group members say, and will encourage people to speak freely in the group. One of the rules of the group should be that no group members should discuss the contributions of other group members outside the group. The therapist should maintain that they also would not discuss anything group members say outside of the group, except in certain circumstances. Exceptional circumstances include the safety or distress of any group member.

In addition the therapist will inform the group member's treatment team of general progress of the therapy.

Equipment

Throughout the group therapy the therapist should take notes of the session onto a **flip chart**. This enables the patients to be focus on the topic as well as acting as a reminder to the group of previous discussions. At the final session the vulnerability stress model is produced by the group members with guided questioning by the therapist.

The self esteem group and the coping strategy group will require some **small file cards** so that information about homework and the self esteem game can be played.

Group 1

- S Introduce selves.
- S Show first half of video (Horizon - Hearing Voices). At the end ask the group to say what is the same or different about their voices.

Issues dealt with:

- X Sharing of information about voices:
 - S when did you begin to hear voices?
 - S how often do you hear your voice(s)?
 - S how long do they usually last?
 - S what kind of things do they say?
 - S are the voices loud or soft?
 - S when do they usually happen - when alone? at night? when not busy?
 - S how do they voices make you feel?
 - S do you know anybody else who has the same experiences?

* EMPHASISE THE SIMILARITIES BETWEEN GROUP MEMBERS EXPERIENCES

- X Introduce 'Normalising Rational:
 - S leaders relate any odd experiences they may have had.
 - S note wide experience of voice hearers in video.
- X Introduce idea of 'Continuum of Experience:
 - S variety of odd or abnormal experience i.e. mysticism, creative inspiration, voice the Gods (as in ancient mythology), etc.

Therapist/s should maintain that the experience of voices is valid and real to the person themselves. Members should realise that although their experience of hearing voices is unique and personal to themselves, they are not the only voice hearers. Some voice hearers are present in society and are not in contact with psychiatric services. Therapists should suggest that for these people it may be that they differ in a number of different ways to people in the group. They may experience less distress or they might feel that the voices are less powerful than theones experienced by the members of the group.

Group 2

- S Show second half of video.

Issues dealt with:

- X Models of psychosis in the video:
S medical model:- chemical imbalance in the brain, need medication to put it right, though it doesn't always work.
S psychological model:- it's all in my head, it isn't real.
S both models combined:- use of medication to reduce vulnerability so that you can talk about the voices.

* ASK GROUP MEMBERS TO COMMENT ON THE ISSUES COVERED IN THE VIDEO

- X Medication:
S is it helpful?
S if so, how is it helpful?
S does it get rid of the voices?
S does it make them more bearable?
- X Other treatments for voices:
S does it help to talk about the voices?
S does it help knowing that others share the same experiences?
- X Epidemiology of voice:
S many people hear voices.
S some people come into contact with psychiatric services.
S others do not receive any kind of help.

Group 3

Issues dealt with:

- X Models of hallucinations:
 - S where do the voices sound like they are coming from:- inside head? outside head? inside and outside?
 - S if they sound like they're coming from outside the head, why can't anybody else hear them?
 - S what do you think the voices are?
 - S what do you think causes the voices? The brain? Spirits? The devil? Other people's thoughts? God? Etc.
 - S

EMPHASISE THIS POINT AND ASK ABOUT BEHAVIOURAL TESTS OF ANY HYPOTHESES

Themes of Explanation

- S Are the voices malevolent or benevolent?
- S Grandiose, persecutory, punishment for past deeds, other peoples voices etc.
- S How powerful are the voices?
- S how should one treat the voices?
- S What might happen if you ignore or disobey them?

Homework - Ask people to carry out a behavioural test of one of their voices.

Group 4

Review the previous session on powerfulness. What did the group members try to do. How did it work? Are there any conclusions to be drawn from these experiences. For instance if a group member was able to resist a voice even if it was for only a limited amount of time does that help other voice hearers to reassess the powerfulness of their own voices.

When are voices at their most powerful? Are there any similar circumstances in which voices are powerful amongst the group members. Some circumstances may be: stressful life events, periods of depression etc.

Methods of coping

Therapist should acknowledge that they realise many group members have been using coping strategies and have been coping with their voices on their own for a long time. Their resourcefulness and capabilities should also be acknowledged.

- S what do you do to cope with the voices?
- S how well do they work?
- S have you tried any of the following strategies?:-
 - < distraction - listening to music, watching television, talking to somebody
 - < increased or decreased stimulation
 - < ignoring the commands of the voices
 - < telling the voices to go away
 - < postponing the voices until a later time in the day
 - < humming or singing to yourself
 - < focusing on the physical characteristics voices - volume, tone, male/female, etc.
 - < thinking about something nice and positive about yourself while you try to ignore the voice.

Acknowledge that coping strategies can require much effort and that different coping strategies are appropriate for different occasions. Sometimes they will work and sometimes they don't.

What are the consistent strategies which work and in what situations do they work. Summarise findings on the flip chart. The strategies which work tend to be those which require some auditory processing and active involvement. Talking to someone is usually more effective than listening to music. Ask the group members to rate each of the strategies and see if there is any consistency..

- X Homework:
- S each patient to try a new strategy for dealing with the voices

WRITE EACH OF THE SELECTED COPING STRATEGIES DOWN ON A FILE CARD FOR THE GROUP MEMBER TO TAKE HOME

Group 5

Issues dealt with:

- X Feed back the success of new strategies:
 - S have new strategies been applied since the last meeting?
 - S if so, what did you do and was it helpful?
 - S do the strategies need modifying?
 - S do different members need to use different methods of coping?

- X Discussion of stigma and labelling:
 - S do you think that your symptoms are due to mental illness?
 - S diagnosis: does it help to know that the voices are due to an illness?
 - S does the fact that you have different experiences make you any worse than others?

- X The role of medication:
 - S is it helpful?
 - S how is it helpful?
 - S Only if the issue arises spontaneously but can suggest the way in which medicine can affect the brain neurochemistry. Liken it to other effects e.g. pain relief. If necessary agree to get more information such as that provided by the drug information service at the Maudsley

- X Recreational drugs, including alcohol:
 - S do these make the voices worse or better?

- X Homework:
 - S each patient to try another new strategy for dealing with the voices and to think of other strategies that may be helpful.

