# Doctorate in Clinical Psychology

## Thesis:

## Coping with Hearing Voices: A Repertory Grid Study

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# 1. Abstract

Hearing voices is a well researched experience, found in both schizophrenia and the general population. Previous research investigating the unusual experience has reinforced cognitive psychology concepts such as beliefs, power, core beliefs about the self, intent and identity. It has been suggested that these factors all mediate individual coping with the experience. Coping with voices is a clinically significant area of research pioneered by Romme and Escher and requires careful consideration. Kelly's Personal Construct Psychology and the repertory grid technique were used in the study to compare two ways of coping with voices: engaging and resisting coping. The groups were compared on the repertory grid measures of construed distance between the self and the voice, salience of the self and voice, and tightness of the overall construct system. In a sample of 18 voice hearers, the Beliefs about Voices Questionnaire- Revised (BAVQ-R), a measure of psychological distress (OQ45.2) and Kelly's repertory grid were administered. The study also used three case examples and content analysis of construct poles applied to the dominant voice and the self as coper to supplement the quantitative analysis with a more in-depth exploration.

Resisting coping was found to be associated with a greater construed distance between the self and the voice, a more salient view of the voice, and a tighter construct system. However, neither resisting nor engaging coping was associated with psychological distress. In addition, voice malevolence was associated with distancing oneself from the voice, suggesting that distancing was an adaptive coping strategy used, possibly as a way to preserve selfhood. The study therefore added to the list of mediating factors between the voice hearing experience and the coping strategy adopted. As a result, the repertory grid showed some scope in assessing the three areas of interest. The findings suggest that clinically, voice hearers can best be supported by adopting the appropriate relational approach with the voice (closeness or distance), reducing the salience of the voice and moving through Kelly's Creativity and Experience Cycle.

# 2. Introduction

The Introduction will begin by looking at the historical perspective of the unusual experience of hearing voices leading to more recent definitions and the risk factors to the experience. The prevalence of the experience will then be discussed, including an introduction to cultural and spiritual factors. This will then lead to a discussion of the current perspectives on the phenomenon including the Hearing Voices Movement, as well as medical, developmental and psychological perspectives. The more recent literature exploring the importance of the individual's relationship with their voices will then be explored. Personal Construct Psychology (PCP, Kelly, 1955) will finally be introduced as a model to explore the way the experience is construed and compared to models of coping.

## 2.1 The position of the researcher and inspiration for the study

My inspiration for carrying out the research came from my fortunate opportunity to facilitate a hearing voices group in an outpatient adult mental health service. From group members I heard many stories of what it was like to be a psychiatric patient, where often the voices were dismissed as psychopathology and drowned out with anti-psychotic medication. I heard a multitude of stories about coping with the experience which appeared to be mediated by many factors including the way each voice hearer could relate to and make sense of their voices and the importance of the voice in the rest of the hearer's world. It should be stated that my position as a researcher is one that remains with the belief that the dichotomy between mental illness and mental health is often a subjective myth and I believe that the consequences of defining such concrete categories can often be harmful and stigmatising. George Kelly (1955, p.775) wrote that diagnosis was 'all too frequently an attempt to cram a whole live struggling client into a nosological category'. As well as the validity of the concept, the word 'schizophrenia' carries many negative connotations and associated stigma. The focus of the current study is therefore on the singular and unique experience of hearing voices.

The unusual experience under investigation comes under many names: 'verbal and auditory hallucinations', 'hearing voices' and 'positive symptoms' being just three of

many. It should be noted that the term 'hearing voices' is chosen as the term of choice for the research as it is the term used most frequently by user-led organisations, the main United Kingdom (UK) one being the Hearing Voices Network (Hearing Voices Network, 2008). It should also be noted that reference will be made to 'psychosis' and 'schizophrenia' throughout, as research has suggested that seventy per cent of those suffering from core schizophrenia will experience auditory or visual hallucinations at some point (Sartorius, Shapiro & Jablensky, 1974, as cited in Knudson and Coyle, 1999).

## 2.2 The aetiology of hearing voices

### 2.2.1 A historical perspective

The experience of hearing voices has been noted for more than 2,000 years (Leudar & Thomas, 2000) and the list of historical figures who reportedly heard voices is impressive, for example Pythagoras, Socrates, and Joan of Arc, as well as current celebrities, including Anthony Hopkins. Myers wrote that, 'Socrates is not usually seen as a religious visionary. Some would say that he is the father of logic and rationality, and he certainly seems to be the epitome of sanity, shrewdness, physical robustness, and moral integrity' (Myers, 1903, as cited in Leudar & Thomas, 2000, p. 7). Socrates referred to his voice as a 'daemon', and it was this daemon that was one of the charges levelled against him at his trial, and could be said to have cost him his life. In the nineteenth century Socrates' daemon became known as a 'hallucination' and he was declared insane by means of retrospective diagnosis (James, 1995, as cited in Leudar & Thomas, 2000). Nietzche (1994, as cited in Leudar & Thomas, 2000) wrote 'the Socrates daemonion likewise is perhaps a disease of the ear, which he explains in accordance with his prevailing moral thinking, but other than how it would be explained today. It is no different with madness and ravings of prophets and oracular priests: it is always the degree of knowledge' (p. 7). This historical perspective is important as it allows one to deconstruct the meaning of hearing voices by considering changes in attitudes towards the experience over time.

*2.2.2 Definitions of hearing voices*

The original Latin meaning of the term 'hallucination' is to 'confabulate' and to 'ramble' and more recently an interesting debate has been over whether a hallucination can co-exist with reason. Many would argue that hallucinations are, by themselves, indisputable signs of madness (Leudar & Thomas, 2000). An argument against this view would be the common experience of those who have suffered a bereavement and whilst grieving experience hearing the voice of the deceased person (Reese, 1971, as cited in Fernyhough, 2004).

More recent definitions of a hallucination include 'a sensory perception without external stimulation of the relevant sensory organ' (American Psychological Association [APA], 1994), and 'any percept-like experience which (a) occurs in the absence of an appropriate stimulus (b) has a full force or impact of the corresponding actual (real) perception and (c) is not amenable to direct or voluntary control by the experiencer' (Slade & Bentall, 1988, p. 23). These newer definitions allow for a more modern, context specific distinction to be made in comparison to more historical depictions. An important evolution of thinking was based on the research that continued to promote the idea that psychosis existed on a continuum (Strauss, 1969; van Os, Hanssen, Bijl & Ravelli, 2000). In addition, Slade and Bentall (1988) proposed a concept of control, which could also provide an adequate distinction between those who experience psychopathological hallucinations and those, such as artists and musicians, who often describe more developed internal visions and auditions.

Traditionally, voices heard outside of the head were regarded as more pathological than those heard inside, and the psychiatric term 'pseudohallucination' to define the latter has been open to much debate. However, more recent literature has suggested the difficulties with separating out the two. Nayani and David (1996) reported that 38% of voice hearers' voices were solely internal, 49% exclusively external, and 12% reported both. Copolov, Trauer and Mackinnon (2004), in a large scale study of 190 voice hearers found that approximately one third of voice hearers located them inside their head, and 38% experienced both internal and external voices. They also found that internal voices were just as troubling to the hearer as external voices. Also, inconsistent with early ideas of internal voices, Copolov et al. (2004) found that the majority of their sample described their voices as clear and very real. The current

study therefore aims to include all participants who describe themselves as voice hearers: internal or external.

### 2.2.3 Risk factors to psychosis and hearing voices

Although causal hypotheses differ, most authors have built on some combination of genetics, stress, or other multi causal hypotheses (Rosenthal, 1970, as cited in McGuire & Troisi, 1998). A percentage of the population appear to carry pre-disposing genes that contribute to vulnerability (Jabelensky, 1987, as cited in McGuire & Troisi, 1998).

Read, van Os, Morrison and Ross (2005) published a review of 180 studies of psychosis and concluded that 'symptoms considered indicative of psychosis and schizophrenia, particularly hallucinations, were at least as strongly related to childhood abuse and neglect as many other mental health problems. Recent large scale general population studies have indicated that the relationship is a causal one, with a dose effect' (Read et al., 2005, p.330). This link was shown in both clinical (Ross, Anderson & Clark, 1994; Read & Argyle, 1999), and community samples (Ross & Joshi, 1992). A qualitative study undertaken by Ensink (1992) also emphasised the relationship between sexual abuse and hearing voices. Linked to this is Romme's (1998) research which concluded that seventy percent of voice hearers reported voices being triggered after a severe traumatic or emotional event, for example, an accident, a divorce or a bereavement.

## 2.3 The prevalence of hearing voices

### 2.3.1 Recent estimates of prevalence

A United States (US) population based study of 18,572 community residents estimated an adult prevalence of hearing voices between 8% and 15% depending on age and gender (10% for men and 15% for women) (Tien, 1991). A community sample study across England and Wales of 8,063 people reported a prevalence of 4% across the White British sample (Johns, Hemsley & Kuipers 2002), by endorsing

a hallucination question. They also found that only 25% of those who reported these experiences would meet the criteria for psychosis. The Johns et al. study asked respondents whether or not they had heard or seen things that others had not and included both visual and auditory hallucinatory experiences. The Johns et al. prevalence figure was considerably lower than the US based Tien study, and one explanation may be that the Johns et al. study represented an annual prevalence, whereas the Tien study a lifetime prevalence. Another explanation may be that the Johns et al. study asked questions which aimed to assess symptoms of psychosis, which may have reduced respondents' willingness to disclose. In comparison, the Tien study used the broader National Institute of Mental Health Diagnostic Interview Schedule (DIS, Robins, Helzer & Croughan, 1981) and included both auditory and visual hallucinations. Lastly, like the cultural differences found in the Johns et al. study, the difference between the US and England and Wales studies may have captured Western cultural variations in attitudes and beliefs about the experience.

In the Johns et al. study, reports of hallucinations varied significantly across ethnic groups. The highest rates were in the Caribbean group (9.8%) and the lowest in the South Asian group (2.3%). This variation was in accordance with other previous reports (Al-Issa, 1977). Schwab (1977, as cited in Al-Issa, 1995) found that Black-Americans reported a higher frequency of voices compared to White respondents, but there was a strong association with religious affiliation in the Black-American sample. One explanation for the variation in the Johns et al. study may be a poorer understanding of the questions in the South Asian group. Although efforts were made to match interviewers' and interviewees' ethnicity, Berthoud and Nazroo (1997, as cited in Johns et al., 2002) found that measures which are outside of a cultures' boundaries are less reliable as some of the ideas may be unfamiliar. Another consideration should be the meaning the different ethnic groups make of the experience. For example, certain cultures are more likely to view the experience as within 'normal' boundaries and less likely to report it as a hallucination. Al-Issa writes 'it is possible that in these (non Western) societies the high frequency of reported voices may merely mean that culturally sanctioned voices come more often into the public domain through self description' (1995, p. 370).

Among religious groups, Schwab (1977) found that Black Baptists, Black Methodists, and Church of God members had the highest number of voices, whilst the Lutherans, Presbyterians, White Methodists and Jews had the lowest.

The Johns et al. study found that hallucinatory experiences were most commonly reported by 16 to 19 year olds, which was similar to the distribution of auditory hallucinations in the Tien study. The Johns study reported similar rates in men and women, in contrast to the higher rates of women in the Tien study. Other studies have also reported that hearing voices is more frequently reported in females, compared to reports for visual hallucinations, which are reported equal across both genders (Rector & Seeman, 1992). This compares to the ratio of men: women (1:4.1) for the diagnosis of schizophrenia (Abel, Drake & Goldstein 2010), which research suggests is representative of men having a poorer pre-morbid adjustment, greater levels of substance misuse and neurodevelopmental differences (Abel et al., 2010). This research may be highlighting a difference in the social effects, coping strategies, and beliefs between men and women when hearing voices.

### 2.4 Cultural and spiritual factors

In an influential paper by Al-Issa (1995) published in The British Journal of Psychiatry, an interesting argument was initiated. Al-Issa made a distinction between Western and non Western cultures and their concepts of hallucinations and reality. He defined Western cultures as rational and making rigid distinctions between reality and fantasy, and subsequently placing a negative judgement on the latter. He believed that such negative attitudes resulted in people being less familiar with the workings of their own imagination, and thus the emergence of imagery may lead to anxiety and/or a denial of responsibility and a tendency to attribute it to the external world. This anxiety associated with negative attitudes towards hallucinations was said to interfere with effective information processing and cause confusion between fantasy and external stimuli (Slade & Bentall, 1988). In contrast, many non Western societies made no distinction between hallucinations and other imagery and attributed these experiences to possession by spirits, or a trance, where there was a contact between the individual and the spirit world (Bourguignon, 1970, as cited in Al-Issa, 1995). These meanings were also often shared by the community creating a community narrative. Jocano (1971, as cited in Al-Issa, 1995) reported on a village in the Philippines where imaginary noises, smells and other images were reinforced and people saw and heard fairy like spirits in the trees. The author concluded that information about inclusion of ethnicity and religious beliefs was essential for

clinicians as well as researchers. 'Awareness of culturally sanctioned hallucinations would help the professional to avoid the misdiagnosis of patients from ethnic and minority groups' (p. 372). The National Institute of Clinical Excellence (NICE) guidelines for schizophrenia (2009) recognise the importance of cultural diversity and recommend cultural awareness training for all of those who provide care to those with schizophrenia.

## 2.5 Recent advances in thinking

### 2.5.1 Hearing Voices and the media

*'The court heard Yousef had been suffering from delusional thinking and hallucinations for a two year period before killing her daughter' (The Independent, 2010).*

Research shows that the public have different expectations and can distinguish between different categories of mental disorder. In the UK, psychosis is linked with chronicity and dangerousness (Mental Health Foundation, 1999, as cited in Gray, 2002), and newspaper headlines such as the one above are common features of the UK's most popular newspapers. Negative media representation is likely to mean that voice hearers are fearful of admitting to the experience. One voice hearer wrote in Romme, Escher, Dillon, Corstens & Morris's (1999) book, 'I was 16 when I first heard voices, I was so afraid of being seen as mad that I told no one' (p. 34).

### 2.5.2 The hearing voices movement

Romme, Noorthoorn and Escher (1992) found that hearing voices often started as a helping influence, giving people hope for the future. Evidence from the 1990's suggests that about two thirds of those who hear voices sometimes view them as helpful (Bijl, Ravelli & van Zessen, 1998; Eaton, Romanoski, Anthony & Nestadt, 1991; Tien, 1991).

The Hearing Voices Network (HVN) aims to de-stigmatise voice hearing, and other unusual sensations, believing that this will lead to greater tolerance and

understanding of the experience. The movement is based on revolutionary research by Romme and Escher (1989) who propose that the way to cope with voices is to talk about them. This is particularly important as the research was conducted at a time when psychiatry dominated and encouraged people not to talk about the experience (Hamilton, 1984, as cited in Leudar, 2000). However, Romme and Escher found that, under the psychiatric model, often the voices did not go away and people suffered severe side effects from the anti-psychotic medication which often had a detrimental effect on their quality of life. They decided that in order to help people who were not coping with the experience they needed to find people who were. They chose to appear on a Dutch television programme and invited people to contact them after the show. Seven hundred people contacted them, out of whom three hundred said they were not coping well. This was the beginning of Hearing Voices Network and subsequent international supportive hearing voices groups. Romme and Escher's research was however open to sample biases because of their very public method of recruitment which required individuals to be motivated enough to contact the show. The research was also conducted in the Netherlands which has a very different, non individualistic and socially focussed, mental health care system.

Hearing voices groups have been described as having a number of advantages: people learn from each other, gain new coping strategies, realise they are not alone, feel heard and realise they are not mad (Romme et al., 1992). Members are able to share their experiences and may regain some power through solidarity and establish new, more positive self identities (Meddings, 1998). In addition, the Mental Health Foundation (2000) found that National Health Service (NHS) patients wanted more opportunities for organising self help groups. Based on this, it is essential that the current study includes participants who are part of a support group as well as those who are not. Participants will be recruited through both NHS and voluntary services in order to obtain a sample that is representative of the hearing voices population.

### 2.5.3 Hearing voices and psychological distress

Research suggests that over 60% of voice hearers are 'severely depressed' and over 75% report that they are 'highly distressed' by the experience (Birchwood, Meaden, Trower, Gilbert & Plaistow, 2000). There are three possible models linking voices and distress. The first suggests that depression is a core symptom of psychosis itself.

Evidence for this comes from a factor analytic study identifying depression as a distinct dimension of psychosis (Stefanis, Hanssen & Smirnis, 2002). The second model suggests that the greater the loudness and frequency of the voice, the greater the distress and depression. This model is a common position of psychiatry (Birchwood, 2003). The third model combines the cognitive model of voices (Birchwood & Chadwick, 1997) with interpersonal research (Gilbert, 1989, 1992), and suggests that an interpersonal schema (subordination to the voices) determines the hearer's level of distress, irrespective of their content. This last model is supported by Birchwood, Gilbert, Gilbert, Trower, Meaden and Hay (2004) who have found an association between powerlessness and inferiority in the hearer's interpersonal relationships and power of the voices.