AGAIN WRITE DOWN THE STRATEGIES ON FILE CARDS FOR THE PERSON TO TAKE HOME WITH THEM AS A REMINDER

Group 6

Issues dealt with:

- X Feed back the success of new strategies:
 - S ask patients to describe the coping strategies that they tried.
 - S which ones did you find to be the most helpful?
 - S are there any other coping strategies that you can think of?
 - S encourage the experience of self efficacy

- X Self-esteem:
 - S does your mood affect the experience of voices e.g. frequency severity?
 - S do the voices affect mood i.e. circular maintaining model?
 - S what do you think that other people think about you?
 - S play the *self esteem game* but only if members are willing to comply with ie it will not produce more paranoid ideation. This is based on an educational tool devised for improving self esteem and group cohesion in adolescents. Each group member writes his or her name down on a file card and passes it to the person on their right. This person writes down one positive thing about the person whose name is on the card and then passes it to their right and so on. When the card returns to the person whose name is at the top the game stops. Positive comments can include She is jolly, She is easy to talk to, He always seems cheerful etc. After the game ask how group members now feel. Usually the game produces increased feelings of well being.
 - S discuss how group members can use the cards or think of positive things about themselves, especially when they hear the voices. Group members are encouraged to use the cards to help to improve their mood or to remind themselves about some of their good points .

- X Homework:
 - S try to modify coping strategies using another strategy which has not been tried yet and encourage positive thinking with the use of the file card from the *self esteem game*.
 - S NOTE that a good strategy is humming which seems to work for everyone and requires little effort if group members have difficulty in using any strategy.

Group 7

In this group the model of voices is presented and it is very important for group members to own the model. For this reason the therapist/s should try to use the words which are suggested by the group in this session rather than the words usually used in describing these models in psychological or psychiatric texts.

- X Feed back the success of new strategies:
 - S ask patients to describe the coping strategies that they tried.
 - S which ones did you find to be the most helpful?

- X Discuss the vulnerability-stress model and write it onto the flip chart using the words that group members use. A basic model is presented in the appendix for the therapist to use as a template. Identify with group members the different possible ways of helping to reduce these distressing experiences e.g. medication for biological vulnerability (or psychological sensitivity), improving coping strategies, improving mood, decreasing stress in your life etc. When the model has been produced group members often want to write this onto a piece of paper to keep so ensure that there is enough writing tools available.

- X Discussion of how members experienced the group:
 - S what do you think you have learned?
 - S how many different methods of coping do you now know of? (Perhaps get patients to write down two different coping strategies on index cards which they found the most helpful so that they can remember them more easily when they are experiencing their voices.)
 - S how do you want to deal with the voices in the future?

Appendix - E

Semi-structured interview schedule

Can you describe to me the groups that you went to?

- What happened
- What did people talk about
- What was the experience like
- Who else was in the group
- What were they like
- What was it like talking to other people that also heard voices
- Who lead the group
- What were they like
- Did they say anything that was useful/not useful
- Did the group change as time went on

How did you find the groups that you went to?

- Like/not like
- Useful/ not useful
- Did you learn anything? If so what
- Were there things that could try at home or hospital in between groups. (homework). If so how did this go
- Do you think anything at home or hospital as changed since beginning the group
- Are you doing more of certain activities
- Are you doing less of certain things

Can you tell me a bit about how the voices have been in the last week?

- Frequency
- Friendly/unfriendly
- Content examples
- How many voices
- Who are they m f etc known unknown
- Where do they come from explanations
- Inside/outside
- Loud/quiet
- Very strong or powerful/not

When do they talk to you?

- Are there times when you notice that you hear them more
- Less
- When e.g. night day
- School/ relaxing
- Alone/with others
- Happy/unhappy (other emotions)

What sort of things have you been doing lately when you hear voices?

- Is it easy to ignore them or do you have to listen to them
- Can you make them talk to you/go away
- Have you got ways of blocking them out/ making them go
- What activities make them better/worse
- Do you talk to them If yes what sort of things do you say
- Do they ever upset annoy you? When, examples
- Do they interfere with things that you are doing. When examples what do you do?
- Do you take medicine what effect does this have if any
- Are there things that other people can do to help? What?

Appendix F – QUOTES TO ILLUSTRATE EACH THEME AND SUB THEME

Theme 1 - The Voices Group As A Place To Explore Shared Experiences

(please note that line numbers represent the line numbers on the original transcripts and that all names and identifying information has been replaced in these excerpts)

Normalising and De-stigmatising

MARK

Lines 63-93

RUTH : was there anyone else you talked to about it

MARK: no

RUTH: not family or friends...

MARK: no

RUTH: so you were saying that when you came to the group you hadn't really discussed the kind of issues that you talked about before with anyone

MARK: no

RUTH: were they helpful to talk to about them

MARK: (yawns) yeah

RUTH: you look tired...was it helpful to talk

MARK: yeah

RUTH: why was it helpful to talk

MARK: because I was talking to people who have similar experiences to myself, so it was quite helpful to understand and see the similarities between the cases, which was quite remarkable how similar it was and how the voices started...most people who heard the voices starting said they felt suicidal. When I heard my voices, um, I wasn't feeling suicidal although when I before I jumped into the Thames, I jumped into the Thames, I heard the voices telling me to do it

Lines 406-419

RUTH: 'Are you glad that you came along to the group?'

MARK: 'Yeah.'

RUTH: 'Yeah? Why's that?'

MARK: 'Cos I met people who had been through the same thing as me.'

RUTH: 'and was that a good thing?'

MARK: 'That was encouraging.'

PATIENCE

Lines 145-160

RUTH: and was there anything that you learned from the group that you didn't know before, do you think

PATIENCE: just that there are more people . of my age group have this problem, I'm not the only person that's got this problem, so I don't have to feel like I'm crazy or anything like that

RUTH: is that how you felt before

PATIENCE: yeah, a bit [pauses] yeah, other people's got my problem, it's not, it's not...

RUTH: yeah. It's not just something that you, it's not just you, it's other people, and other people of your age as well

PATIENCE: yeah

RUTH: 'And what about in the group, talking to people in the group, did that help?'

PATIENCE: 'Yeah that helped a lot, cos you got to know people who was, who had the same problems as you and you can just, like Jocasta, I have made a friend like, who's, like who's been through the same thing as me and she's just cool with it.'

ANGELO

Lines 50-67

RUTH: so you've been feeling very depressed before

ANGELO: yeah

RUTH: how would you describe that feeling?

ANGELO: sad feeling, feeling bad

RUTH: all the time?

ANGELO: yeah, when it comes

RUTH: but that's got a bit better since you've been coming to the group?

ANGELO: yeah

RUTH: do you think it's anything to do with coming to the group?

ANGELO: yeah

RUTH: what do you think has helped?

ANGELO: the social support in this group

RUTH: in the group as well, so being able to talk to other people. Is it about talking to other people who have had similar experiences?

ANGELO: yeah

RUTH: why's that helpful do you think?

ANGELO: it helps you to realise your problem

JOCASTA

Lines 33-45

RUTH: what kind of things did you say about your voices?

JOCASTA: about what they did, and what they did to me, and how I felt and I asked if anybody else feel what I did and all stuff like that

RUTH: and did you find that other people had been through the same kind of things?

JOCASTA: yeah, it helped me

RUTH: that was helpful, to know that people had had similar experiences

JOCASTA: yeah

RUTH: and, and did you learn ways of sort of coping better with the voices?

JOCASTA: yeah, well I knew them already

RUTH: right, what kind of things did you know already?

JOCASTA: to..... or to read a book or watch telly or listen to music, I knew to do that stuff already

RUTH: how did you know that.. did you work it out for yourself

JOCASTA: yeah

RUTH: so they were things you'd found out already to do

JOCASTA: yeah

RUTH: and then you found that in the group that's what you were talking about

JOCASTA: yeah

RUTH: did you learn anything new, anything that you didn't know?

JOCASTA: not really, no

RUTH: was that disappointing, were you hoping to learn new things?

JOCASTA: no, cos I got to meet people like me

RUTH: had you not met many people who heard voices like you

JOCASTA: no, never

A safe place to talk

CHIDI

Lines 164-175

RUTH: do you talk to anyone about them?

CHIDI: in the old hospital called T I did, a nurse called E

RUTH: when you were in hospital

CHIDI: yeah

RUTH: you talked to her?

CHIDI: yeah

RUTH: and did that help

CHIDI: little bit, yeah

RUTH: and why don't you talk to anyone else?

CHIDI: a bit private really

RUTH: right, you want to keep ... (inaudible)

CHIDI: yep

JOCASTA

Lines 73-98

RUTH: was that disappointing, were you hoping to learn new things?

JOCASTA: no, cos I got to meet people like me

RUTH: had you not met many people who heard voices like you

JOCASTA: no, never

RUTH: never, really, that was the first time

JOCASTA: yeah

RUTH: so I was just wondering how it felt before when you didn't know people who heard voices

JOCASTA: it felt lonely and. ..different

RUTH: did you have people you could talk to, was there anyone you could talk to?

JOCASTA: yeah, my Mum, but she didn't, she hasn't... she didn't hear voices before

RUTH: so she didn't really understand

JOCASTA: she understand, but she didn't ...

PATIENCE

Lines 145-160

RUTH: 'Was there anything that you learned from the group that you didn't know before, do you think?'

PATIENCE: 'Just that there are more people ... of my age group have this problem. I'm not the only person that's got this problem, so I don't have to feel like I'm crazy or anything like that.'

RUTH: 'Is that how you felt before?'

PATIENCE: 'Yeah a bit ... yeah, other people's got my problem its not just ...'

RUTH: 'Yeah. Its not just something that you, its not just you, it's other people and other people of your age as well.'

PATIENCE: 'Yeah.'

Learning from and helping others

JOCASTA

Lines 69- 72

RUTH: 'And did you learn ways of sort of coping with the voices?'

Jocasta: 'Yeah, well I knew them already.'

RUTH: 'Right what kind of things did you know already?'

JOCASTA : 'To (inaudible) or to read a book or watch telly or listen to music, I knew to do that stuff already.'

RUTH: did you learn anything new, anything that you didn't know?

JOCASTA: not really, no

RUTH: was that disappointing, were you hoping to learn new things?

JOCASTA: no, cos I got to meet people like me

Line 388

JOCASTA: 'It was good because you got to meet people like yourself... and that's it, and you went over your strategies and stuff like that and you could help each other and stuff like that.'

PATIENCE

Lines 268-296

PATIENCE: no, it's been quite good coming the group and just speaking to other people and hearing some other people of my age with the problem, something else, yeah, it's been good

RUTH: do you think you were expecting more from the group

PATIENCE: no I wasn't expecting more, no, not really, I know.. believe that you have to help your, you have to believe in yourself to help you and change things that's going on in your life, you can't really just speak to people and it changes but it can help you, their views and ideas can help you come to like different decisions on how to change yourself or what to do, or what not to do

RUTH: so do you think other people can help?

PATIENCE: yeah

RUTH: is there anything particular you think other people can do, maybe outside the group

PATIENCE: just talk about their experiences and their coping strategies and how they try to help them and what they believe in now and like how things have changed from how they were to when they first started hearing voices to how they are now

RUTH: hearing people's stories, that helps

PATIENCE: yeah

RUTH: sharing things

PATIENCE: yeah

Lines 37-45

PATIENCE: 'Um, well, um, I talked about um, cos like Mark was saying about how he felt like killing himself, he felt that there was nothing to live for and I tried to explain to him that you shouldn't let the voices ruin your life. You shouldn't let the voices affect your life in a way where you can't deal with things or go places or have a normal life, just live like everybody else. Cos you should just try and just ignore them or just think of it as if you have an illness like cancer or some thing and that you should just try your best to overcome it and just aim to do as much as you can with your life.'

ANGELO

Lines 9-27

ANGELO: 'Yeah, it was interesting and it was also about um, we were discussing about what we were going through and how we could cope with our voices.'

RUTH: 'What was it like talking to other people who hear voices, finding out how they cope?'

ANGELO: 'They put up informations on what they could do to cope with the voices and we shared each other's ideas.'

RUTH: 'So did you feel that you learnt anything from talking and sharing experiences?'

ANGELO: 'A lot of the time I felt like what they were saying I knew about it already, cos we were talking about hobbies and interests and how many voices we hear, and what were the voices saying, um but I also learnt more things than what I came in with.'

RUTH: 'What things did you learn , can you remember any of them?'

ANGELO: 'That um, that um, how to cope with the voices like social support and (interruption) '

RUTH: 'Sorry Angelo can you remember what you were saying?'

ANGELO: 'Yeah um, that I learnt, um, that's it, about how to cope with the voices, hobbies and interests and talking about it.'

Lines 264-278

RUTH: and are you aware of the times when they're better and they're worse

ANGELO: yeah

RUTH: and what do you think, what makes them better?

ANGELO: when they're not there

RUTH: when they're not there.. what makes them go away, can you make them go away yourself?

ANGELO: yeah

RUTH: how do you do that

ANGELO: it happens, that's all

RUTH: how does it happen, what do you do to make them go away?

ANGELO: go to school, play football, watch a video, watch a film, try to concentrate, sleep

RUTH: when you're doing different things, really

ANGELO: yeah

RUTH: is that something that you've learned from coming to the group?

ANGELO: yeah

HARINDER

Lines 10-15

HARINDER: they asked us a lot of questions, what times are they worse, what times are they good, what makes them go away, what makes them more.. I said playing football helps, riding my bike helps, listening to music helps, watching video helps, talking to someone helps

CHIDI

Lines 12-30

RUTH: 'What kind of things did people say about how they avoided the voices?'