## 2.6 Models of Hearing Voices

### 2.6.1 The disease model

The most dominant narrative within current mental health services is the medical psychiatric model and therefore an introduction to this approach is paramount. The disease model interprets hearing voices as psychopathology, which in turn often determines the kind of treatment an individual receives. From this perspective the experience of hearing voices is placed outside of what is considered 'normal' and is set apart as a psychotic experience. As early as 1798 the English physician Crichton talked about hallucinations as 'diseased perceptions' (Leudar, 2000), and Maudsley implied that hallucinations were more likely to occur in those whose brains were less well developed, such as children, primitive people or savages. He believed that hallucinations were exclusively pathological (Maudsley, 1867, as cited in Leudar, 2000).

Within the medical model, the person's experiences are interpreted as a symptom of mental illness. Reports suggest that often professionals are only interested in gathering enough information in order to clarify a diagnosis of a psychotic disorder. The strict medical model often disregards allowing the individual to talk about their experiences as it is thought that this may actually increase the person's pre-occupation with the experience (Romme & Escher, 1989). The overall medical and

societal view is often that the best treatment for newly diagnosed psychotic disorders is anti-psychotic medication, followed by psychological and social support (NICE, 2009). Following their many years of experience in the field Romme et al. (2009) stated, 'from understanding the perspective of the voice hearer, we have observed that the attitude of mental healthcare researchers and professionals is one of regarding voices, not as a source of information, but as a sign of a 'non-existent' reality; it is this attitude that disables people from finding more adequate and helpful information about the experience' (p. 4). One particular voice hearer wrote; 'they told me that I had an illness. I was mentally ill. I was expected to be the passive recipient of treatment for a disorder I had; that medication was the only option open to me, and that, actually, I would never really get better anyway... the fact that I listened to my voices was evidence of my illness' (Romme et al., 2009, p.26).

This section can be summed up with a recommendation by Hamilton (1984, p. 145, as cited in Copolov, 2002) as written in *Fish's Schizophrenia*: 'the clinician is not to go along with the patient's delusions and hallucinations; on the contrary, the patient should be encouraged to ignore them'. It should however be noted that Hamilton wrote this in 1984 and subsequent psychiatric research and thinking has changed somewhat. It should also be noted that although still dominant, modern psychiatry emphasises the role of psychological treatment, which has been reflected by the change in the latest NICE schizophrenia guidelines to include the provision of cognitive behaviour therapy and family therapy as an evidence-based treatment alongside anti-psychotic medication (NICE, 2009).

### 2.6.2 DSM-IV definition of schizophrenia and Schneider's (1959) first rank symptoms (FRS)

Within the disease model and according to the DSM-IV (APA, 1994), a person can be diagnosed with schizophrenia if they present with two or more of the following characteristic symptoms for a significant portion of time during a one month period:

- Delusions
- Hallucinations
- Disorganised speech (e.g. frequent derailment or incoherence)
- Grossly disorganised or catatonic behaviour

- Negative symptoms i.e. affective flattening, alogia, or avolition

The DSM-IV definition also includes a number of social and occupational impairments. There have been calls to redefine the concept of schizophrenia within the DSM-V since the DSM-IV fails to distinguish pathological from non pathological experiences, and in addition it fails to consider cultural and religious beliefs (Liester, 1998). Auditory hallucinations are also present in a number of other psychiatric disorders such as bipolar disorder, major depression and dissociative states (Asaad & Shapiro, 1986, as cited in Knudson & Coyle, 1999), as well as more physical conditions including brain damage to particular auditory neural pathways.

Kurt Schneider described voices, especially those that were commenting on the person, as being part of the 'first rank' symptoms of schizophrenia (Schneider, 1959). Before the work of Schneider the emphasis on a diagnosis of schizophrenia was the decline in cognitive abilities. The inclusion of hallucinations as a first rank symptom meant that the emphasis changed and voices became of paramount importance.

Kelly (1955) noted that one of the drawbacks of the disease model was that clients' difficulties may be ignored if they did not easily fit into one of the discrete categories.

### 2.6.3 Neuropsychological models of auditory hallucinations

Studies of brain functioning have shown that there seem to be differences in the areas of activity in those who actively hear voices when compared to controls. Differences were shown in regions associated with language, such as Broca's area and reduced activity in Wernicke's area (Cleghorn, Franco & Szechtman, 1992). 'Auditory hallucinatory state' is also linked with reduced activity in temporal cortical regions. These regions normally process external speech, so the reduction in activity could possibly be because of competition for limited neurophysiological resources (Woodruff, Wright, Bullimore, Brammer, Howard, & Williams, 1997). The neuropsychological model is unable to explain every voice hearing experience, but it is evidence for the 'realness' of the experience for the voice hearer, which may help professionals and carers take a more empathic stance.

*2.6.4 A developmental account*

Developmental accounts have been drawn from Vygotskian ideas about the development of inner speech (Vygotsky, 1934, 1987, as cited in Fernyhough, 2004). He proposed that 'inner speech was the end result of a gradual process of internalisation of dialogue which begins with the child's first entry into linguistic exchanges' (Fernyhough, 2004, p.53). Vygotsky's account described four levels of the development of inner speech: external dialogue, private speech, expanded inner speech and condensed inner speech. Without any disruption a person could expect to develop to level four and reach a stage of thinking in pure meaning, where the inner speech has lost most of its acoustic and structural qualities of external speech. In this model the development of inner speech requires a complex coordination of multiple voices, and an understanding of the perspective of the other. With a disruption of this usual process it may be that the 'otherness' is experienced as somewhat alien.

Based on Vygotsky's ideas there have been two models proposed which try to explain the development of hearing voices. Firstly, the Disruption to Internalisation (DI) model suggests that the process of internalisation is disrupted. This results in an inner speech which is excessively expanded retaining the linguistic characteristics of external speech. Because these experiences arise in the absence of any external stimuli they are experienced as alien.  Evidence for this model has been taken from the attachment literature as it is assumed that children who lack a secure attachment and opportunities for two-sided dialogues with a care-giver have fewer opportunities for internalising dialogue. This is supported by Dozier and Lee (1995) who found an association between an insecure attachment style and symptoms such as delusions and hallucinations. However, the designs of these studies have to date been retrospective and psychotic patients are shown to have difficulty accessing autobiographical information, providing particularly dismissive accounts of attachment styles (Kaney, Bowen-Jones & Bentall, 1999).

In the second model, the Re-Expansion (RE) model, inner speech is fully internalised but it temporarily re-expands into external dialogue under conditions of stress, and the individual can move from level 4 to level 3, or even 2. What makes voice hearers different from the general population is their interpretation of the re-expansion. Healthy individuals can also experience re-expansion during stressful conditions but

they may not interpret the experience as alien. Evidence for this model has been borrowed from literature that suggests an association between the onset of hearing voices and stress, for example, the widely used stress vulnerability model (Zubin & Spring, 1977).

However, one of the gaps in these models is any understanding of exactly what conditions need to be met in order for people to move between the levels. Also, how do these cognitive demands take from other cognitive functions, for example working memory? Lastly, why does the development of hearing voices mainly become problematic in adolescence and adulthood? This latter point raises the question of the social construction of the experience and the increased acceptance of the unusual experience as a child (e.g. imaginary friends). 'What may be pathological in adulthood may not necessarily be pathological in childhood' (Fernyhough, 2004, p.64).

Implications of the developmental approach for therapy may be to encourage voice hearers to engage with their voices (Perez-Alvarez, Garcia-Montes, Perona-Garcelan & Vallina-Fernandez, 2008). In doing so it could allow the individual to correct any abnormalities in the internalisation process. In this way, 'an alien voice might become a true inner dialogue, condensed, abbreviated, semantically transformed, and indistinguishable from normal inner speech' (Fernyhough, 2004, p.65).

### 2.6.5 Psychological models of hearing voices

Any psychological model of hearing voices must be able to account for a paradox which has confused researchers for many years. Voice hearers report that they experience the voice as a voice other than their own, yet at the same time the voice is usually accepted to have arisen within the boundaries of the self (Fernyhough, 2004). This has come to be known as the 'alien yet self' paradox (Leudar & Thomas, 2000). This is represented by the following quote; 'I started to realise that in a certain way the voices expressed my own thoughts. It is rather strange, but they are your own thoughts about an emotion' (Romme et al., 1999, p. 15).

Freud (1911, as cited in Leudar, 2000), one of the founders of psychotherapy, believed that accusatory voices stemmed from a harsh super-ego expressing criticism towards the drive of the id. He understood advisory voices as stemming from

both the ego and the super-ego. More recent cognitive research addressing the relevance of the self in psychosis developed the psychoanalytic idea of hallucinations functioning as defences (Bentall, 1990).

One of the most influential models which tried to explain the 'alien yet self' phenomenon was by Hoffman (1986). He proposed that because of a breakdown of a voice hearer's normal discourse planning process they experienced some inner speech utterances as unintended. According to this model this resulted in an attribution of the experience as coming from an external source. Akins and Dennett (1986) criticised this model on the grounds that any verbal thought must be preceded by an intention, which in itself is a thought. A second hypothesis which was not open to this criticism was proposed by Bentall (1990, 2003). He drew on the literature that voice hearers have difficulties distinguishing between internally and externally generated changes in their perceptual experience (Johns & McGuire, 1999). Bentall proposed that voice hearers mistakenly labelled their inner speech as coming from an external source. However, what this model did fail to account for was precisely why voice hearers selected an external attribution as opposed to internal.

Chadwick and Birchwood (1994) proposed a cognitive model of the maintenance of auditory hallucinations. The model proposed that peoples' emotional and behavioural responses to the voice reflected more than the content and form of the voice. They stated that the meaning given to the voice, including beliefs about identity, purpose, omnipotence and the consequences of compliance or resistance, was indicative of the individual's reaction. The development of the Beliefs about Voices Questionnaire (BAVQ, Chadwick & Birchwood, 1995) offered support for the role of beliefs about voices and found that those who perceived the voice as malevolent and omnipotent showed behavioural resistance and negative affect. The current study utilises this model and is interested in how certain variables are associated with the two coping responses identified by the BAVQ: resisting and engaging. Chadwick and Birchwood made the following distinction:

- Resisting coping: arguing and shouting (overt and covert), non compliance or reluctant compliance when pressure is extreme, avoidance of cues that trigger voices and distraction.
- Engaging coping: elective listening, willing compliance and doing things to bring on the voices.

The present study administers the more recent and amended BAVQ-Revised (BAVQ-R) and compares the results with those in the Chadwick and Birchwood (1995) study to investigate whether there is a positive association between voice malevolence and omnipotence with the coping response of resisting, and voice benevolence with engagement. There will also be an examination of whether voice omnipotence and malevolence are associated with greater levels of psychological distress. This would be similar to the finding by Sorrell, Hayward and Meddings (2009) that psychological distress was significantly associated with perceptions of the voice as omnipotent and malevolent. If the coping response of resistance is associated with psychological distress then it can be assumed that an engaging coping style is the most clinically and personally desirable.

### 2.7 Hearing voices and a relational framework

This section continues from the last to explore how the experience of hearing voices has been considered within a relational framework. Benjamin (1989) was the first to explore the interpersonal nature of voice hearing and concluded that voice hearers have an 'integrated, personally coherent relationship with their voice' (p.308). This led the way for an avenue of research exploring the relationship between the hearer and the voice, as well as how this relationship linked to levels of distress (Vaughan & Fowler, 2004). Hayward (2003) found that voice closeness was associated with a lessening of distress compared to voice distance.

Romme et al. (1999) published fifty stories of recovery from hearing voices and concluded a common pathway that included the importance of the relationship to the voice. Relationships with voices has been shown to be a complex and multi dimensional area of investigation, including notions such as power (Birchwood et al., 2000), companionship (Romme & Escher, 2000), and personal intimacy (Nayani & David, 1996).

The current study aims to explore further interpersonal concepts such 'closeness' (similarity) and 'distance' (dissimilarity) with voices using the repertory grid (Kelly, 1955) by measuring the construed distance between the hearer and the voice for both engaging and resisting copers. The study explores the concepts of closeness and distance and hypothesises that there will be a relationship between the hearer's

closeness/ distance to their voice and their adopted coping strategy and psychological distress.


### 2.7.1 Using research from interpersonal relationships

Al-Issa (1977) proposed that auditory hallucinations in psychotic patients across all cultures reflected the relative involvement of hearing in interpersonal and social interactions. It is therefore important to consider what social psychology research suggests about closeness in relationships with others. Social-cognition research states that closeness is central to an individual's conception of an 'ideal' social relationship and levels of engagement (Fletcher, Simpson, Thomas & Giles, 1999). Olson (1999) also discussed the importance of interpersonal closeness and distance in marital and family systems as a determination of functioning, and suggested that a balance between the two was most functional. Furthermore, social psychology describes the concept of 'othering', which is a tendency to differentiate self from other in such a way as to bolster and protect the self (Gillespie, 2007). Chin, Hayward and Drinnan (2009), in their interpretative phenomenological analysis also found that participants preferred to implement boundaries and create a space between them and the voice. Based on this, the current study also hypothesises that individuals who view their voices as malevolent will wish to maintain selfhood and create a space between themselves and the voice.


### 2.7.2 Relational theories and hearing voices

Two theories of inter-personal relating are appropriate to discuss here as being accessible and in keeping with the current study: Gilbert's Social Rank Theory and Birtchnell's Relating Theory.


### 2.7.2.1 Gilbert's Social Rank Theory (Gilbert & Allan, 1998)

Social rank theory suggests that both acquisitive and defensive (submissive) human displays are centred on the evolutionary desires to gain, and fear of losing attractiveness in the minds of others. When exploring the role of power as a mediator

of distress in the voice hearer, Birchwood et al. (2000) found that power and rank differentials between the hearer and the dominant voice were mirrored in the relationship between the self and other in their social world.

### *2.7.2.2 Birtchnell's Relating Theory (1996, 2002)*

Birtchnell's theory addressed both power and proximity, using what he described as an 'interpersonal octagon', represented by two poles (see diagram 1). The first axis of power distinguishes 'upper' and 'lower', and the second, proximity, represented by 'distant' and 'close'. The four positions represent innate predispositions towards simple, identifiable goals: closeness (attaining close proximity and involvement), distance (escaping from the threat of others and ensuring survival of the self), upperness (gaining advantage over others) and lowerness (seeking support from others).

Birtchnell also distinguished between positive and negative relating (see diagram 2), the difference being the individual's competencies in relating. They suggested that a person who had accumulated a satisfactory store of relating experiences in each octant would be more versatile in moving between them. Vaughan and Fowler (2004) applied the model to voice hearing and demonstrated that the concept of negative relating could be applied to a person's relationship with his or her voice. Using Birtchnell's concept of negative relating it can be predicted that the salience of the dominant voice (voice upperness) may force the person to relate to it from the reciprocal role of helplessness and submissiveness (resisting). The current study therefore hypothesises that there will be a positive association between the salience (importance) of the dominant voice and a resisting coping style.