CHIDI: 'Watching TV, playing football.'

RUTH: 'And what things did you say?'

CHIDI: 'Watching TV.'

RUTH: 'But not playing football!'

CHIDI: 'No.'

RUTH: 'Is there anything else that you do?'

CHIDI: 'Listen to some music.'

RUTH: 'Does that make the voices go away?'

CHIDI: 'Watching TV does.'

RUTH: 'Does that make them go away completely?'

CHIDI: 'Yeah.'

RUTH: 'And what about listening to music?'

CHIDI: 'Yeah, that works.'

RUTH: 'Do you have any other ways?'

CHIDI: 'No.'

RUTH: 'Maybe you learnt, did you learn from the group any new ways of helping the voices to go away?'

CHIDI: 'No.'

MARK

Lines 281-291

RUTH: 'Did you sort of try things at home?'

MARK: 'Yeah, I tried singing.'

RUTH: 'Singing?'

MARK: 'And um...'

RUTH: 'Did that work?'

MARK: 'Not really.'

LEONIE

Lines 155-179

RUTH: well we'll try and just do this quite quickly... so you learned things that you could try at home, were there things that you tried at home to do

LEONIE: listen to music, pray, do cooking or watch TV, that sort of thing

RUTH: oh right, was that all new things

LEONIE: go shopping, go outside, you know

RUTH: right, so lots of different things

LEONIE: I don't hear voices when I'm outside.... I don't know, man

RUTH: more inside when you hear them

LEONIE: yeah

RUTH: is that more when your on your own than with other people

LEONIE: when I'm inside a place I hear voices less/worse, so long as I'm...

RUTH: right. So, outside is worse, is that what you're saying, you hear voices more?

LEONIE: ...I don't know...can I please go now

Lines 31-60

RUTH: what did you talk about in the group

LEONIE: um me, um , well the voices, how you can get the voices, all that stuff

RUTH: right.. did you learn anything

LEONIE: yeah, yeah

RUTH: yeah, what did you learn

LEONIE: um, talk to the voices, ignore them and all that stuff

RUTH: you learned to ignore them

LEONIE: yeah

RUTH: was that something you didn't do before

LEONIE: no, I always talk to them a lot

RUTH: yeah, you talked to them

LEONIE: I talk to them sometimes, lucky they have stopped

RUTH: you don't like talking to the voices

LEONIE: no

The role of the facilitators

JOCASTA

Lines 401-453

RUTH: was there anything particular that the group leaders did that you thought was useful?

JOCASTA: well, made us feel special individually

RUTH: right

JOCASTA: made us all get our voice heard and stuff like that, made us feel all important

RUTH: are you somebody who's quite good at talking in groups?

JOCASTA: um, yeah, I'm quiet most times, but I like to talk because I want to talk about it so I did talk a lot about it

RUTH: and they gave you the opportunity to do that

JOCASTA: yeah

RUTH: right, and that felt good

JOCASTA: yeah

RUTH: how did they make you feel special

JOCASTA: like, we all got to talk about, say our views

RUTH: and they listened

JOCASTA: and they wrote it down on the board stuff like that

RUTH: did other people in the group listen to each other as well?

JOCASTA: yeah

RUTH: was that something that the leaders had to help you with, to listen to each other, sometimes

JOCASTA: yeah

RUTH: why do you think you needed help with that?

JOCASTA: cos some people just talk over other people

RUTH: right

JOCASTA: cos they don't know any better, but the leaders will help

HARINDER

Lines 29-46

RUTH: what about the people who were running the group.., what were they like

HARINDER: yeah they were all right, yeah

RUTH: what kind of things did they say?

HARINDER: good things

RUTH: good things? What good things?

HARINDER: well questions, like, like I said, about the voices

RUTH: mmm, so they were good questions were they?

HARINDER: yeah

RUTH: why were they good questions?

HARINDER: because, I mean, I could see what helped me and what didn't help me

RUTH: in terms of..

HARINDER: what made the voices, what made me stop hearing voices and what didn't stop me from hearing voices

RUTH: right

HARINDER: so now I can see why playing football, watching TV, going out, helps, but if I just sit all alone and keep on listening to my voices it's not going to help

TRACEY

Lines 195-207

RUTH: yeah, you think coming to the group has helped you to feel better about yourself?

TRACEY: yeah, and every time I leave here I feel good about myself

RUTH: do you know why that is?

TRACEY: because you're doctors and you help us

RUTH: because of the doctors

TRACEY: yeah

RUTH: what about the people, the other young people in the group? Does it help talking to them as well?

TRACEY: yeah

RUTH: what helped, talking to the other young people in the group? I know you said that you found you had things in common, didn't you, was it with Patience

TRACEY: yeah

RUTH: do you think that was helpful yeah?... did it make you feel differently about yourself.. was that one of the things that made you feel better about yourself

TRACEY: yeah

RUTH: you're not sure

RUTH: was there anything about the group that was not helpful?

TRACEY: no

RUTH: anything you didn't like about it?

TRACEY: no

RUTH: or anything that you would like to have done or found out more about that wasn't included in the group?

TRACEY: no

RUTH: can you think of anything?

TRACEY: no

RUTH: so what was the best thing about it for you? What was the best thing about the group that you'll take away from it?

TRACEY: I'm not sure

RUTH: I was just thinking that you said you felt, every time you went away from the group you felt a lot better about yourself – was that a good thing?

TRACEY: yeah

RUTH: yeah

TRACEY: every time I walked away I felt better about myself, so, yeah, that made me feel good and I feel more talkative when I walk away

RUTH: right.. so, you don't always feel talkative.. is that right?

TRACEY: no

TRACEY: 'Yeah, because I had a breakdown, a breakdown.'

RUTH: 'Yeah? What happened when you had a breakdown?'

TRACEY: 'I stopped talking for a long time.'

RUTH: 'Completely?'

TRACEY: 'Completely, and I still feel its hard now...I felt talkative when I walk away(from the group)'

RUTH: 'Mm is that a big difference?'

TRACEY: 'It was good meeting in the groups because you talk to them and you get to commu- like communicate with them and meeting with them and communicating with them and its good. '

RUTH: 'And did you feel that the doctors listened to you as well and'

TRACEY (interrupts): 'Yeah, they listened to me.'

PATIENCE

Lines 134-143

PATIENCE: 'They (the facilitators) made sure like everyone like had a chance to speak and everyone got their point across.'

RUTH: 'Do you think that was important?'

PATIENCE: 'Yeah.'

RUTH: 'That everyone had a chance to talk?'

PATIENCE: 'Yeah.'

Theme 2 – A Heuristic Model Of Auditory Hallucinations

Examples of explanations

HARINDER

Lines 156-244

HARINDER: I don't know, I remember talking about djinns

RUTH: about djinns – what's a djinn?

HARINDER: it's a spirit

RUTH: a spirit?

HARINDER: yeah, so I was thinking that's my voices, that's how they are, I was talking about that, I was talking, talking, talking (laughs)

RUTH: right, can you say a bit more about that – you can talk about it now, that's OK

HARINDER: It's made out of fire, the spirit, and it's a belief of Islam and that's what I thought my voices are, that's how they try to get a connection with me maybe, that's only a thought.... Maybe it's not, maybe it is.. trying to get a connection with me healers, people that heal people, I might become one of those

RUTH: you're thinking that you might become one of those

HARINDER: maybe

RUTH: how do you think that would help... would that be to help other people or to help yourself

HARINDER: yeah, that would be to help me

RUTH: Right... so you're saying that a djinn is something that's made out of fire, and would it be inside you or outside you?

HARINDER: No, the voices aren't inside me, but well, it's not inside me but it's talking through me, so when I stop talking, when I'm just breathing, I can hear it there on my breath.....

RUTH: and what does that feel like

HARINDER: well, there was a time I felt really scared, I didn't go to sleep that night, I stayed awake all night, then it was morning, I was tired, I couldn't lay down on the bed, I had to get up, I was so.. the anxiety, I was feeling so, so mad, the anxiety was getting really worse and so I had to get up and go downstairs and sit down and watch TV so I did that and my sister came downstairs and she went to work and the TV wasn't on and I was just sitting down and looking at the garden and I could feel something behind me and it was one of the voices that came and actually put his fingers on my back, right next to me

RUTH: touching you

HARINDER: yeah and telling me, say that thing to her, say that thing to her, say that thing to her, say that thing to her

RUTH: right, and what was the thing that they wanted you to say

HARINDER: I don't know, that's all they said, that's all, well, the voice that I was hearing sounded like my next door neighbours, next door neighbour boy, I was thinking he was doing... so I was thinking of doing something to him like... But I didn't, because my mother stopped me, because I kept on going to the house and knocking on the door to try and get them out to tell them Look I'm hearing your voices, but my mum stopped me, she said just go in..

RUTH: so can you tell me a bit more about you said that a djinn is a belief of Islam, can you say a bit more about that – are they seen to be good, bad, are they different?

HARINDER: no there are bad ones like there are good ones, like us people, there are bad people and good people, there's people that are ... really bad, that you can't actually talk to they'll just tell you off, there are people that are so kind that, I don't know, they do a lot of things really kind, it's like that, there's good ones, there's bad ones, they can change and do anything they want, turn into a dog, into a cat, into a mouse, into a rat, into an insect, into a human being

RUTH: right, right. And where do they come from, djinns?

HARINDER: they're a creation from God, they're another best creation that he created, they're like the second, so they're like, they're supposed to .. (stops) ..yeah they can change into anything and, there are people that have got them

RUTH: inside them

HARINDER: yeah, they can call them, they can appear inside them but they can't see them, you can ask them anything and they just can tell you the future, they can tell you what's happened to you, what's going to happen to you, things like that, they can help you with, your problems, they can help you with that.. but not if it's a case of doctors, then they can't help you

RUTH: so are some people seen to have good djinns and other people have bad ones

HARINDER: yep, yep

RUTH: and which do think your djinn might be?

HARINDER: because.... You have to pray five times a day if you have a good one, but they will pray five times if they are good one

RUTH: that's an islamic belief?

HARINDER: 20 times or 30 times but that's the five times is the main prayers that you have to do

RUTH: what do you have to pray for?

HARINDER: to..pray for, pray for heaven and my ones just talk, they don't give me.. or nothing, just talk, like I said just repeat the words

Lines 260-287

RUTH: And how have the voices been in the last week, can you tell me a bit
250about that?

HARINDER: I could feel one actually in.. I show you, that's how it's been actually,
throwing air at me, like it's been actually blowing at me

RUTH: it's been blowing at you?

HARINDER: yeah, when I've gone to sleep, half asleep

RUTH: so you can feel air on your face?

HARINDER: yes (smiles)

RUTH: right

HARINDER: and..

RUTH: (interrupts)hot or cold?

HARINDER: it's cold, so, sometimes on my face, sometimes on there, sometimes
on my head, like yesterday I couldn't feel no air, so I looked up and I couldn't feel it, I
could feel it all over my face then, because they were actually blowing my..don't
know who it is or what it is, maybe the window, I don't know, because I'm close to
the window, might be hole, might be coming through the hole, maybe I don't know

RUTH: mm, so that was in the last few days

HARINDER: yeah, I've been getting this, but I don't know what it is, maybe whispers

RUTH: (interrupts) but not voices?

HARINDER: and the voices are, aren't that loud, they're more slow, more calm,
that's after I started taking the medicines.

RUTH: right, and how long have you been taking those?

HARINDER: for a couple of months now

RUTH: yeah, and then are they still repeating what you're saying

HARINDER: yeah

RUTH: and do they repeat what you're saying in different, I mean does it sound
exactly like you just said, or do they sometimes sound, I don't know, angry, or..

HARINDER: yeah

RUTH: or are they ever shouting?

HARINDER: they say ... things like

RUTH: so why do you think they're repeating , why do you think that's happening,
how do you explain it to yourself?

HARINDER: I used to get really angry before and I think that's what caused the voices.

RUTH: because you were getting very angry?

HARINDER: I used to get really angry ...

RUTH: who did you get angry with

HARINDER: my family

MARK

Lines 118-143

MARK: I think it's a spirit of suicide

RUTH: a spirit of suicide

MARK: yeah

RUTH: can you say a bit more about that

MARK: I think it's a spirit that's related to death

RUTH: mm, what do spirits mean to you

MARK: not real things...like if there's a spirit in my brain, in my head which speaks to me

RUTH: is that how you understand where the voices are coming from

MARK: yeah

RUTH: a spirit inside you

MARK: yeah

RUTH: is it inside you, or outside you

MARK: inside my head

Lines 359-360

MARK: this is my punishment because I prophesied against the churches.. this is my punishment...

JOCASTA

Lines 123-165

RUTH: what kind of things would you like to have heard from a doctor

JOCASTA: what I want to hear, they can't tell me, how it happens

RUTH: that's what you'd like to know really

JOCASTA: yeah

RUTH: sort of why it happens in the first place

JOCASTA: yeah

RUTH: right, so maybe that's still something you'd like to find out

JOCASTA: yeah

RUTH: but you were saying you don't think they could tell you that anyway

JOCASTA: yeah

RUTH: do you think that's something that nobody knows then

JOCASTA: yeah

RUTH: really... have you got any idea why it happened, have you got your own explanation

JOCASTA: umm.. I don't know

RUTH: you don't know, is that something you think about quite a lot still

JOCASTA: no, just get on with it

RUTH: did you think about it a lot before, when it first started?