Upper

UD

UC

Leading
Guiding
Advising

Controlling &
maintaining
order

Protecting
Helping
Providing for

Distant

Needing personal
space & privacy

Friendly
Involvement &
Interest

Close

Obedient,
loyal &
respectful

Seeking care
& protection

Seeking direction
guidance & advice

LD

LC

Lower
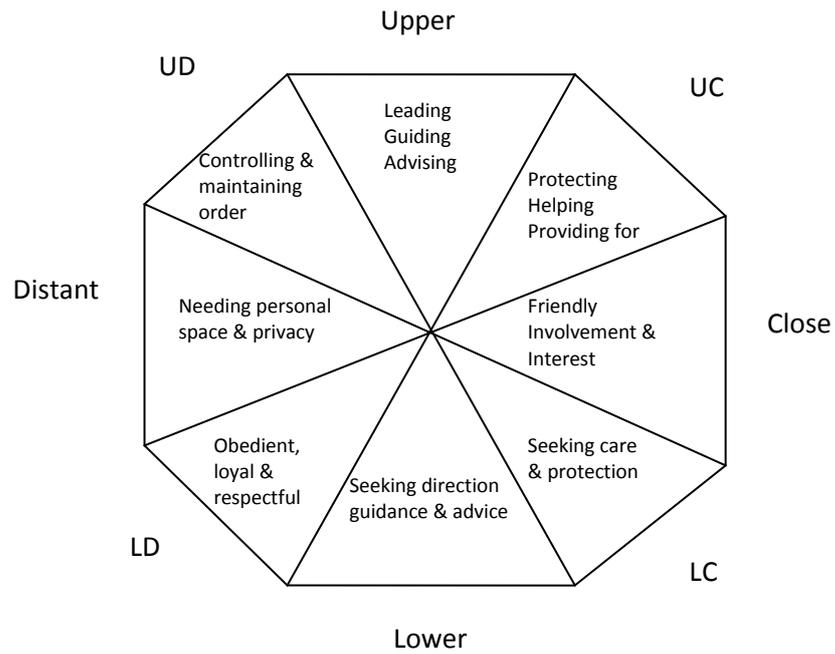
**Diagram 1**: Birchnell's interpersonal octagon- positive relating

Upper

UD

UC

Pompous Boastful
Dominating
Insulting

Sadistic
Intimidating
Tyrannising

Intrusive
Restrictive
Possessive

Distant

Suspicious
Uncommunicative
Self-reliant

Fear of separation &
being alone

Close

Acquiescent
Subservient
Withdrawn

Fear of rejection &
disapproval

Helpless, Shunning
responsibility, Self
denigrating

LD

LC

Lower
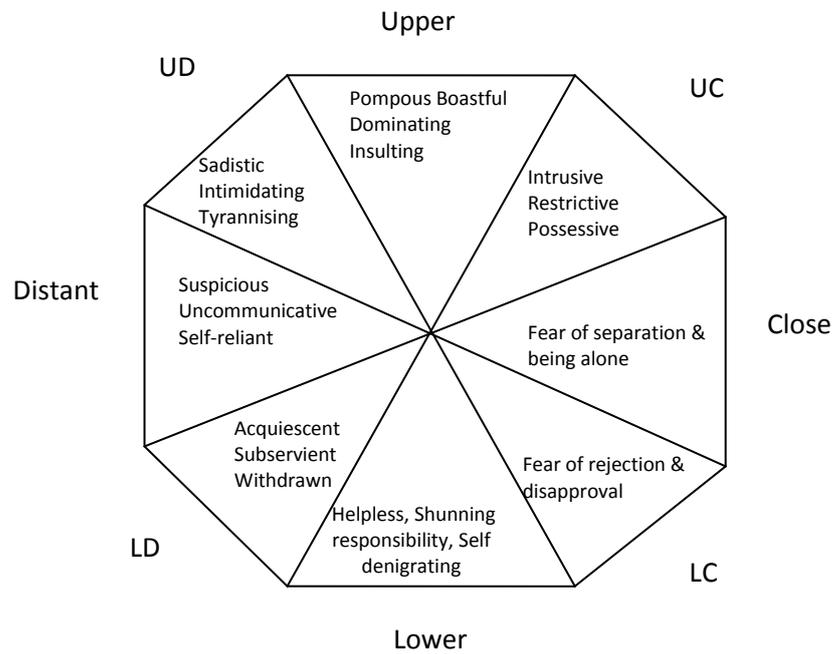
**Diagram 2**: Birchnell's interpersonal octagon- negative relating

## 2.8 The psychology of coping

The following section will firstly explore generic definitions and theories of coping and then apply these to the literature on hearing voices.

### 2.8.1 Definitions of coping

'Coping is a response aimed at diminishing the physical, emotional and psychological burden that is linked to stressful life events and daily hassles' (Snyder, 1999, p.5). The effectiveness of the coping strategy depends on the relief of immediate distress as well as contributing to more long term well being (Snyder, 1999). Freud was the first to study coping and within the psychodynamic model, coping was seen as a defence mechanism that enabled one to deal with unconscious sexual and aggressive conflicts (Freud, 1894, as cited in Snyder, 1999). According to Freud, one common defence mechanism involved in coping was denial. Denial is the refusal to accept reality or fact, acting as if a painful event, thought or feeling does not exist. It is considered one of the most primitive of the defence mechanisms because it is characteristic of early childhood development. He believed that many people used denial in their everyday lives to avoid dealing with painful feelings or areas of their life to which they did not wish to admit. For instance, a person who is hearing voices will often simply deny and ignore the experience. It can be assumed therefore that denial is an important and common characteristic of a resisting style of coping. Rammohan, Rao and Subbakrishna (2002), in a study of caregivers of those with schizophrenia, found that parents tended to use denial as a coping strategy, suggesting that they found it hard to accept the reality of the child's illness.

More recent writers view coping as different to defence mechanisms because they view coping as more forward looking, flexible, largely conscious and attentive to reality (Taylor, 1999, as cited in Synder, 1999). Lazarus (1966) led the field with moving theories of coping in line with the dominating cognitive psychology by introducing the appraisal/transactional model. He emphasised the interaction between the individual and the environment with a specific concept, namely, coping. Lazarus defined coping as 'constantly changing cognitive, behavioural (and emotional) efforts to manage particular external and/or internal demands that were appraised as taxing or exceeding the resources of the person' (Lazarus, 1984, as

cited in Synder, 1999 p. 9). Two proposed forms of coping were identified: problem focussed coping and emotion focussed coping. The former described efforts to control or manage the source of the threat by finding out more information about the stressor and adapting one's life and beliefs to accommodate the stressor. The latter is an attempt at managing emotional responses to the stressor including distancing oneself from the problem and avoiding it. In brief, problem focussed coping is more similar to the engaging style of coping defined by Chadwick and Birchwood (1994), and emotion focussed coping more similar to the resistant style.

Although this model suggests that coping is inherently neutral, research consistently reports that coping strategies are effective when used by the appropriate person undergoing a particular stressor in the right context. In addition, the reality is that people tend to use a mixture of both emotion and problem focussed coping, and coping mechanisms usually change over time. Nevertheless, research suggests that those who use problem focussed coping adjust better to the experience (Ritsner, Ben-Avi, Ponizovsky, Timinsky, Bistrov & Modai, 2003), although Rudnick (2001) found no difference in quality of life between those with schizophrenia adopting a problem or emotion focussed coping strategy.

### 2.8.2 Coping with hearing voices

Falloon and Talbot (1981) undertook the first piece of research to explore the relationship between individuals' experience of hearing voices and self initiated coping strategies. They found that most individuals were able to initiate their own ways of coping, which included increased interpersonal contact and resisting and ignoring/not attending to the voice. Since then a number of researchers have investigated this link (Breier & Strauss, 1983; Carr, 1988; Cohen & Berk, 1985; Frederick & Cotanch, 1995; O'Sullivan, 1994; Romme & Escher, 1989; Romme et al., 1992; Tarrier, 1987), and the diversity of the coping strategies reported in these studies is impressive. The majority of these studies used open ended interviews with those experiencing hearing voices. The research showed that between 70 to 100 percent of the samples developed self initiated coping strategies in an attempt to alleviate distress. Tarrier, Harwood, Yusopoff, Beckett and Baker (1990) believed that focussing on the development of an individual's coping strategies was highly effective in relieving the distress associated with psychotic symptoms. In another study by

Tarrier (1993), it was found that reinforcing coping strategies improved short term outcomes. In addition, coping strategies were also influenced by culture. Wahass and Kent (1997) found that a Saudi group of voice hearers were much more likely to use religious ideas in coping.

In a review by Knudson and Coyle (1999), the following coping strategies for hearing voices were consistently reported: social contact, sensory stimulation, physiological arousal and cognitive strategies. Studies also generally found that participants increased their social contact rather than reduced it (Carr, 1988; Cohen & Berk, 1985; Falloon & Talbot, 1981; O'Sullivan, 1994; Tarrier, 1987). This may be surprising when considering the negative symptoms associated with psychosis, for example low mood and social withdrawal, as well as social avoidance as a consequence of serial invalidation of the experience (Bannister, 1963, 1965). This may be linked to the mere comforting effect of being with other human beings, which may provide further support for the helpfulness of being part of a hearing voices support group. It may also be that social contact is serving as a form of distraction. Other cognitive strategies include engaging with the voice instead of ignoring it. For example, Romme and Escher (1989) found that ignoring the voices was generally not an effective way of coping.

For coping to be effective it is thought that the explanations must be within the individual's view of the world. Escher wrote that 'making sense of voices was like putting together a jigsaw puzzle...it is necessary to have a strategy for organising the pieces so that the puzzle will be completed' (1999, p.54). In a conference held by Romme in 1992, voice hearers brought frames of reference which included psychodynamic, mystical, para-psychological, and medical. Each of these enabled the individual to make meaning of their experience within their own construct system. This highlighted the human experience of searching for meaning for what could otherwise be a frightening and chaotic experience (Frankl, 1973, as cited in Knudson & Coyle, 1999). This also points to the importance of working within the individual's own unique construct system in a therapeutic environment.

Knudson and Coyle (1999) said that what was missing from most of the research was the inclusion of process elements (i.e. how do each of the strategies work?) and predictive elements (i.e. for whom do the strategies work best?). This last point appears significant as the majority of research reports that individuals employ

opposite methods of coping, for example, reducing or increasing interpersonal contact and resisting or engaging with the voice. In addition, the coping strategy used may depend on the relationship that the person has developed with the voice (Benjamin, 1989). The individual is more likely to resist malevolent voices and engage with benevolent voices (Chadwick & Birchwood, 1995). Another important area for debate is to do with those who experience pleasant voices (Nayani & David, 1996). Does research still need to consider coping strategies for this group of people because why would someone need to cope with a pleasant experience?

Another criticism of research in the field of coping is to do with classification. For example, both Falloon and Talbot (1981) and Frederick and Cotanch (1995) classify 'listening to loud music' as an attempt to increase arousal, but it could be considered more appropriate to classify it under distraction. Classifications of coping strategies could therefore become problematic unless operational definitions are agreed upon. The current study chooses to merely classify the sample as either engaging or resisting copers, as consistent with Chadwick and Birchwood and Romme and Escher's model which both suggest that they act as two ends of a dichotomy. This therefore does not rely on any potential biases in classification by specific technique. In addition, the use of the repertory grid, in line with personal construct psychology, is selected as an appropriate measure to explore voice hearers' construing of themselves as copers. This allows a more person-centred approach which enables the individual to define coping based on their own unique understanding and social construction of what it means to cope. This approach therefore aims to creatively capture the great diversity of how coping is construed across cultures, ethnicities, ages and life experiences.

To consider the question 'which coping strategies are most valuable?' the study compares the levels of psychological distress in those defined as engaging and those defined as resisting copers. Based on previous literature it is hypothesised that those who employ a resisting coping style will score higher on measures of psychological distress compared to those who adopt an engaging style with their dominant voice.

## 2.9 Personal Construct Psychology

This section will explore the application of Kelly's (1955) Personal Construct Psychology (PCP) to understand the processes involved in working with those who hear voices. PCP is selected as a suitable theoretical model as it emphasises each individual's unique experience and is non-pathologising.

### 2.9.1 The PCP model

Central to PCP is the notion of constructive alternativism, meaning that there are an infinite number of possible ways of construing our experiences, and some constructions will be more useful than others in making sense of what we perceive, feel and think (Butt & Burr, 2004).

At the base of Kelly's (1955) theory is the view of 'person as scientist', which acknowledges the human capacity for meaning making, agency, and ongoing revision of personal systems of knowing across time. Similar to scientists, humans are assumed to make hypotheses about their experiences, in order to attempt to make them predictable. These hypotheses are based upon what were to be known as 'personal constructs'. The most important property of a personal construct is that it is bi-polar (the dichotomy corollary). It is this dichotomy that distinguishes a construct from a concept. For example, by saying that someone is 'attractive' we are also saying that people who are not attractive are 'unattractive', or whatever it is that we contrast with being attractive. This gives a basic example of a construct that someone might use to make meaning of their experiences. A possible bi-polar construct applied to a voice might be 'loud' and 'quiet'. Another important feature of a construct is that each bi polar construct exists within a larger construct system. This larger construct system is in essence, an individual's view of reality.

In PCP, constructs are applied to what are termed 'elements'. It is through the use of elements that personal constructs are elicited. Kelly defined an element as 'the things or events which are abstracted by a construct' and it is seen as one of the 'formal aspects of a construct' (Kelly, 1955, p. 137). The elements used in the current study are a mixture of 'self' and 'voice' elements: 'self now', 'ideal self', 'self before the voice', 'self without the voice', 'self as coper', 'self as a non coper', 'dominant voice', 'ideal voice' and 'worst voice'. These are selected as it is important that the elements

are representative of the area being investigated (Yorke, 1985, as cited in Fransella, Bell & Bannister, 2004).

### 2.9.2 The repertory grid technique.

Repertory grids are a flexible set of tools for assessing systems of personal meanings. They have been described as a 'psychic X-Ray' (Butt & Burr, 2004, p.124). The repertory grid provides a visual and semantic representational map of an individual's construct system and how it applies to important features of a person's life (e.g. relationships with the self and others).

### 2.9.3 Application of repertory grids to psychosis and hearing voices

The following sections introduce relevant Kellian ideas.

### 2.9.3.1 The Fundamental Postulate

Kelly's view of human motivation was presented as the fundamental postulate. He postulated that 'a person's processes were psychologically channelized by the way in which they anticipate events' (Kelly, 1955, p.46). Allen (2008) proposed that people who heard voices experienced a construct system that was exposed to multiple channels of communication from the voices. She suggested that this may compromise the ability of the voice hearer to anticipate events in an effective manner.

### 2.9.3.2 The Organisation Corollary

Constructs are believed to be hierarchical in nature, divided into superordinate, core and peripheral constructs, based on what the person views as important in life. The most important constructs are those which are core to our sense of being. These are resistant to change and can cause psychological distress if they are threatened in any way (Kelly, 1955). The non-consensual nature of voice hearing often means that when faced with other people who place voice hearing as outside of what they

consider 'normal' the voice hearer experiences communication and behavioural problems (Allen, 2008). Jacqui Dillon (2011), Chair of the Hearing Voices Network, UK, believes that psychosis should be defined as a 'de-contextualised experience', rather than pathology. Based on her own experiences of hearing voices, she feels that the experience becomes problematic for the individual and their system if it is placed outside of what is considered normal.

*2.9.3.3 Distance and Closeness to the Voice*

PCP proposes that it is part of fundamental human nature to make sense of our experience by looking for common themes, by adopting dimensions which roughly sort our experiences into meaningful categories (Kelly, 1955). 'The way in which the self is construed must necessarily be the way we construe others. This is because we do not have a self concept as such, only a bipolar 'self-not self' construct' (Bannister & Agnew, 1977, p. 99).

A body of research has explored how some of these aspects contribute to the creation of personal construct systems and interpersonal relationships in different areas, such as: personal development (Salmon, 1970; Shotter, 1970, as cited in Cipolletta, 2011), friendship relations (Craig & Duck, 1977; Duck, 1975; Duck & Spencer, 1972; Neimeyer & Neimeyer, 1981, as cited in Cipolletta, 2011), intimate relationships (Leitner & Klion, 1986; Neimeyer & Hudson, 1985; O'Loughlin, 1989, as cited in Cipolletta, 2011), and family relations (Cipolletta, 1998; Cipolletta & Racerro, 2003; Harter, Neimeyer, & Alexander, 1989; Procter, 2002, as cited in Cipolletta, 2011).

What these studies suggest is that people construe themselves and others along a dimension of similarity and dissimilarity, depending on how they construe themselves and the other. There has been a whole body of research looking at the relational framework of the voice hearing experience which was discussed earlier on in the chapter. Research suggests that both closeness and distance between the self and the voice is associated with the content of the voice (malevolence or benevolence) as well as the adopted coping style.

### 2.9.3.4 Salience of the 'Voice' and 'Self'

The concept 'salience' can be thought of as how prominent/important a particular element is for the individual compared to other elements which is measured using the sum of squares. The sum of squares accounted for by each element, and these scores as a percentage of the total sum of squares, show the meaningfulness of the element to the participant (Winter, 1992). A high score suggests that the element is relevant whilst a low score suggests that it has been rated close to the mid-point on most constructs. For example, a child may construe their best friend as a very prominent person in their life, compared to say their maths teacher. The current study is particularly interested in how the salience of the 'self' and the 'dominant voice' relates to coping style and psychological distress. The study hypothesises that individuals who have a salient 'dominant voice' will have a resistant style of coping and increased psychological distress. This is because there might be a conflict between what the person sees as important in their view of the world and what Western society views as normal. This links to previous discussions in the chapter about the current Western pathological narrative of voice hearing. Alternatively, a salient 'self now' element will be associated with engaging with the voice, and less psychological distress, because an autonomous, individualistic view of the world is in line with the Western narrative (Allen, 1997).

In addition, the study also aims to investigate whether the salience of the 'dominant voice' correlates with a measure of voice omnipotence. This will give further insight into individuals' meaning of voice omnipotence, and can provide support for the use of the repertory grid to assess people who hear voices.

### 2.9.3.5 Tightness, Invalidation and Denial

Tightness of construing was a measure developed by Kelly (1955), and refers to the tightness of organisation in an individual's construct system.

Constructs themselves can be either tight or loose. A loose construct is one which may or may not lead to the same behaviour each time, which can make life difficult for others as they may not be able to predict the actions of the person. A tight construct on the other hand always leads to the same actions. These people generally have firm habits and strongly held beliefs. When a person's construing is

predominantly tight their thinking will be concrete and lacking in new ideas (Bannister & Fransella, 1986). People who have tight construct systems are likely to be vulnerable to invalidation since their construct systems will be fragile and prone to collapse. It is through moving from loose construing into tight construing that an individual can express creativity, and was hence named the Creativity Cycle by Kelly (1955).