JOCASTA: yeah

RUTH: but not so much now

JOCASTA: yeah

RUTH: so you were saying you just get over it.. what does that mean?

JOCASTA: like, don't bother think about, just think about something else, do something else, what you want, so your mind's on different things

Lines 192-213

RUTH: have you got any idea, if there's anything in particular that has made them..

JOCASTA: maybe stress

RUTH: what, less stress, or more stress?

JOCASTA: I mean, stress made them come

RUTH: right, I see

JOCASTA: and less stress made them leave

RUTH: does that make sense if you think about what's happened to you in the last year or so, can you see that when you were hearing voices more you felt there were stressful things going on

JOCASTA: yeah

RUTH: and now not so much

JOCASTA: mm

PATIENCE

Lines 240-245

PATIENCE: no, I thought at first that people were talking to me and wanting to hurt me then afterwards the doctors, spoke to the doctors and... I'm hearing voices and especially taking medication started making them quieter I started to believe it's voices, I'm just hearing voices and not people actually talking to me and wanting to hurt me

Examples of content

HARINDER

Lines 249-265

RUTH: And how have the voices been in the last week, can you tell me a bit about that?

HARINDER: I could feel one actually in.. I show you, that's how it's been actually, throwing air at me, like it's been actually blowing at me

RUTH: it's been blowing at you?

HARINDER: yeah, when I've gone to sleep, half asleep

RUTH: so you can feel air on your face?

HARINDER: yes (smiles)

RUTH: right

HARINDER: and..

RUTH: (interrupts) hot or cold?

HARINDER: it's cold, so, sometimes on my face, sometimes on there, sometimes on my head, like yesterday I couldn't feel no air, so I looked up and I couldn't feel it, I could feel it all over my face then, because they were actually blowing my... don't know who it is or what it is, maybe the window, I don't know, because I'm close to the window, might be hole, might be coming through the hole, maybe I don't know

RUTH: mm, so that was in the last few days

HARINDER: yeah, I've been getting this, but I don't know what it is, maybe whispers

RUTH: (interrupts) but not voices?

yourself, like whether or not you're going mad or if, well, just what's going on basically. But after a while, and especially after you've seen like, like doctors and stuff and they've told you (reassured you?) that it's voices that you're hearing, then it's nothing really to be scared of, they can't, they can't hurt you, they may say horrible things to you but they can't actually physically hurt you.

Lines 221-227

PATIENCE: well at first I was a bit quiet, I was just, I used to just hear them, they used to scare me, I used to get frightened of them, I thought they were going to hurt me or they was going to kill me or something, and then afterwards I just thought, after a while, especially when I start taking medication, when I started taking medication they started getting quieter

RUTH: right

PATIENCE: so it was easier to ignore them, and just get on and just try and ignore them

LEONIE

Lines 199-208

RUTH: I was wondering what it felt like to sit through the groups for you, was it hard work, did you get fed up sometimes

LEONIE: yeah a little bit yeah

RUTH: why was that

LEONIE: I just felt upset with it all, that the voices could ruin my life, they're already ruining my life (mutters) can I go please

CHIDI

Lines 145-154

CHIDI: No. And this boy called R. he said, this other boy said "Oh, he say he fancied you, and he said Are you mad?"

RUTH: and how did that make you feel?

CHIDI: upset

RUTH: so when you hear those voices now, does it upset you?

CHIDI: a little bit

RUTH: and how do you cope when that happens?

CHIDI: don't know

RUTH: does it feel like you don't know what to do?

CHIDI: yep

MARK: yeah

RUTH: is that something you've talked about with the doctors in the group

MARK: yeah, I am going to kill myself

RUTH: mm

MARK: because I am going to, I feel my life is going down the drain... my life is going down the drain

RUTH: is that what feeling suicidal is about

MARK: mm, I haven't got anything to live for

RUTH: is that because of the voices

MARK: yeah. I haven't got anything to live for, my whole life's going down the drain

Lines 483-487

RUTH: and how does that feel to talk about that now

MARK: it feels good because I'll be dead and the voices will go away

RUTH: and is that the best thing to do for you

MARK: yeah

PATIENCE

Lines 50-65

PATIENCE: um.. well, um, I talked about, um, cos, like M. was saying about how he felt like killing himself, he felt that there was nothing to live for and I tried to explain to him that you shouldn't let the voices ruin your life, you shouldn't let the voices affect your life in a way where you can't deal with things or go places or have a normal life, just live like everybody else, cos you should just try and just ignore them or just think of it as if you have an illness like cancer or something and that you should just try your best to just overcome it and just aim to do as much as you can with your life.

RUTH: is that what you've tried to do in your life

PATIENCE: yeah

RUTH: just to, to get on with things and to, to sort of accept..

PATIENCE: yeah

RUTH: right. Is it easy to do that?

PATIENCE: not at first, not when you first start hearing voices cos you're not sure what's going on or how to deal with it or, like you start to question

HARINDER: like if I go to the market with my Mum, I went to the market Wednesday or Tuesday with my Mum, we went to Sainsburys and on the way I just said I'm going to go back home, she told me off,...my legs were in pain, so

RUTH: your legs were hurting, was that why you wanted to go home?

HARINDER: Yep, I just got bored after about 20-30 minutes I just got ... I 've got problems like, I can't go outside, I feel scared

RUTH: why, what are you scared of

HARINDER: I dunno, someone might attack me or somebody mug me and I'm scared of that.

RUTH: so that's two problems, both to do with going out, it makes it difficult to go out.

HARINDER: Yeah

RUTH: but you were saying that when you went out you said your legs were hurting and then you got bored

HARINDER: Yeah

RUTH: Do you think the two things were connected?

HARINDER: at the same time, yep at the same time

RUTH: and how does it feel when you get bored, how do you feel?

HARINDER: I just want to sit down and go home, I just want to do something, play football.... Just suddenly get bored

RUTH: but I was thinking you said you were worried about going out, so, how did it feel to go out with your Mum to the market

HARINDER: that's all right, I'm fine with my Mum, or... if there's a cab driver, like coming here.....but if someone tells me to go to the shop I'll be, I mean, if someone goes beside, you know, really close to me, I just think he's trying to push me or something, just get a bit anxious, and if someone's walking behind me, thinking they're following me, I have to go back.. things like that.

MARK

Lines 144-171

RUTH: and how does that feel to have that sense of a spirit inside your head?

MARK: not good

RUTH: does it never feel good?

MARK: no, because I feel like killing myself and I am going to do it

RUTH: you are going to do it?

LEONIE: listen to music, pray, do cooking or watch TV, that sort of thing

RUTH: oh right, was that all new things

LEONIE: go shopping, go outside, you know

RUTH: right, so lots of different things

LEONIE: I don't hear voices when I'm outside.... I don't know, man

RUTH: more inside when you hear them

LEONIE: yeah

RUTH: is that more when your on your own than with other people

LEONIE: when I'm inside a place I hear voices less/worse, so long as I'm...

RUTH: right. So, outside is worse, is that what you're saying, you hear voices more?

LEONIE: I don't know... can I please go now

Examples of emotional response

HARINDER

Lines 176-188

HARINDER: No, the voices aren't inside me, but well, it's not inside me but it's talking through me, so when I stop talking, when I'm just breathing, I can hear it there on my breath...

RUTH: and what does that feel like

HARINDER: well, there was a time I felt really scared, I didn't go to sleep that night, I stayed awake all night, then it was morning, I was tired, I couldn't lay down on the bed, I had to get up, I was so.. the anxiety, I was feeling so, so mad, the anxiety was getting really worse and so I had to get up and go downstairs and sit down and watch TV so I did that and my sister came downstairs and she went to work and the TV wasn't on and I was just sitting down and looking at the garden and I could feel something behind me and it was one of the voices that came and actually put his fingers on my back, right next to me

Lines 74-106

RUTH: can you say a bit more about the problems?

HARINDER; um, I've got quite a lot, um, see, I've got a problem with walking.

RUTH: with walking?

HARINDER: if I'm alone I can't walk too much

RUTH: what happens when you walk too much

JOCASTA

Lines 47-58

RUTH: and, and did you learn ways of sort of coping better with the voices?

JOCASTA: yeah, well I knew them already

RUTH: right, what kind of things did you know already?

JOCASTA: to..... or to read a book or watch telly or listen to music, I knew to do that stuff already

RUTH: how did you know that.. did you work it out for yourself

JOCASTA: yeah

ANGELO

Lines 264-279

RUTH: and are you aware of the times when they're better and they're worse

ANGELO: yeah

RUTH: and what do you think, what makes them better?

ANGELO: when they're not there

RUTH: when they're not there.. what makes them go away, can you make them go away yourself?

ANGELO: yeah

RUTH: how do you do that

ANGELO: it happens, that's all

RUTH: how does it happen, what do you do to make them go away?

ANGELO: go to school, play football, watch a video, watch a film, try to concentrate, sleep

RUTH: when you're doing different things, really

ANGELO: yeah

RUTH: is that something that you've learned from coming to the group?

ANGELO: yeah

LEONIE

Lines 154-178

RUTH: well we'll try and just do this quite quickly.. so you learned things that you could try at home, were there things that you tried at home to do

RUTH: was there anything that you learned from the group to help you to know what to do? What kind of things did people suggest to help you to cope with the voices?

CHIDI: don't know

RUTH: and have you been able to talk to anyone about them recently?

CHIDI: (Inaudible)

RUTH: you haven't? Did you say yes or no?

CHIDI: No

RUTH: do you ever talk to anyone about them?

CHIDI: old hospital called T... I did, a nurse called E.

RUTH: when you were in hospital

CHIDI: yeah

RUTH: you talked to her?

CHIDI: yeah

RUTH: and did that help

CHIDI: little bit, yeah

RUTH: and why don't you talk to anyone else?

CHIDI: a bit private really

MARK

Lines 319-331

RUTH: so do you feel there's anything you can do to..

MARK: (*Interjects*) no, it's either me that goes or they go and I think it's going to be me

RUTH: are they that powerful?

MARK: yeah

RUTH: there's nothing you can do

MARK: no

Lines 392-398

RUTH: right, have you got any.. do you have any coping strategies

MARK: no

ANGELO: yeah

RUTH: so, how does that feel when your thoughts are changing from one thing to another

ANGELO: upset

RUTH: it upsets you

ANGELO: yeah

RUTH: is that because of what the thoughts are like, they're upsetting thoughts

ANGELO: yeah. They um slack, they give you misguidance, I think it is

RUTH: but they're not the same as the voices?

ANGELO: I don't know

RUTH: you're not sure. So, when they're giving misguidance, what does that mean, are they telling things, or..

ANGELO: yeah

RUTH: what kind of things do they tell you?

ANGELO: they tell me.. that I'm a failure

RUTH: in what way?

ANGELO: in the sense that I can't concentrate and it's quite bad because it's difficult at school

Examples of coping

CHIDI

Lines 145-146

RUTH: and how did that make you feel?

CHIDI: upset

RUTH: so when you hear those voices now, does it upset you?

CHIDI: a little bit

RUTH: and how do you cope when that happens?

CHIDI: don't know

RUTH: does it feel like you don't know what to do?

CHIDI: yep

CHIDI

Lines 100-117

RUTH: the same. So what kind of things are they saying to you?

CHIDI: in my old school called L... this teacher called I.. she said I'm better this person because that person do better than me

RUTH: she was saying that somebody else was better than you?

CHIDI: yeah

RUTH: and that's the voice that you've been hearing this week?

CHIDI: yeah

RUTH: have you been hearing other ones as well this week?

CHIDI: I went this trip to S and this girl called E said , said um "M she's better than you"

RUTH: why did she say that do you think?

CHIDI: because she don't like me

RUTH: and why do you think she didn't like you? Do you know?

CHIDI: at that time I wear glasses on, so, she didn't like me, she just don't like me. She thinks I've got a big mouth, so..

RUTH: and she told you that

CHIDI: yeah

ANGELO

Lines 147-173

ANGELO: I get bored, the changes.. er actually, um, my thoughts change from one way to another

RUTH: from one week to another?

ANGELO: from one thought to another,

RUTH: right

ANGELO: um in a bizarre way

RUTH: right. Can you give me an example?

ANGELO: I don't remember if I can.

RUTH: is that because you can't remember?

HARINDER: and the voices are, aren't that loud, they're more slow, more calm, that's after I started taking the medicines.

RUTH: right, and how long have you been taking those?

HARINDER: for a couple of months now

RUTH: yeah, and then are they still repeating what you're saying

HARINDER: yeah

RUTH: and do they repeat what you're saying in different, I mean does it sound exactly like you just said, or do they sometimes sound, I don't know, angry, or..

HARINDER: yeah

Lines 291-307

HARINDER: I don't know, I used to guess things, that I can remember what they are, I can remember I used to guess things, when I used to just tell them off, just because I guessed things

RUTH: you guessed things?