Bannister (1963, 1965) developed a theory that proposed that schizophrenic thought disorder could be explained by serial invalidation. He believed that the disorder was caused by individuals consistently making predictions about the world which were serially invalidated. If a person's constructs cease to be able to make sense of the world their construct systems become loose or vague and the constructs are said to have a weak relationship with one another. This serves to protect the individual from further invalidation because the predictions become vague. Radley (1974, as cited in Winter, 1992), in a review of Bannister's work, proposed that the link between schizophrenic thought disorder and loose construing was not as clear as Bannister originally proposed. Radley thought that it was not possible to differentiate between the loose construing of the thought disordered and the complex thinking of non disordered individuals. Individuals who used their constructs in a number of different ways also showed weak relationships between constructs.

Personal construct theory researchers have noted that individuals who tend to use denial frequently employ tight construing. What this means is that they tend to construe all situations as replicas of previous experiences, and ignore any changes (Catina, Gitzinger & Hoeckh, 1992). Catina et al. proposed that tight construing was associated with constriction, which was a strategy for excluding anxiety provoking information from consciousness. Myers, Brewin and Winter (1999) conducted repertory grid research into repressive coping and self reports of parenting, and found that repressors were significantly tighter in construing than non repressors.

Assuming that a resisting coping style encapsulates the defence mechanism denial, the current study hypothesises that an increased tightness of the construct system will be associated with resisting coping. Conversely, a looser construct system will be associated with an engaging coping style. An individual may be coping with the experience using resistance if the experience fails to integrate into their narrow view of reality. This has important clinical implications as one essential component of

personal construct psychotherapy is encouraging the client to be freed from their fixed way of viewing things and encouraging new ways of viewing the self and others (Kelly, 1955).

### 2.9.4 Repertory grid studies of coping

At least two published papers use the repertory grid technique to investigate the concept of coping: one addressing low back pain (Large & Strong, 1997) and another, parenting and repressive coping (Myers et al., 1999). The first of these used a sample of low back pain sufferers who defined themselves as copers. From their qualitative analysis of the grid, they found that copers associated coping closely with authenticity, obligatory, cautiousness and being limited in activity. Myers et al. (1999) interviewed female repressors (low anxiety, high defensiveness) to investigate the quality and content of their childhood experience. The study used the repertory grid technique and found the technique to capture a more accurate portrayal of the coping strategies in question. They stated that 'information concerning repressors' childhoods may be very different, depending on whether data are collected using interview or questionnaire methodology' (p.79). This provides further support for the use of the repertory grid to measure different types of coping. They also found that repressors exhibited overly positive ratings of their fathers possibly as a way of avoiding negative and painful memories, which the authors linked to an avoidant attachment style (Myers & Vetere, 1996). This finding adds to previous research which suggests that repressors use a defensive style of coping in which negative information was excluded.  Based on this research, it might be expected that there will be a difference in the way coping and the dominant voice is construed between both engaging and resisting coping groups.

The current study is interested in how participants use the construct of coping in their own construct systems, by exploring how the 'self as a coper' is construed between both engaging and resisting groups.

## 2.10 Rationale for the study

The concept of schizophrenia as a diagnosis has been criticised heavily on the basis of its questionable objectivity (Bentall, 1990; Slade & Cooper, 1979), as well as the doubt cast over its reliability, construct and predictive validity. In addition the aetiology remains unclear even after over a century of intensive research (Knudson & Coyle, 1999). A popular reason for this is that schizophrenia does not denote a unitary condition, but rather a more complex mixture of individualistic experiences. With this in mind it can be suggested that a more informative research strategy will focus on particular symptoms, for example hearing voices. Also, this approach sheds more light on the reality of the psychotic disorder for the research population.

Research into the experience of hearing voices has recognised a number of mediating factors influencing an individual's coping response (Hayward, 2003). These include beliefs about the voices' power, intent and identity (Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994), the social empowerment of the hearer (Romme & Escher, 1993, 2000), core beliefs about the self (Close & Garety, 1998) and the social significance of the voice talk (Leuder & Thomas, 2000). The current study aims to add to this list of mediating factors by researching PCP ideas such as, salience of the voice and self, tightness of construing and distance between the self and the voice. These mediating factors will be investigated in relation to the coping strategy used (engaging or resisting), as well as with levels of psychological distress. Repertory grid studies have frequently been utilised as a measure of these factors and for this reason the repertory grid was selected as an appropriate measure to use to explore an individual's construction of parts of their self as well as their voice, in relation to coping.

Furthermore, by focussing on a voice hearer's personal constructs of coping, the study provides an original and invaluable contribution to the literature on both the interpersonal nature of voices and links to revolutionary literature on coping with voices pioneered by Romme and Escher (1989). Tunks and Bellissimo (1988, as cited in Large & Strong, 1997) stated that coping research requires novel research strategies, and therefore the current study chooses to adopt a more idiographic methodology than previous research.

*2.11 Hypotheses*

The following hypotheses will be investigated:

1). Voice malevolence, benevolence and omnipotence:

    a. Construed salience of the 'dominant voice' will correlate positively with voice omnipotence.

    b. Construed distance between the 'dominant voice' and the 'ideal voice' will correlate negatively with voice benevolence.

    c. Construed distance between the 'dominant voice' and the 'worst voice' will correlate negatively with voice malevolence.

2). Relationships with voices:

    a. There will be a relationship between the closeness/distance between the hearer and the voice and their adopted coping strategy.

    b. Malevolence of the dominant voice will be associated with increased distance between the 'self now' and the 'dominant voice'.

3). An engaging style of coping will be associated with:

    a. Reduced psychological distress.

    b. A more salient view of the 'self' and a reduced salience of the 'dominant voice'.

    c. A loose construct system.

4). A resisting style of coping will be associated with:

    a. Increased psychological distress.

    b. A more salient view of the 'dominant voice' and a reduced salience of the 'self now'.

    c. A tight construct system.

In addition, the following research questions will be examined:

5). How is the dominant voice construed?

6). How is coping construed?

# 3. Method

## *3.1 Design*

The study used mixed quantitative and qualitative methodology.

Quantitative: The study was a cross sectional correlational design comparing two groups; those defined as engaging copers and those defined as resisting copers from the Beliefs About Voices Questionnaire- Revised (BAVQ-R, Chadwick & Birchwood, 2000). The groups were defined by whatever percentage score was greatest (engaging or resisting) from the BAVQ-R.

Qualitative: The study included case studies, using case examples from three participants, as well as carrying out content analysis of construct poles of both groups.

The study assumed a non parametric design based on the small sample size.

## *3.2 Participants*

Participants were individuals who had experienced hearing voices for at least six months and who had actively heard voices within the last three months. This made the assumption that within six months individuals would have developed their own self initiated coping strategies (Farhall, Greenwood & Jackson, 2007). Individuals recruited were between the ages of 18 and 65 years of age and were recruited through NHS adult mental health services and charities using convenience sampling. Those who were recruited through NHS trusts were recruited through their care coordinators, and those recruited through charities were recruited through their support group facilitators. A diagnosis under the DSM-IV umbrella of 'schizophrenia and other psychotic disorders' was not an inclusion criterion, although the entire sample did have a diagnosis under this category. It was also important that the participants had a basic grasp of English. Those individuals who were deemed at significant risk to themselves or others by their care coordinators or group facilitators were not recruited into the study, and this included participants who were actively using illicit substances. Participants with a mild learning disability were chosen to be recruited as long as they were informally considered to have mental capacity to

understand their participation by those who knew them, although those with moderate to severe learning disabilities were excluded. Broad inclusion criteria were used in order to obtain a generalisable sample of those people who heard voices. This was similar to other studies that used a cross sectional design and convenience sampling (e.g. Kilcommons & Morrison, 2005; Mueser, Trumbetta, Rosenberg, Vidaver, Goodman & Oscher, 1998).

### 3.3 Measures overview

A main consideration was that of complexity and time consumption. The literature has indicated the effect actively hearing voices has on the consumption of limited cognitive resources, including concentration and attention (Tandon, Keshavan & Nasrallah, 2008). The negative symptoms of psychosis also needed to be taken into account, including fatigue and lethargy. It was therefore important that the minimum number of measures were used to reflect the research questions. The repertory grid was also deliberately designed as short to reduce time consumption, yet long enough to adequately collect the necessary information. It was expected that the repertory grid would take about an hour and the BAVQ-R and OQ45.2 both 10 minutes each. On average interviews lasted about an hour and a half.

#### 3.3.1 Demographic data

The researcher gathered certain demographic information in order to describe the sample. Again, this was kept to a minimum as it would be unethical to collect personal details that were not relevant to the research question. Having this conversation at the beginning of the interview also allowed the researcher to build rapport with the participant. The following demographic information was therefore collected:

- Age
- Gender
- Ethnicity
- Medication
- Diagnosis
- Attendance of a support group

*3.3.2 The Beliefs about Voices Questionnaire- Revised (Chadwick, Lees &
Birchwood, 2000)*

The BAVQ-R is a 35 item measure of people's beliefs about auditory hallucinations,
and their emotional and behavioural reactions to them (Chadwick et al., 2000). The
questionnaire consists of three sub-scales relating to beliefs:

1. *Malevolence- 6 items, (e.g. 'my voice is punishing me for something I have
   done').*
2. *Benevolence- 6 items, (e.g. 'my voice wants to protect me').*
3. *Omnipotence- 6 items, (e.g. 'my voice is very powerful').*

The questionnaire also has two further sub-scales measuring behavioural and
emotional relationships to auditory hallucinations:

1. Resistance- 5 items on emotion (e.g. 'my voice frightens me') and 4 on
   behaviour (e.g. 'when I hear my voice usually I tell it to leave me alone').
2. Engagement – 4 items on emotion (e.g. 'my voice reassures me') and 4 on
   behaviour (e.g. 'when I hear my voice usually I listen to it because I want to').

All responses are rated on a 4-point scale: disagree (0), unsure (1), slightly agree (2)
and strongly agree (3). Individuals who hear more than one voice are asked to rate
their dominant voice over the last week. The total percentage scores for resistance
and engagement were chosen to define the groups, as previous literature has
recognised that coping is made up of a combination of both emotional and
behavioural factors (Lazarus, 1966).

The BAVQ-R is a questionnaire based on the BAVQ (Chadwick & Birchwood, 1995).
The BAVQ was developed following the proposal of a cognitive model of voices,
which suggested that reactions to voices were mediated by beliefs about the voices'
identity, power, purpose and the consequences of obedience and disobedience.
Chadwick and Birchwood found that the test-retest and internal reliability correlations
were high for the BAVQ, indicating that the characteristics being measured were well
defined and, in the short term, stable. The BAVQ found that voice related beliefs,
emotion, and coping behaviour were connected, and in the directions found
previously. The revised BAVQ was developed in response to the weaknesses of the
BAVQ. Firstly, participants answered 'yes' or 'no' on the BAVQ, which prevented
small individual differences from being detected, and secondly, the BAVQ only

included one item for omnipotence, and research has consistently reported the importance of this construct (Chadwick et al., 2000). The BAVQ-R therefore provided a further five items measuring voice omnipotence.

### 3.3.2.1 Psychometric properties of the scale

In a study of 73 people with drug resistant auditory hallucinations, Chadwick et al. (2000) presented the psychometric properties of the BAVQ-R. They reported that 'Cronbach's α (internal consistency) scores for each sub-scale, including the new omnipotence sub-scale were uniformly high between 0.74-0.88' (p. 230). Test-retest reliability was not reported for the BAVQ-R but the BAVQ had high test-retest reliability. In the validation study (Chadwick et al., 2000), 58 participants completed the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983). Malevolence, omnipotence and resistance were all associated with anxiety and depression (r=0.30-0.44) and engagement was negatively associated with depression (r=-0.42) and with anxiety (r=-0.36). They also found that malevolence and resistance were strongly related (r=0.68), as well as benevolence and engagement (r=0.80). In addition, omnipotence was positively associated with malevolence (r=0.70), and with resistance (r =0.50) and negatively associated with engagement (r=-0.26). Further support for construct validity comes from research that found an association of malevolence, resistance and omnipotence with depression, hopelessness and suicidal ideation (Simms, McCormack, Anderson & Mulholland, 2007).

The authors concluded that the questionnaire continued to measure clear and stable aspects of an individual's relationship with their voices. In a review of the assessment tools for auditory hallucinations, Ratcliff, Farhall and Shawyer (2010) stated that 'the BAVQ and BAVQ-R have proved valuable for researching the cognitive model of auditory hallucinations' (p. 735).

### 3.3.3 Measurements of psychological distress- The Outcome Questionnaire

The main outcome variable in schizophrenia is often symptom severity, which may not always be the most desirable outcome from the client's perspective (Lobban,

Barrowclough, & Jones, 2004). The OQ45.2 was therefore selected as a suitable measure that captured emotional state, functioning and interpersonal relationships.

The Outcome Questionnaire 45.2 (OQ45.2, Lambert et al., 2004) is a brief 45-item measure intended to measure three domains: symptom distress (e.g. 'I feel nervous'), interpersonal relations (e.g. 'I get along well with others'), and social role performance (e.g. 'I enjoy my spare time). The questionnaire also contains five questions addressing the level of risk (e.g. 'I have thoughts of ending my life'). Participants respond to the items on a continuum ranging from 'never' to 'almost always' as to how they were feeling or functioning in the preceding week. Total scores can range in value from 0 to 180, with a total score of 63 or higher falling in the clinical range. The three domains are made up of the following dimensions:

Symptom Distress (SD):

- Anxiety disorders
- Affective disorders
- Stress related illnesses

Interpersonal Relations (IR)

- Loneliness
- Conflict with others
- Family difficulties

Social Role Performance (SR)

- Conflicts at work
- Relationships
- Interaction with parents, adults, and peers

### 3.3.3.1 Psychometric properties of the scale

The OQ45.2 has been extensively researched and has been found to meet the multiple needs of both practitioners and researchers. Lambert et al. (1996) reported that the OQ45.2 validity was supported by high correlations with other measures of psychological distress, including the Beck Depression Inventory, Zung Self-Rating Depression and Anxiety Scales, Taylor Manifest Scale, and the Symptom Checklist

90-R. It also had a high correlation with measures of interpersonal functioning, such as the Inventory of Interpersonal Problems and the Rand SF36. Lastly, it correlated highly with a measure of social role, the Social Adjustment Scale. The authors also reported that the OQ45.2 had a test-retest reliability in the range of 0.78 to 0.84.

Other studies also found test–retest and internal consistency reliability as well as concurrent validity to be robust (Lambert et al., 1996). Nebeker, Lambert and Huefner (1995) examined ethnic differences and also found no significant differences on domain or total scores. In conclusion, the OQ45.2 is a US standardised instrument based on normative data with validity and reliability that exceed the usual standard.

### 3.4 Structured Interview

The majority of the time spent with participants was taken up completing the repertory grid. Although the repertory grid method is partly based on an interview (Winter, 1992), because individuals elicit their own constructs for given elements, it is more similar to a questionnaire. A repertory grid is a methodological tool originally used by Kelly (1955) to elicit an individual's personal construct system. George Kelly saw the grid as 'no more and no less than another way of stating his theory of personal constructs. It is not an add-on. It is personal construct theory in action' (Fransella et al., 2004, p.1). Each of us has many implicit theoretical beliefs (for example, about God or about love) and a repertory grid provides a way of exploring the content and structure of such theories. Kelly also proposed that constructs were best viewed as being made up of hierarchical sets of bipolar constructs (for example, love-- hate, loud-- quiet). The repertory grid was chosen as a suitable research tool because it was believed that the grid was a great deal more sensitive to the nature of a person than just a questionnaire (Fransella et al., 2004).

Jankowicz (2004) noted that there were four main components to a repertory grid namely, the topic, constructs, elements, and ratings. The topic represents the realm of discourse under investigation. In the current study the topic was how participants viewed themselves, coping and their dominant voice. The constructs are bipolar attributes that the person uses to make sense of their experience. The elements are examples of, samples of, instances of, or occurrences within, a given topic (Jankowicz, 2004). In the current study the elements were a mixture of 'selves' as

well as different voices. Lastly, the ratings are numbers on a scale that are applied to each element on each construct. In the current study a 7-point scale was used (Fransella et al., 2004).

Kelly (1955) indicated that the chosen elements in a grid must be within the range of convenience of the constructs used. Yorke (1985, as cited in Fransella et al., 2004) reiterated this point by suggesting that elements should reflect context. Table 1 presents the elements chosen for the current study. The elements reflect three different categories: the self in different positions (4 elements), the self in relation to coping (2 elements) and the voice, to reflect 3 different positions of voice. The elements were presented to each participant in the order of Table 1.

**Table 1:** Elements selected for the repertory grid.

| Category | Element |
|---|---|
| **Self in different positions** | Self now |
| | Ideal self |
| | Self before the voice |
| | Self without the voice |
| **Self in relation to coping** | Self as a coper |
| | Self as a non coper |
| **The voice** | The dominant voice |
| | The ideal voice |
| | The worst voice |

To elicit each individual's bi-polar constructs, the triadic method was used. Kelly originally described six ways to elicit constructs, one of which he called the sequential form. Here the elements are presented systematically by changing one element in the triad with another, for example, presenting cards with the elements 1,2,3 and then replacing the element 1 with element card 4. Using this method, in the current study a total of 7 bi-polar constructs were elicited from each individual. Nine elements and 7 bi-polar constructs is a small number in comparison to other studies, but, Leach, Freshwater, Aldridge, and Sunderland (2001, as cited in Fransella et al., 2004) stated that the number of element triads should be selected randomly by the researcher to

reflect the context and time constraints. A small grid seemed important based on research suggesting limited cognitive resources as well as the knowledge from other voice hearers who report that voices become louder and more distracting in settings where the voice is being spoken about.

In order to obtain the emergent pole of the construct, each element was written on a separate card and presented to participants as a triad. Participants were then asked 'in what way are two of these cards similar, but different from the third?' This was similar to Kelly's (1955) original method of eliciting the emergent pole. Epting, Suchman, and Nickeson (1971, as cited in Fransella, 2004) suggested that to elicit the implicit (contrast) pole, the individual could be asked 'what is the opposite of this?' (the emergent pole). This is known as the opposite method. This method was selected because the researcher wished to ensure that the opposite of the construct given was obtained rather than the opposite of another construct (which could happen if the contrast pole was taken as 'the way one element from the triad was different'). Yorke (1983, as cited in Fransella, 2004) believed that taking the 'difference' can produce 'bent' constructs, so the opposite technique meant this mistake was avoided. Epting et al. (1971, as cited in Fransella, 2004) found that the opposite method elicited more clearly defined bi-polar constructs than did the difference method.

### 3.5 Analysis of repertory grids

#### 3.5.1 Slater's (1972) analysis

It can be said that the most significant contribution to repertory grid mathematical analysis was made by Slater and his INGRID programme (Slater, 1972). This programme involves the application of the Principal Components Analysis (PCA) to repertory grid data with interval scores. This mathematical procedure converts a number of variables (elements or constructs) into a lesser number of hypothetical variables (components or factors) which explain the maximum possible variance. The components can then be used as the axes where the constructs are plotted according to their factor loadings.

*3.5.2 Idiogrid*

This software was used to calculate all repertory grid measures: element distances, salience of elements and tightness of the construct system (see Table 2). Idiogrid produces graphical representations of repertory grid results which are presented in Chapter 4. The graphs are 2-dimensional representations of an individual's construct system. They are plotted against Slater's (1972) two principal component axes: the horizontal representing the first component (Comp 1) and the vertical representing the second component (Comp 2) of the grid. Idiogrid plots elements and constructs into an area of 2-dimensional space and visually shows how far apart elements and constructs lie in relation to one another.

Table 2 shows definitions of the terms used in the current study from the three measures used.

**Table 2:** Operationalisation of terms from the 3 measures used

| Measure | Scale | Definition |
| --- | --- | --- |
| **Repertory Grid** | Salience | The percentage of the sum of squares accounted for by a given element. |
| | Tightness/ Looseness | The percentage of variance accounted for by the first principal component of the grid (Slater, 1972). |
| | Distance | A measure of the extent of construed dissimilarity between two elements on the repertory grid, for example the 'self now' and the 'dominant voice'- ranging from 0 (no distance) to approximately 2 (large distance). |
| **BAVQ-R** | Engaging Coping | Elective listening, willing compliance and doing things to bring on the voices. |
| | Resisting Coping | Arguing and shouting (overt and covert), non compliance or reluctant compliance when pressure is extreme, avoidance of cues that trigger voices and distraction. |
| | Malevolence | The wish to do evil. |
| | Benevolence | The wish to do good. |
| | Omnipotence | Powerful. |

| OQ45.2 | Symptom Distress | Anxiety disorders, Affective disorders, Stress related illnesses. |
|--------|------------------|---------------------------------------------------------------|
|        | Interpersonal Relationships | Loneliness, Conflict with others, Family difficulties. |
|        | Social Role | Conflicts at work, Relationships, Interaction with parents, adults, and peers. |
|        | Risk | Thoughts about or intent to harm the self or others. |
|        | Psychological Distress | Total score of: Symptom Distress+ Interpersonal Relationships + Social Role + Risk. |

### 3.5.3 The classification system for personal constructs (CSPC, Feixas, Geldschlager & Neimeyer, 2002)

In addition to quantitative analysis of the repertory grids, qualitative analysis was also selected as appropriate to consider the final two hypotheses exploring how participants construed the 'dominant voice' and the 'self as a coper'. This addition was important because, 'the Kellian psychologist adopts a credulous approach in which the client's perspective is spelt out, elaborated and discussed. The aim is not to arrive at a tightly defined set of constructs, neatly pinned down to a set of verbal labels. We are not getting at a person's constructs, but looking at the way they construe' (Butt & Burr, 2004, p. 126).

The use of CSPC allowed the identification of the thematic areas of coded constructs. It is thought that the use of a coding system complements correlational analysis of a grid by allowing qualitative analysis of structure and content of constructs. Landfield (1971) provided the original means to categorise constructs into 22 categories. However, Feixas, Geldschlager, and Neimeyer (2002) provided a list of the drawbacks of using these categories, including the overlap between categories, the non comprehensive nature of the categories and the treatment of each construct pole as separate rather than as one complete as originally proposed by Kelly (1955). This led Feixas et al. (2002) to develop their own, more recent classification system to

rectify the disadvantages of the original Landfield system. The Feixas system included the use of 45 content categories which were divided into six basic areas: moral, emotional, relational, personal, intellectual/operational and values/interests, as well as two possible supplemental areas: existential and concrete descriptors.

In the current study for each participant the construct pole on which the elements 'dominant voice' and 'self as coper' were given an extreme score (1 or 7) were selected. The construct poles were then rated by the researcher and another trainee clinical psychologist with experience of the rating system to determine inter-rater reliability. Any disagreements between raters were discussed and a consensus decided upon. A percentage of disagreement is later reported.

### 3.5.3.1 Psychometric properties of the system

Feixas et al. (2002) reported that the relational, personal and emotional areas were coded most frequently (20-25%), followed by the moral area (15%), and the remaining areas (5%). They also reported that the total percentage of agreement between raters was 87.3% across all 45 categories, with the smallest agreement being 66.7%. This figure was compared to the 62% benchmark used by Landfield (1971) to exclude those categories with poor reliability. Cohen's $\varkappa$ (kappa) coefficient was 0.9 over the 45 categories and 0.95 over 6 areas. These figures confirm the high level of reliability of the CSPC.

### 3.6 Methodology

Once ethical approval had been obtained, two NHS Trusts and two charities (Rethink and Family Action Plus) were approached to recruit participants. Rethink and Family Action Plus were two charities that were approached from the list of group organisers from the Hearing Voices Network website, and both replied giving their approval for the research to be reviewed by their independent ethics committees. Within the NHS Trusts care coordinators from the Community Mental Health Teams, Early Intervention in Psychosis Teams, and Assertive Outreach Teams were given information on the study as well as the inclusion and exclusion criteria. In some cases team meetings were also attended to present the research. An NHS run hearing

voices group was also approached and the researcher attended the group on two occasions to meet the group attendees. As part of the agreement with Rethink, support groups as well as their website and Facebook page were used to advertise the study. Family Action Plus held one support group and following ethical agreement the researcher asked the group facilitator to introduce the research to the group.

Once a potential participant was identified by the care coordinator or group facilitator a copy of the information sheet was sent to the participant (see appendix 1). The researcher then phoned them if they gave their consent to be contacted. Participants who identified themselves as interested from the Rethink website or Facebook page were given a number for a research phone owned by the researcher to discuss the study. A decision was made by the researcher during this conversation about their suitability for the study.

Meetings were arranged with participants either at an NHS building, a university building, the location of their group meeting, or for those in supported living, the staff room. One interview was also carried out on the phone because the participant suffered severe social anxiety. Participants were made aware that interviews could take up to two hours.

Upon meeting the participants the researcher took every effort to make the participant feel comfortable and relaxed by finding a suitable, comfortable and quiet location. The researcher went through the participant information sheet with each participant, emphasising their ability to withdraw at any point, and the level of confidentiality. An opportunity for questions was always offered. If they wished to continue with participation the individual was then asked to sign the consent form. Participants were encouraged to ask for a break at any point throughout the meeting, and highlight to the researcher if they were beginning to feel distressed by the interview.

The interview with the participant then began and the three measures were completed. Once this had been done, the participant was provided with a debriefing sheet (appendix 3) which outlined a number of helpful resources (phone numbers, websites and support groups) for the person to take away. Participants generally received this very positively. Participants were then asked whether or not they would like to receive feedback from their repertory grid over the phone. This was in-built into the study as it was felt important that the validity of the grid was checked with the

participants. Participants chose not to receive a feedback phone call, but most chose to be sent a summary of the results of the study.

If the participant was recruited through the NHS, following the interview a letter was sent to their care coordinators and G.P's informing them of their participation (the letter did not include any individual scoring). For those recruited through Rethink or Family Action Plus a letter was sent to either the group facilitator and their G.P, or just their G.P. Each person was made aware of this in the consent form.

### 3.7 Ethical considerations

Approval for the study was applied for from the Research Ethics Committee (REC) in May 2010. Permission to proceed with the study was given in August 2010 (see Appendix 5). Approval for the study was also obtained by the Rethink ethics panel in November 2010, and the Family Action Plus ethics committee in November 2010 (see appendix 5).

An individual licence was also obtained from the OQ authors, which enabled the use of the OQ45.2 for research purposes by the principal researcher only (see appendix 9).

#### 3.7.1 Confidentiality

Each participant was anonymised using a number that was only known to the researcher and participant. Anonymised data included all three questionnaires. Named information was kept separate and in a locked filing cabinet. In addition, the same participant information was kept securely electronically using password protection.

#### 3.7.2 Informed Consent

Each participant was both verbally and in writing reminded that their participation was voluntary and that if they chose to withdraw at the time of the interview, or a later

date, their information would be destroyed and their care not affected (see appendix 2).

The three participants who were written up as case studies were individuals who were not prompted but chose to informally share their stories either before or after the questionnaires were administered. This information was originally planned to be gathered from the individual's medical notes (which is why this point was included in the informed consent form) although the researcher felt that an up to date, personal account of the individual's experience would be more meaningful than a professionals account taken from medical records. By using this approach it also meant that what was included in the final write up was information that the participant felt pertinent to their experience. The individuals selected as case studies were not selected beforehand, and each gave their verbal informed consent after being asked whether their accounts could be written up as part of the research. Before continuing with the informal conversation about their experience, the individual was asked whether or not any information they chose to provide me with could be used as a more detailed case study. On average, this conversation lasted 15 minutes, and afterwards I summarised what I heard and queried any points that were not clear. The participant was again reminded that their information would be used as a case study. Each of the three participants told me that they were eager for their stories to be shared, which may have been indicative of a selection bias, but the case studies did not contribute to any form of statistical analysis and were purely explorative.  Anonymous written notes were kept by the researcher to record the information.  Although this approach had the advantage of including individual accounts that were personal and meaningful, it could also be said that the information given by the participant was biased based on what was at the forefront of their minds. This was especially the case as there were no pre determined standardised questions for each case study.

### 3.7.3 *Managing participants' distress*

Potential participants who were deemed at significant risk to themselves or others were not recruited into the study. This information was gathered beforehand via care coordinators, home managers or group facilitators. The very nature of the topic meant that the questions were likely to evoke difficult thoughts and feelings for the participants, as well as be a trigger for malevolent voices. However, it was also likely

that by talking about the voices and their experiences they would receive some therapeutic benefit (Romme & Escher, 1989).

If participants showed distress during the interview then the following procedure was adhered to:

1. If the researcher witnessed levels of distress the decision would be made to suspend the interview.
2. If the distress could be managed by offering a break from the questions, support with what was causing the distress, or basic relaxation, then the best course of action would be discussed with the participant: continuing, suspending for a later date, or withdrawing.
3. If the distress could not be managed using step 2 then the participants care coordinator, group facilitator or home manager would be contacted immediately, preferably with the participant's consent. In order to protect the researcher from risk, all of the interviews were conducted on sites where either medical, educational or residential staff were present for the duration of the meeting.

A conversation with each participant was had at the end of the meeting about their level of distress, and also whether they had any concerns or questions regarding the interview. Each participant was provided with a debriefing sheet that included their local emergency numbers as well as support phone lines and forums including Rethink and the Hearing Voices Network (see appendix 3).

### 3.8 Time considerations

Meetings with participants lasted on average between 60-90 minutes. The variation depended on how much informal conversation the participant wished to have and how easily they adapted to the administration of the repertory grid. Some participants also chose to take drink and cigarette breaks to help with their concentration. Every participant completed the questionnaires over one session.

### 3.9 Statistical data analysis

Using Cohen's conventions for effect sizes (Cohen, 1992), a minimum sample size of 25 would be required to detect a medium effect size correlation (r= 0.50, power = 0.80, alpha error = 10%, 1 tailed).

However, the final sample size was lower than 25 and so the power reported (Cohen, 1992) was lower than that anticipated.  In addition, given that the sample size was small, non-parametric tests were selected. The non parametric tests selected were the Spearman's Rank correlation test, the Mann Whitney U test and the Wilcoxon Signed Ranks test of difference.

As the majority of the statistical analysis was correlational in design, Cohen's recommendation for effect sizes was important. Cohen (1988) gave the following guidelines for the social sciences:

- Small effect size, $r < 0.30$
- Medium, $r = 0.30 - 0.50$
- Large, $r > 0.50$

# 4. Results

This section will begin with a demographic description of the sample. Each hypothesis will then be investigated in turn, leading to content analysis of the constructs exploring both engaging and resisting copers' construal of the 'dominant voice' and the 'self as coper'. The chapter will end with detailed presentation of three participants. Finally, a synopsis will be presented of all the findings.

## 4.1 Demographic Information

The results for the demographic information are summarised in Table's 3 and 4. The overall sample consisted of 18 participants (13 male and 5 female), all of whom had heard voices within the last three months and for at least six months. The age range was between 23 and 55 years, with an overall mean of 37 years of age. In terms of ethnicity, 11 participants were White British, 3 Black Caribbean, 2 Black African, 1 European and 1 Asian. All the participants had a DSM-IV diagnosis of 'schizophrenia and other psychotic disorders'. Of the 18 participants, only 2 did not take prescribed anti-psychotic medication. Ten participants took prescribed anti-depressant medication, 6 benzodiazepines, and 2 mood stabilisers. Seventeen participants were living in the community, and only one participant was sectioned under the Mental Health Act (2007). Eleven participants were not part of a hearing voices support group, and 7 were. All participants had received support through mental health services at some point because of their voice hearing.

**Table 3:** Distribution of ages between males and females

|     |      | Male (n=13) | Female (n= 5) | Overall sample (n=18) |
| --- | --- | --- | --- | --- |
| Age | Mean | 36.4 | 38.2 | 36.9 |
|     | SD   | 10.5 | 13.8 | 11.1 |
|     | Range | 23-53 | 24-55 | 23-55 |

**Table 4:** Percentages of ethnic groups, support groups, and medication across males and females

|  |  | Male (n=13) | Female (n=5) | Overall sample (n=18) |
|---|---|---|---|---|
| **Ethnicity** | **White British** | 62% | 60% | 61% |
|  | **Black Caribbean** | 16% | 20% | 17% |
|  | **Black African** | 8% | 20% | 10% |
|  | **Asian** | 8% | 0% | 6% |
|  | **European** | 8% | 0% | 6% |
| **Support group** | **No** | 69% | 40% | 61% |
|  | **Yes** | 31% | 60% | 39% |
| **Medication** | **Anti- psychotics** | 92% | 80% | 89% |
|  | **Anti-depressants** | 54% | 60% | 56% |
|  | **Benzodiazepines** | 31% | 40% | 33% |
|  | **Mood stabilisers** | 15% | 0% | 11% |

### 4.1.1 Drop outs

There were two drop outs from the study. Both participants showed interest in the study after reading the information sheet. However, upon making a time to meet, both participants felt that their mental health was not stable enough to be able to participate. Both of these individuals lived in the community, one was female and one male. One attended a hearing voices support group and one accessed an adult mental health service.

### 4.1.2 Male/Female comparisons

An independent samples Mann Whitney U test found that the only significant gender difference was with tightness of construing (U=10, p<0.05, 2-tailed). The mean tightness score for males was 79.87 (SD= 14.36), compared to a mean female score of 63.18 (SD= 12.83). Therefore, males presented with a tighter construct system.