HARINDER: yeah

RUTH: what kind of things?

HARINDER: I don't know, for example, you didn't swear at me, and I just guessed you did, now

RUTH: right, me?

HARINDER: yeah, and I was just going to tell you off now, I just guessed...I must have been really ill then... But now I'm much calmer, I listen to my family what they say, do more things at home, in the house

RUTH: so you were imagining that they were saying things to you, and then what would happen, would you, you'd get angry, and would you explain

HARINDER: yep, they used to get angry with me and I used to get angry with them

RUTH: right, would you explain to them why you were angry

HARINDER: no, either I used to get out or either they used to get out

MARK

Lines 237-240

RUTH: what kind of things do the voices say to you

MARK: they tell me to kill myself, to blaspheme against God...they threaten to kill me

Examples of social context

HARINDER

Lines 56-66

HARINDER: well the first group, when I came, half through it I felt like going

RUTH: did you, why?

HARINDER: yeah, I don't know, I just felt bored

RUTH: you felt bored, really, not interested in what people were talking about?

HARINDER: No, not really but just.. yeah, actually I got really bored.. we were watching a programme and they were talking about their voices and I got bored, but I came back, I went to the toilet, I came back.

RUTH: you came back the next week? Oh, I see you went to the toilet and 64came back

HARINDER: came back after 5 minutes

RUTH: so, were you thinking about not coming back?

Lines 382-391

HARINDER: yeah, it's like a couple of weeks ago I was talking to my Mum, my Mum got so, I don't know maybe she get bored or, bored of me, she said I've got to take my medicine, (Laughs) she just goes from there, gets out of the way or goes upstairs, says I'm going to bed

RUTH: right (laughs)

HARINDER: that's how much I talk

RUTH: right, so did you think that other people in the group were getting bored

HARINDER: maybe, I don't know.. there was a boy, I can't remember his name, he was.. he got up and went out of the group

Lines 109-117

RUTH: And you said that one of the reasons you stuck with the group on that first day when you were feeling bored ... was that your Mum thought you should go

HARINDER: persuaded me

RUTH: she persuaded you did she, what did she say?

HARINDER: well she told me it's good for me to come here .. she wants me to get well, and I want to get well, so that's why

RUTH: are you able to talk to your Mum about those problems?

HARINDER: yeah, I talk to my Mum, I talk to my sister, talk to my brother

RUTH: and do you talk to them about the voices as well?

HARINDER: yep

PATIENCE

Lines 66-100

RUTH: 'Mmm and do your voices say horrible things to you?'

PATIENCE : 'Yeah.'

RUTH: 'And how did you learn what you were just telling me about? How did you learn to take that, to take that attitude?'

PATIENCE: 'I just started to have it, because, speaking to my boyfriend, he used to tell me to just, just ignore them and don't worry about it and things like that.'

RUTH: 'So, you used to talk to your boyfriend about it?'

PATIENCE: 'Yeah.'

RUTH: 'And how did he react?'

PATIENCE: 'He didn't react badly. He just, cos at first we didn't know what was going on, I thought people were around me, I thought people were talking to me, I didn't know I was hearing voices. I thought I was hearing people's voices I knew, I thought they, like they wanted to come and beat me up or something, so, then, sorry, what were we saying?'

RUTH: 'I was just saying did- what was his reaction?'

PATIENCE: 'Yeah, he was, like he was just trying to help me get through.'

JOCASTA

Lines 341-360

RUTH: 'Is there anything that other people can do to help you? It sounds like you've found a lot of ways of helping yourself, what about is there anything that other people can do? '

JOCASTA: ' No...well actually, because I go to college I think they should help me cos I can't take too much stress. That's why I will take days out and.... 90% attendance and I think I can't handle doing, things like that right. If a doctor could write me a letter saying what's the problem and stuff like that, that's one of the ways... '

Appendix G - Suggestions for future qualitative research with this participant group

1. Having **prior knowledge** and clinical experience of young people with psychosis. This allowed us to hypothesise about what difficulties we may encounter before carrying out the interviews. For example we anticipated that the young people may lack confidence in speaking in an interview, they may find difficult to express themselves and may have a low level of comprehension and verbal expression. Our hypothesise were reflected in the design of the interview schedule (see point 2).
2. A **more extensive interview schedule** than is advocated was developed because we hypothesised that the participants may find it difficult to speak without prompting for extended periods of time. The interview schedule included five main open questions but beneath these was added a series of more concrete prompts which could be used by the interviewer to guide the participant to speak about the topic.

e.g. *How did you find the groups that you went to?*

- *Like/not like*
- *Useful/ not useful*
- *Did you learn anything? If so what?*
- *Were there things that you could try at home or at hospital in between groups? If so how did this go?*

- *Do you think anything has changed at home or in hospital since beginning the group?*
- *Are you doing more of certain things?*
- *Are you doing less of certain things?*

3. **Awareness of participants' linguistic ability and comprehension**

enabled the interviewer to use simple language to ask questions.

4. **Persistence at pursuing the research goal.** This meant that frequently

questions had to be reworded and repeated to encourage the participant to talk about a topic.

5. **The interviewer did not adhere consistency to the position of *tablau rasa*.** For example to encourage conversation on a topic it was

sometimes necessary for the interviewer to make suggestions to the participants for example showing that she had some knowledge of what had occurred in the group whilst remaining aware that they did not want to ask questions which would lead to acquiescence on the part of the participants. A good example of this is seen in the extract above when Ruth suggests that Tracey may have experienced a feeling of 'oh yes, I've had that experience', Tracey agrees and gives Ruth a concrete example of this.

6. On occasions the interviewer used **interpretative and reflective**

comments which were consistent with the style of a therapeutic intervention rather than qualitative interview. Whilst we recognise the disadvantages of doing this – these are not the words of the

participant could be argued that this was checking-out what the participant meant and led to embellishment of a concept when a participant was unable to articulate what they were trying to convey without assistance.

7. **Using a clinician as an interviewer.** This could be seen as a potential problem as a clinician already has some understanding of the difficulties that the participants face and therefore can not take up a completely ignorant stance. However the therapeutic skills of the interviewer were seen as an advantage in some situations e.g. the ability to deal effectively and efficiently when a participant disclosed suicidal ideation; the ability to develop rapport at a slow and gentle pace as suggested when working with clients with psychosis (Nelson,1996). We suggest that these situations may have been dealt with more effectively by an interviewer with experience of working therapeutically with this population.
8. Similarly **clinical experience** was viewed as important in enabling the interviewer to be aware of none verbal cues which allowed the interviewer to know when it was safe to proceed with the interview and push a participant further or when it was better to discontinue the interview.