### 4.1.3 Ethnicity comparisons

An independent samples Mann Whitney U test found that the only significant difference between those associated with a Western narrative (White British and European) and those defined as associated with a non Western narrative (Black African, Black Caribbean, and Asian) was on the variable voice omnipotence (U=13.5, p<0.05, 2-tailed). Those defined as Western reported greater levels of voice omnipotence (mean= 11.92, SD=4.36) compared to those from non Western cultures (mean=6.33, SD=4.18), represented by the box plot in Figure 1.
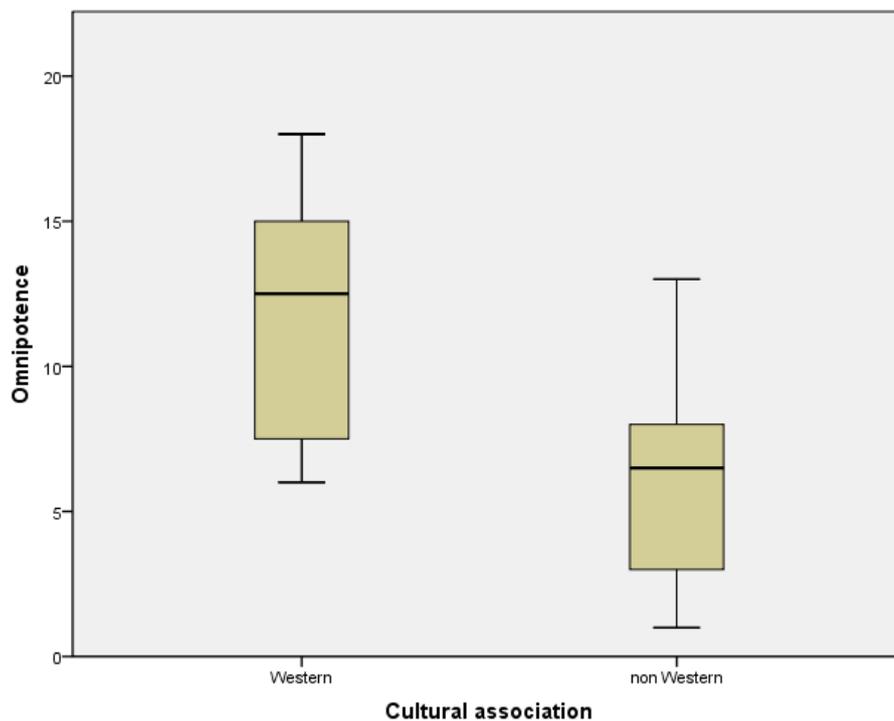


**Figure 1**: Boxplot showing the medians and distributions of voice omnipotence between those defined by the cultural groups 'non Western' (n= 6) and 'Western' (n=12).

### 4.2 Comparison of the sample to Chadwick et al.'s (2000) sample

Four Spearman Rank correlations were carried out to investigate the similarities between the current study and Chadwick et al.'s (2000) study following their cognitive model of hearing voices. Table 5 shows that the sample from the study was similar to the sample of 26 used in the Chadwick et al. study.

**Table 5:** Comparison of the current study with the Chadwick et al. (2000) sample on the BAVQ-R measures

| Correlations | Chadwick study | Current study |
|---|---|---|
| **Malevolence & Resistance** | r=0.60 | ($r_s$=0.84, n=18, p<0.01, 1–tailed) |
| **Omnipotence & Resistance** | r=0.50 | ($r_s$=0.84, n=18, p<0.01, 1-tailed) |
| **Omnipotence & Malevolence** | r=0.70 | ($r_s$=0.75, n=18, p<0.01, 1-tailed) |
| **Benevolence & Engaging** | r=0.80 | ($r_s$=0.70, n=18, p<0.01, 1-tailed) |

### *4.3 Frequencies of scores from the OQ45.2*

Figure 2 represents the distribution of OQ45.2 total scores. The mean overall score from the OQ45.2 was 81.56 (SD= 31.72), which lies in the clinically significant range (clinical cut-off =63). The mean score for symptom distress was 50.28 (SD=21.86), interpersonal relations 18.83 (SD= 7.52), social role 12.44 (SD= 5.58) and risk 4.06 (SD= 3.21).
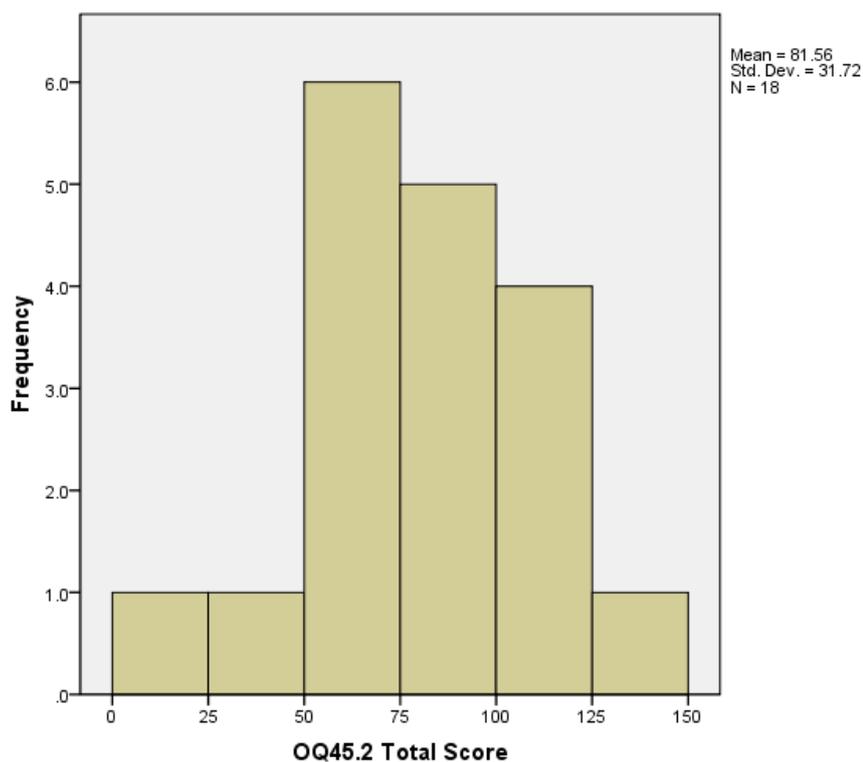


**Figure 2:** Histogram of scores for the OQ45.2 total

***4.4 Comparison between engaging and resisting copers***

*4.4.1 Demographic comparisons between engaging and resisting coping*

Of the whole sample of 18, 6 were defined as engaging copers from the BAVQ-R and 12 resisting copers. The coping style was simply defined as resisting or engaging by whichever total percentage score was greater from the BAVQ-R. This has the disadvantage that group definition could be determined by a difference of just 1 point.

However, a Spearman's Rank correlation found a large negative correlation between engaging and resisting coping ($r_s$=-0.72, n=18, p<0.01, 1-tailed), significant at the 1% level. This suggests that resisting and engaging coping are largely different from one another, which provides support for the classification of the sample into these two groups. This was also supported by a statistically significant difference between the medians of engaging and resisting coping following a Wilcoxon Signed Ranks test (W=34.5, n=18, p<0.05).

The mean age for the group of resisting copers was 39.4 years (SD= 12.24) and the mean age for engaging copers was 31.8 years (SD = 6.68). Of the resisting copers, 9 were male, and 3 female, and of the engaging group, 4 male, and 2 female.

*4.4.2 BAVQ-R comparisons between engaging and resisting copers*

Table 6 shows the differences in the BAVQ-R scores between those defined as engaging copers and those defined as resisting copers. As expected, the mean score of voice malevolence and omnipotence was greater in the resisting group, and similarly, in the engaging group the mean for voice benevolence was greater.

Mann Whitney U tests showed that the mean differences noted in Table 6 between engaging and resisting copers were all statistically significant at the 5% level. The results of the Mann Whitney U tests were: malevolence (U=8.5, p<0.01, 1-tailed), benevolence (U=64, p<0.01, 1-tailed) and omnipotence (U=13.5, p<0.05, 1-tailed).

**Table 6:** Descriptive information from the BAVQ-R

|                       | **Engaging copers (n=6)** | **Resisting copers (n=12)** |
|-----------------------|---------------------------|-----------------------------|
| **Voice Malevolence** | Mean = 2.67               | Mean =12.08                 |
|                       | Range = 0-14              | Range = 2-18                |
|                       | SD = 5.61                 | SD =4.83                    |
| **Voice Benevolence** | Mean =10.17               | Mean =2.50                  |
|                       | Range = 2-16              | Range = 0-12                |
|                       | SD =4.67                  | SD =3.66                    |
| **Voice Omnipotence** | Mean =6.67                | Mean =11.75                 |
|                       | Range = 1-13              | Range = 3-18                |
|                       | SD =3.83                  | SD =4.71                    |

*4.4.3 OQ45.5 comparisons between engaging and resisting copers.*

The information provided in Table 7 shows that the mean score for psychological distress as measured by the OQ45.2 total was 82.58 (SD=3.15) for resisting copers and 79.50 (SD=24.71) for engaging copers. Measures of symptom distress and social role were also greater in the resisting group, and interestingly, in the engaging group, measures of inter personal relations and risk were greater.

However, none of the mean differences in Table 7 were statistically significant following Mann-Whitney U tests, and the small sample group of those defined as engaging copers makes it difficult to report any firm conclusions. The Mann Whitney U test results were: symptom distress (U=27, p=0.64, 1-tailed), interpersonal relations (U=46, p=0.35, 1-tailed), social role (U=40, p=0.71, 1-tailed), risk (U=48.5, p=0.24, 1-tailed) and OQ45.2 total (U=31, p=0.64, 1-tailed).

**Table 7:** Descriptive information between engaging and resisting copers for the OQ45.2

|  | Engaging | Resisting |
|---|---|---|
| **Symptom Distress**<br>(clinical cut-off = 36) | Mean = 46.17<br>SD = 17.59<br>Range =22-72 | Mean = 52.33<br>SD = 24.17<br>Range = 0-82 |
| **Inter Personal Relations**<br>(clinical cut-off = 15) | Mean = 21.33<br>SD = 6.62<br>Range =13-29 | Mean = 17.58<br>SD = 7.90<br>Range =4-30 |
| **Social Role**<br>(clinical cut-off = 12) | Mean = 12<br>SD = 3.41<br>Range =6-16 | Mean = 12.67<br>SD = 8.53<br>Range =3-28 |
| **Risk**<br>(clinical cut-off = 0) | Mean = 5.17<br>SD = 3.31<br>Range =0-8 | Mean = 3.5<br>SD = 3.15<br>Range =0-10 |
| **OQ Total**<br>(clinical cut-off = 63) | Mean = 79.50<br>SD = 24.71<br>Range =49-112 | Mean = 82.58<br>SD = 3.15<br>Range = 0-10 |

### 4.5 Testing the hypotheses

#### 4.5.1 Voice malevolence, benevolence and omnipotence

*Hypothesis: Construed salience of the 'dominant voice' will correlate positively with voice omnipotence.*

There was a large positive correlation between the salience of the element 'dominant voice' from the repertory grid and voice omnipotence as measured by the BAVQ-R ($r_s$=0.63, n=18, p<0.01, 1-tailed), which was significant at the 1% level. Therefore, the measure of construed salience of the dominant voice from the repertory grid was positively associated with voice omnipotence from the BAVQ-R. This is represented graphically in Figure 3.
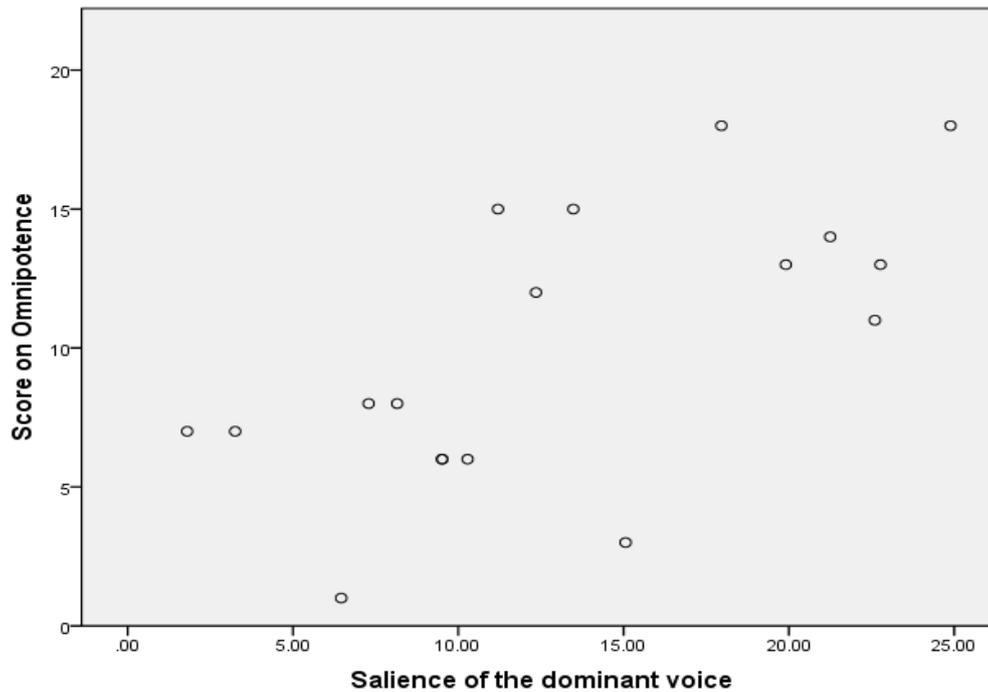
**Figure 3:** A scatter plot showing the correlation between voice omnipotence and salience of the dominant voice.

*Hypothesis: Construed distance between the 'dominant voice' and the 'ideal voice' will correlate negatively with voice benevolence.*

There was a large negative correlation between the distance between the elements 'dominant voice' and the 'ideal voice' and a measure of voice benevolence ($r_s$=-0.69, n=18, p<0.01, 1-tailed), significant at the 1% level. Therefore, the more the person construed the dominant voice as similar to their ideal voice, the more likely they were to view it as benevolent.

*Hypothesis: Construed distance between the 'dominant voice' and the 'worst voice' will correlate negatively with voice malevolence.*

There was a large negative correlation between the distance between the elements 'dominant voice' and 'worst voice' and voice malevolence ($r_s$=-0.56, n=18, p<0.01, 1-tailed) significant at the 1% level. Therefore, the more similar the dominant voice and

the worst voice were construed, the more likely they were to view the dominant voice as malevolent.

### 4.5.2 Which coping style is more valuable?

*Hypothesis: Psychological distress will correlate positively with resisting coping.*

A Spearman's Rank correlation found a medium positive correlation between OQ45.2 total and a measure of resistance ($r_s$=0.38, n=18, p=0.06, 1-tailed) which was not statistically significant. However, there was a statistically significant medium positive correlation between a resisting coping style and a measure of symptom distress ($r_s$=0.46, n=18, p<0.05, 1-tailed). This suggests that resisting coping is associated with increased symptom distress.
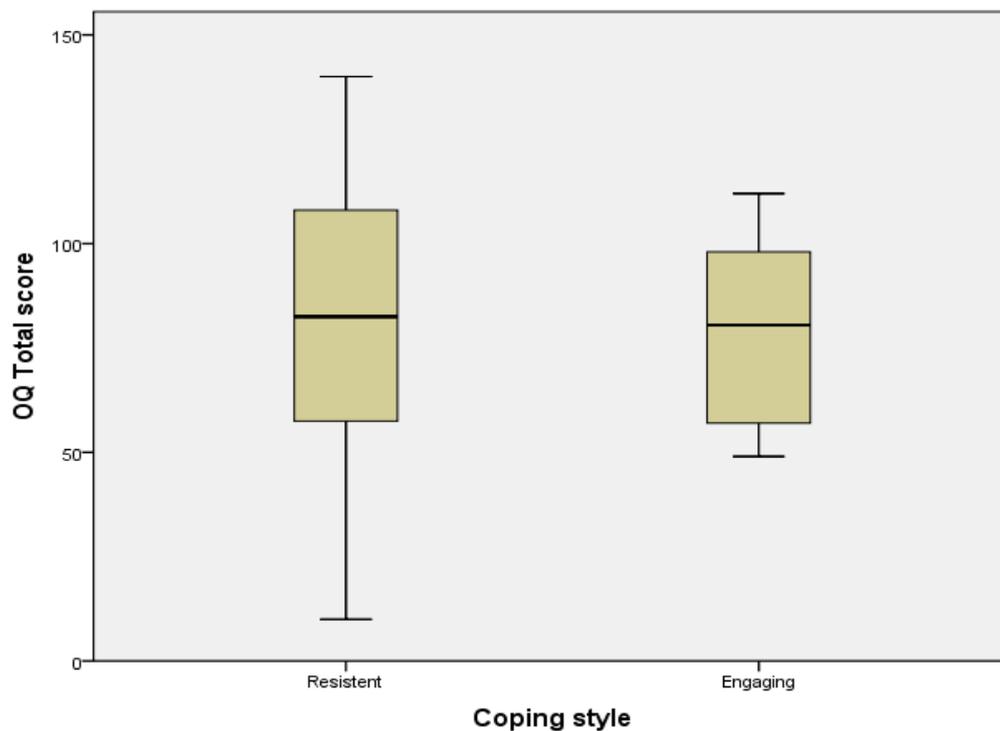


**Figure 4:** Box plot showing the distribution of OQ45.2 total scores for resisting (n= 12) and engaging (n=6) copers.

Conversely, there was a small negative association between engaging coping and OQ45.2 total ($r_s$=-0.06, n=18, p=0.41, 1-tailed) and symptom distress ($r_s$= -0.17, n=18, p= 0.25, 1-tailed), although both correlations were small and neither statistically significant. This suggests that engaging coping is not associated with reduced psychological distress. Figure 4 shows the medians of the OQ45.2 scores across both engaging and resisting groups and shows little difference.

### 4.5.3 Relationships with voices

_Hypothesis_: There will be a relationship between the construed distance between the 'self now' and the 'dominant voice' and the adopted coping style.

To test the above hypotheses two Spearman Rank correlations were carried out between the scores of coping as measured by the BAVQ-R and the distance between the 'self now' and 'dominant voice' elements from the repertory grid.

The first correlation between construed distance between the 'self now' and the 'dominant voice' with a measure of engaging coping found a medium negative correlation ($r_s$=-0.32, n=18, p=0.19, 2-tailed), although the result was not statistically significant at the 5% level. Therefore closeness with the voice cannot be said to be associated with an engaging coping style.

A correlation between construed distance between 'self now' and the 'dominant voice' with a measure of resisting coping found a medium positive correlation ($r_s$=0.48, n=18, p<0.05, 2-tailed), which was statistically significant at the 5% level. This is supported by the scatter plot in Figure 5. In addition, correlations were carried out between the repertory grid measures of distance and OQ45.2 measures to see whether increased distance from the voice was associated with increased psychological distress or increased interpersonal relations disruption. A Spearman's Rank correlation between distance between the 'self now' and the 'dominant voice' with the OQ45.2 total ($r_s$=0.28, n=18, p=0.13, 1-tailed) and the interpersonal relations ($r_s$=0.29, n=18, p=0.13, 1-tailed) measures did not support these hypotheses.
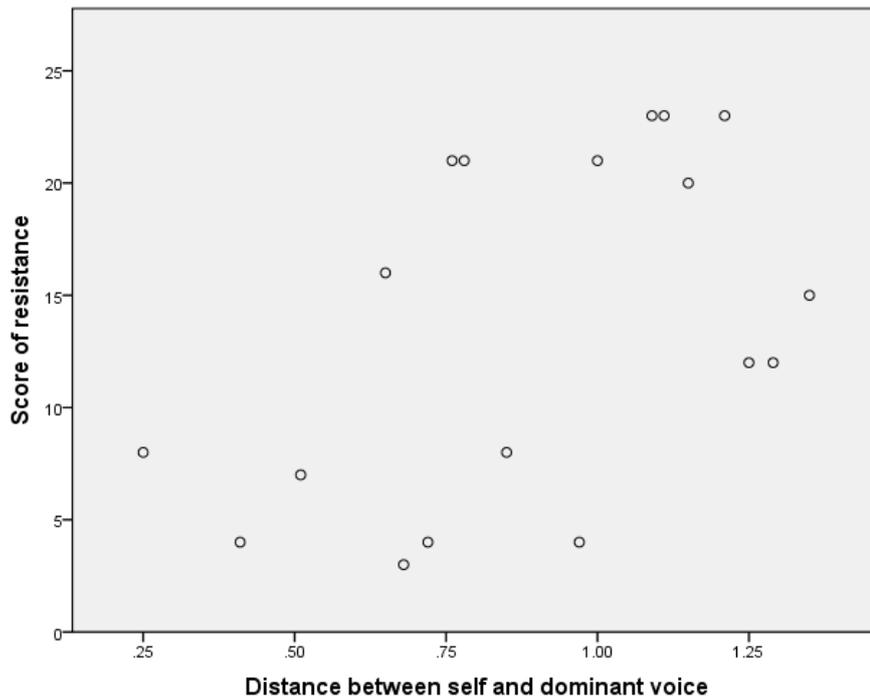
**Figure 5:** Scatter plot showing the correlation between the distance between the 'self now' and the 'dominant voice' and resisting coping.

*Hypothesis: The mean distance between the 'self now' and the 'dominant voice' will be greater in the resisting group compared to the engaging group.*

Figure 6 shows the median and distribution of scores for both engaging and resisting coping groups. The box plot shows that the median distance between the 'self now' and the 'dominant voice' was larger for the resisting group compared to the engaging group. The difference between the means was not statistically significant (U=21, p=0.16, 1-tailed) following a Mann-Whitney U test. However, the mean difference corresponded to a Cohen's d of 0.65, suggesting a considerable difference between the engaging and resisting coping group regarding the construed distance between the 'self now' and 'dominant voice' which is of practical significance. The reason for the statistical insignificant result is the small sample size and consequently a lack in statistical power to discover this effect size.
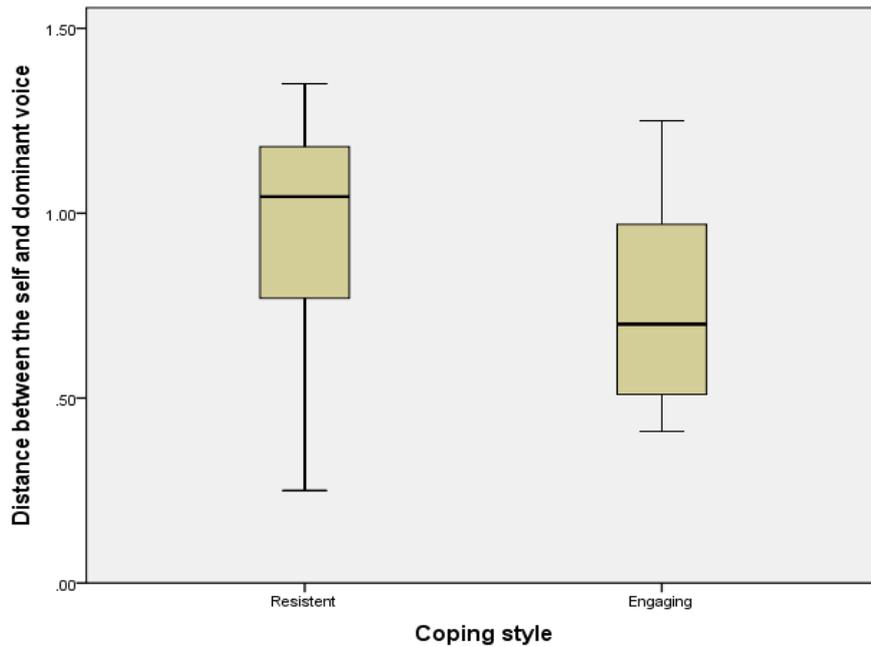
**Figure 6:** Box plot showing the distribution of scores for both engaging and resisting copers on the distance between the 'self now' and the 'dominant voice'.

*Hypothesis: Voice malevolence will be associated with increased distance between the 'self now' and the 'dominant voice'.*

A Spearman's Rank correlation found a statistically significant large positive correlation between voice malevolence and distance between the 'self now' and 'dominant voice' elements from the repertory grid ($r_s$=0.55, n=18, p<0.01, 1-tailed). Similarly, there was a medium negative correlation between voice benevolence and distance between the 'self' and the 'dominant voice' ($r_s$=-0.41, n=18, p<0.05, 1-tailed). Therefore, experiencing malevolent voices is associated with relating to them from a distance and benevolent voices a position of closeness.

### 4.5.4 Salience of the 'self now' and 'dominant voice'

*Hypothesis: Engaging coping will be associated with a more salient view of the 'self now' and a reduced salience of the 'dominant voice'.*

In order to test the above hypotheses two Spearman Rank correlations were carried out between a measure of engaging coping from the BAVQ-R and a measure of salience from the repertory grid. Salience was measured by taking the percent sum of squares of the element 'self now' and 'dominant voice'. There was a small positive correlation between engaging and salience of the 'self now' ($r_s$=0.08, n=18, p=0.38, 1-tailed) which was not statistically significant, and a large negative correlation between engaging and salience of the 'dominant voice' ($r_s$=-0.61, n=18, p<0.01), statistically significant at the 1% level. This suggests that an engaging coping style is associated with a reduced salience of the dominant voice.

*Hypothesis: Resisting coping will be associated with a more salient view of the 'dominant voice' and a reduced salience of the 'self now'.*

A Spearman's Rank correlation between a measure of salience of the 'dominant voice' and resisting coping found a large positive relationship ($r_s$=0.73, n=18, p<0.01, 1-tailed), statistically significant at the 1% level. In addition, there was a small negative association between resisting coping and salience of the 'self now' ($r_s$=-0.17, n=18, p=0.25), which was not statistically significant. Therefore salience of the 'dominant voice' was associated with resisting the experience (represented by Figure 7).
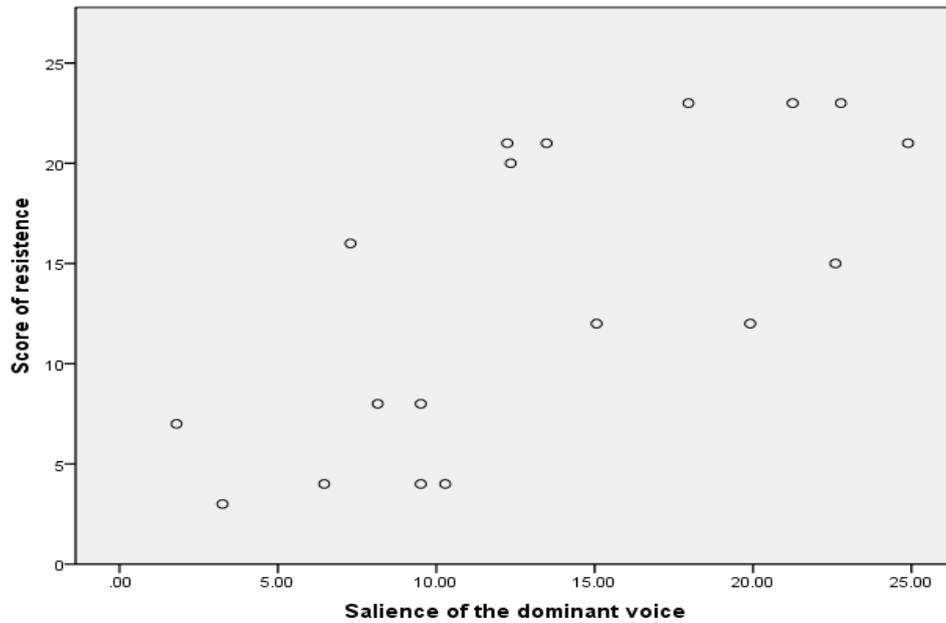
**Figure 7:** Scatter plot showing the correlation between the salience of the 'dominant voice' and the score for resisting coping.

Another interesting finding from the current study was that voice benevolence was negatively associated with salience of the 'dominant voice' ($r_s$=-0.63, n=18, p<0.01, 1-tailed), and voice malevolence positively associated with increased salience of the 'dominant voice' ($r_s$=0.72, n=18, p<0.01, 1-tailed). This suggests that benevolent voices were viewed as less important for the individual than malevolent voices.

*Hypothesis: The salience of the 'dominant voice' will be greater for resisting copers than engaging copers.*

To test the above hypothesis a Mann Whitney U test was carried out. The test revealed a statistically significant difference in the mean salience levels of resisting copers (mean=15.63, SD=6.12) and engaging copers (mean=8.54, SD=6.50), (U=13.5, p<0.05, 1-tailed).

Figure 8 shows the difference between the medians of the two groups and shows that the median salience of the dominant voice for resisting copers is greater than for the engaging copers.
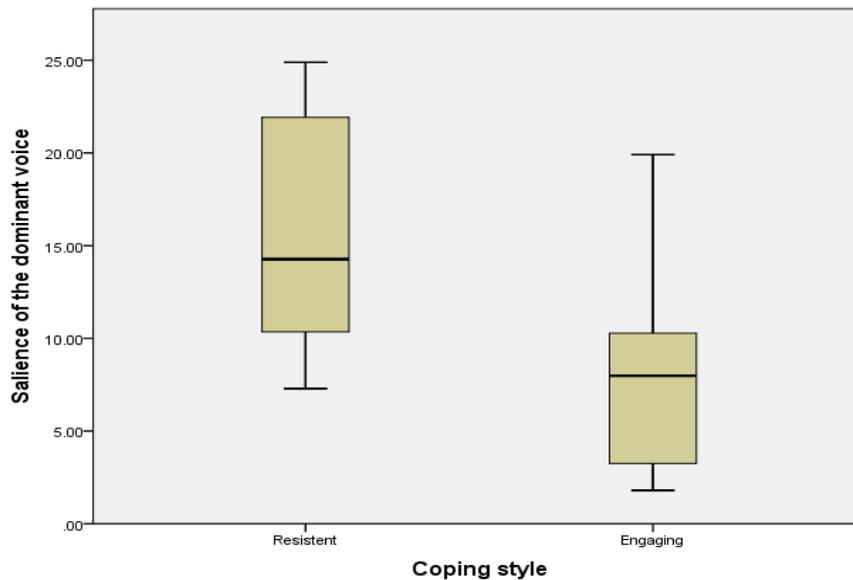
**Figure 8:** Box plot showing the distribution of scores for both engaging copers and resisting copers for scores of salience of the 'dominant voice'

In addition, neither salience of the 'dominant voice' nor salience of the 'self now' was associated with psychological distress: ($r_s$=0.28, n=18, p=0.13, 1-tailed), ($r_s$=-0.19, n=18, p=0.22, 1-tailed) respectively.

### 4.5.5 Tightness of the construct system

*Hypothesis: Tightness of construing will be positively associated with resisting coping and negatively associated with engaging coping.*

A Spearman's Rank correlation found that there was a significant large positive correlation between a resisting coping style and the size of the first principal component of the construct system ($r_s$=0.61, n=18, p<0.01, 1-tailed), indicating that tightness of construing was associated with a resisting style of coping with voices (shown by Figure 9).
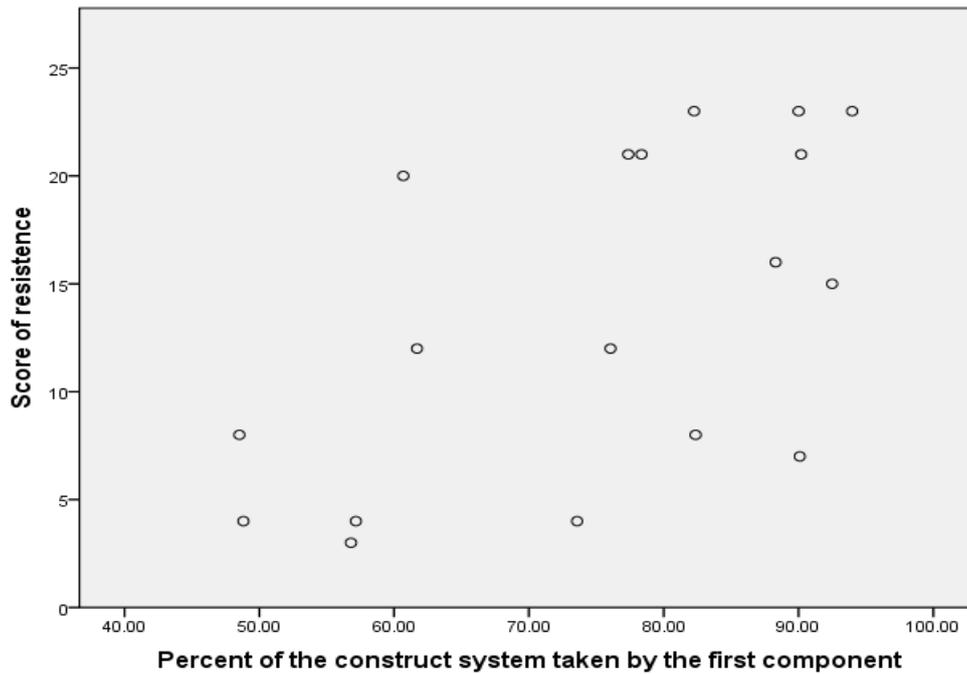
**Figure 9:** A scatter plot showing the correlation between a score of repertory grid tightness and a score of resisting coping.

In addition, a Spearman's Rank correlation test found a statistically significant medium negative correlation ($r_s$=-0.43, n=18, p<0.05, 1-tailed) between an engaging style of coping and the size of the first principal component of the construct system. Therefore an engaging style of coping with voices was associated with a looser construct system (shown by Figure 10).

Finally, tightness of construing was not associated with a measure of psychological distress ($r_s$=-0.05, n=18, p=0.42, 1-tailed).
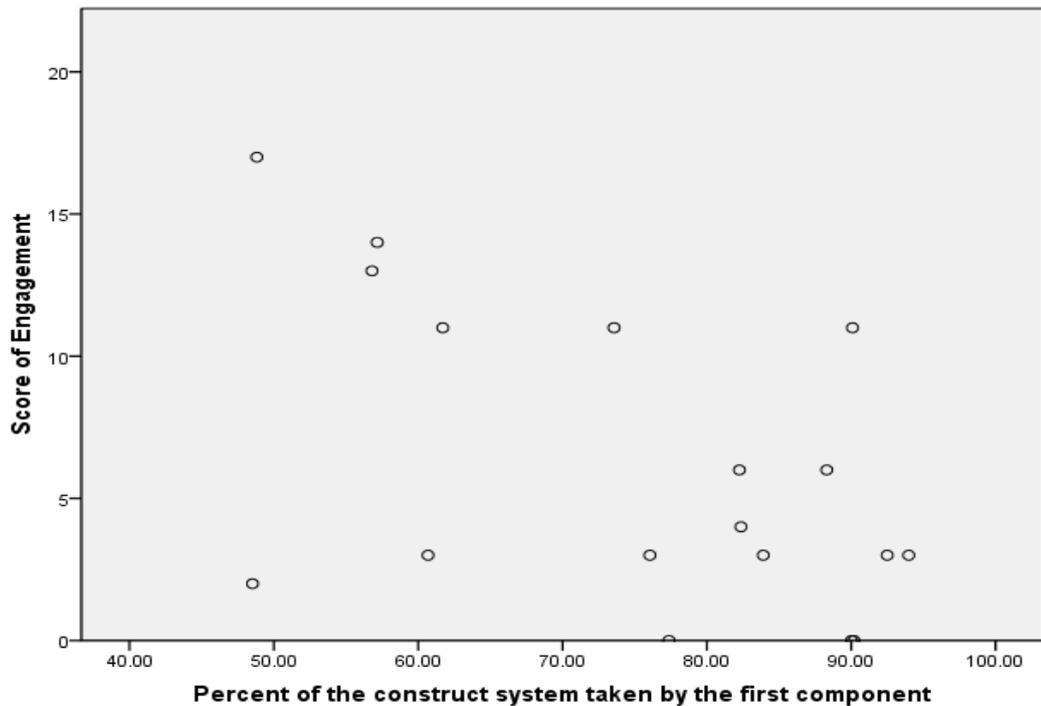
**Figure 10**: Scatter plot showing the correlation between a score of repertory grid tightness and a score of engagement.


_Hypothesis: The mean size of the first principal component of the construct system will be larger for resisting copers compared to engaging copers_

A Mann Whitney U test found that the difference between the first principal component of the grid for engagers and resisters was not significant (U=16, p=0.06, 1-tailed) at the 5% level. The mean first principal component for resisting copers was 80.51 (SD= 13.6), and 64.69 (SD= 14.86) for engagers. The difference between the means was not statistically significant (U=16, p=0.06, 1-tailed) following a Mann-Whitney U test. However, the mean difference corresponded to a Cohen's d of 1.13, suggesting a considerable difference between the engaging and resisting coping group regarding the size of the first principal component of the construct system which is of practical significance. The reason for the statistical insignificant result is the small sample size and consequently a lack in statistical power to discover this effect size.

Figure 11 shows the differences between the medians of the first principal component percentage score between engaging and resisting copers, and shows that the median tightness measure in the resisting group is greater than in the engaging group.
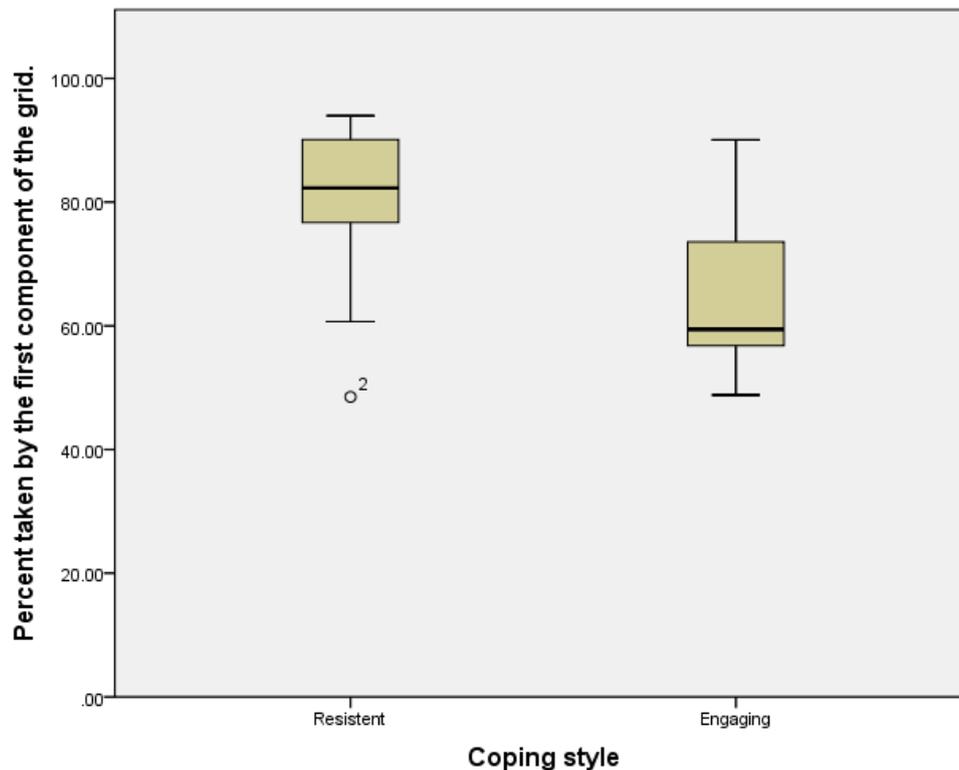


**Figure 11**: A box plot showing the distribution of scores for both resisting and engaging copers on the percentage of variance explained by component one from the repertory grid.

### 4.6 Content analysis of the constructs

*4.6.1 The construct poles applied to the dominant voice will be explored to answer the question how is the dominant voice construed?*

Table a. (appendix 10) shows the frequencies of the construct poles on which the 'dominant voice' was given extreme ratings in the engaging coping group, as

categorised by the Classification System for Personal Constructs (CSPC, Feixas, Geldschlager & Neimeyer, 2002). The most frequent construct pole applied to the dominant voice was 'bad' (e.g. hatred). Figure 12 shows that the area most represented by the engaging groups' constructs was 'moral', and 'relational' which is concerned with the moral value of the dominant voice, and the relationship with the dominant voice.

Table b. (appendix 10) shows the frequencies of the construct poles on which the 'dominant voice' was given extreme ratings in the resisting copers. The table shows that the most frequent category was 'Specific Emotions', (e.g. rubbish and sad) followed by 'unbalanced' (e.g. troubled and tense) and 'pessimist' (e.g. negative). Figure 12 shows that the area most represented by the resisting groups constructs was 'emotional'. The emotional area concerns the degree of emotionality of the dominant voice.
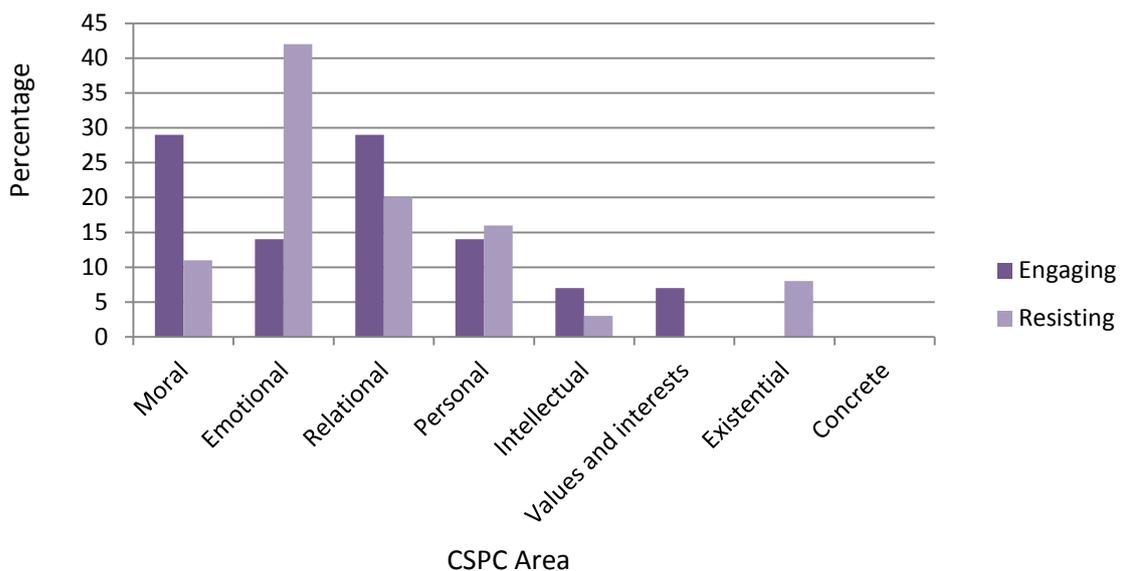


**Figure 12**: A bar chart representing the percentages of constructs assigned to each area for the 'dominant voice' for both engaging and resisting copers.

*4.6.2 The construct poles applied to the 'self as coper' will be explored to answer the question how is coping construed?*

Table c. (appendix 10) shows the engaging coping group and the constructs given extreme ratings for the 'self as coper'. The table shows that the most frequent category was 'specific emotions' (e.g. happy and content) and Figure 13 shows that

the area most represented by the engaging groups constructs was 'emotional'. The emotional area concerns the degree of emotionality of the person described (the 'self as coper'). Table d. (appendix 10) shows the frequencies of the construct poles on which the 'self as coper' was given extreme ratings in the resisting coping group. The table shows that the most frequent category was 'balanced' (e.g. calm, and stable) followed by 'specific emotions' (e.g. joyful and excited). Figure 13 shows that the area most represented by the resisting groups constructs was also 'emotional'. However, it should be noted that the frequencies of the construct poles in each category were so small that few meaningful comparisons can be made between the groups.

For all category classifications there was an overall inter-rater agreement of 70%.
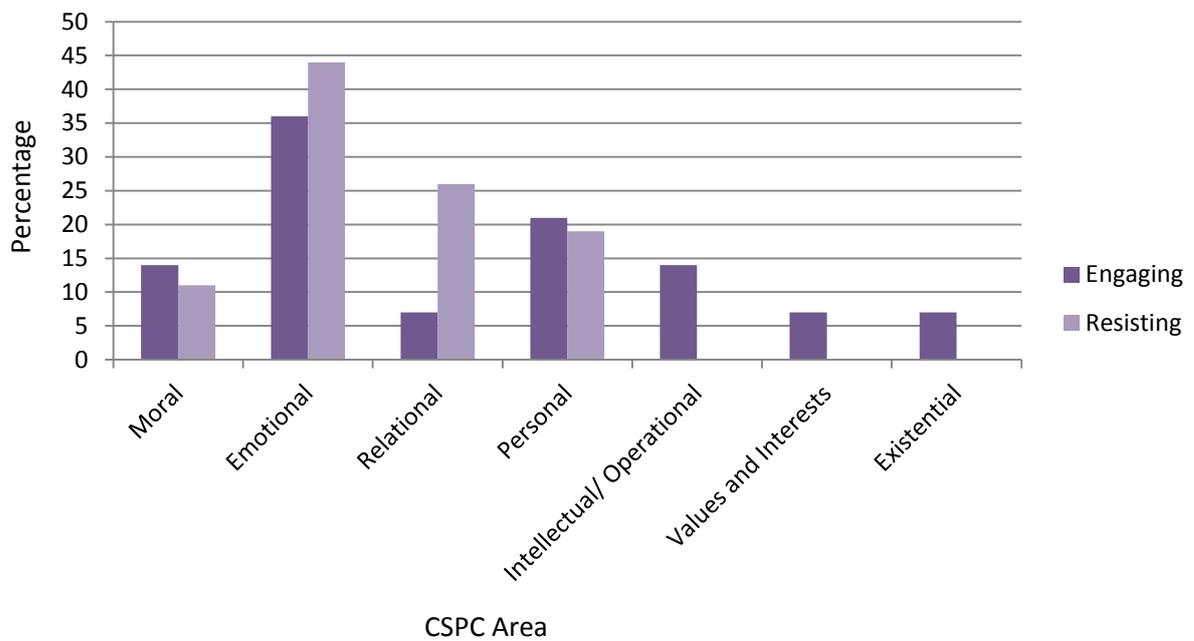


**Figure 13:** A bar chart representing the percentages of constructs assigned to each area for the 'self as coper' for both engaging and resisting copers.

**Case studies**

The following section presents three participants all with different experiences of hearing voices. Each participant will be introduced with relevant background information, followed by a description of individual scores from the 3 measures, leading to an interpretation of their repertory grid.

The individual salience scores for the 'self now' and the 'dominant voice' were interpreted as 'high' or 'low' depending on which was the most salient for the individual. For the tightness score, each individual was compared to the sample tightness mean of 75.24 (SD=15.60). The distance score between the 'self now' and the 'dominant voice' was interpreted as higher or lower than the individual mean element distance from the repertory grid as calculated by Idiogrid.

*4.7 An example of a participant with an engaging coping style who experienced the dominant voice as benevolent.*

*4.7.1 Background Information*

Lindsey (which was not her real name) was a 27 year old, White British, homosexual female diagnosed with rapid cycling bi-polar disorder, borderline personality disorder, and schizoaffective disorder. Her first experience of hearing voices was 3 years prior to the interview, and she described hearing a single male voice. Before this for about 10 years she described that she often saw unusual things like flashing lights, felt things on her skin and smelt unusual things. At the time, Lindsey felt that these experiences were normal, and she made sense of them by believing that she had a vivid imagination. Lindsey was always creative, enjoying poetry and music. She described herself as a successful teenager, achieving high grades at school and university. At university, Lindsey described having a 'break down' which she said was triggered by was the loss of her grandmother.

Lindsey described in detail her first experience of hearing a voice when she was 24 years old. She described the voice as a 'God like' voice as calming and reassuring- saying things like 'you are doing great, don't worry'. At first she was very concerned about the voice, but with time felt comforted by it. She believed the voice to be the

voice of God and therefore chose to obey it. Lindsey was a Christian and said that she felt special because of the voice.

Lindsey described that when she became 'unwell' (stressed) the voice became more malevolent and omnipotent, which coincided with her difficult relationship with her father following the marriage to her wife. She described that the voice commanded her to go to the church where she would be re-united with her grandmother. Following this the voice became nasty, saying things like 'you failed to meet your nan, if you don't make a sacrifice we will hurt people'. Lindsey said that she then believed that the voice could not possibly be God.

Lindsey coped with this experience by eliciting support from her wife and mother and since this difficult experience, Lindsey said that she believed that although she knew the voice was a symptom of mental illness she still believed them to be a special gift to her. Lindsey still heard voices, but mainly the reassuring kind, and she chose to work for a mental health charity and support others with similar experiences. She did however say that she worried that the voices would become nasty again. Lindsey continued to follow Christianity because she felt that in this environment her voices made sense and she felt more comfortable engaging with the experience.

### 4.7.2. Questionnaire scores

**Table 8:** Lindsey's BAVQ-R, OQ45.2 and repertory grid scores and interpretation

| Measure | Sub-scale | Score | Interpretation |
|---|---|---|---|
| **BAVQ-R** | Malevolence | 2 | 2/18 (11%) |
| | Benevolence | 13 | 13/18 (72%) |
| | Omnipotence | 6 | 6/18 (33%) |
| | Resistance | 4 | 4/27 (15%) |
| | Engagement | 14 | 14/24 (58%) |
| **OQ45.2** | Symptom Distress | 72 | Higher than cut-off |
| | Interpersonal relations | 27 | Higher than cut-off |
| | Social Role | 13 | Higher than cut-off |
| | Risk | 8 | Higher than cut-off |
| | Total | 112 | Higher than cut-off |
| **Repertory Grid** | Salience of dominant voice (%) | 9.51 | High |

| | | |
|---|---|---|
| Salience of self (%) | 0.66 | Low |
| Variance of component one (%) | 57.16 | Lower than average |
| Distance between 'self now' and the 'dominant voice' | 0.72 | Lower than individual element distance average |

Table 8 shows that Lindsey adopted an engaging coping style with her dominant voice. The voice was also classified as more benevolent than malevolent and omnipotent. Her scores on the OQ45.2 were higher than the cut off points, showing that she experienced a high level of psychological distress.

### 4.7.3 Elicited constructs

The constructs that were elicited from Lindsey:

1. Calmer – Worried
2. Confident – Anxious
3. Popular -  Lonely
4. Positive – Just existing
5. Working – Unemployed
6. Reassuring – Scary
7. Unbelievable – Believable

### 4.7.4 Idiogrid representation of Lindsey's repertory grid

The Idiogrid computer programme was used to plot the interaction between the elements and constructs from Lindsey's repertory grid (Figure 14). To create the graph the repertory grid was subjected to a Principal Components Analysis (PCA, Slater, 1977). The horizontal axis represents the first principal component (PC1) and the vertical axis represents the second principal component (PC2). The elements and constructs were then plotted according to their loadings on PC1 and PC2.

*4.7.4.1 Distances*

Figure 14 can be used to visually present the distances between elements and constructs from Lindsey's repertory grid. The further apart the elements and constructs are the less alike they are, and the closer they are the more similar they can be viewed.
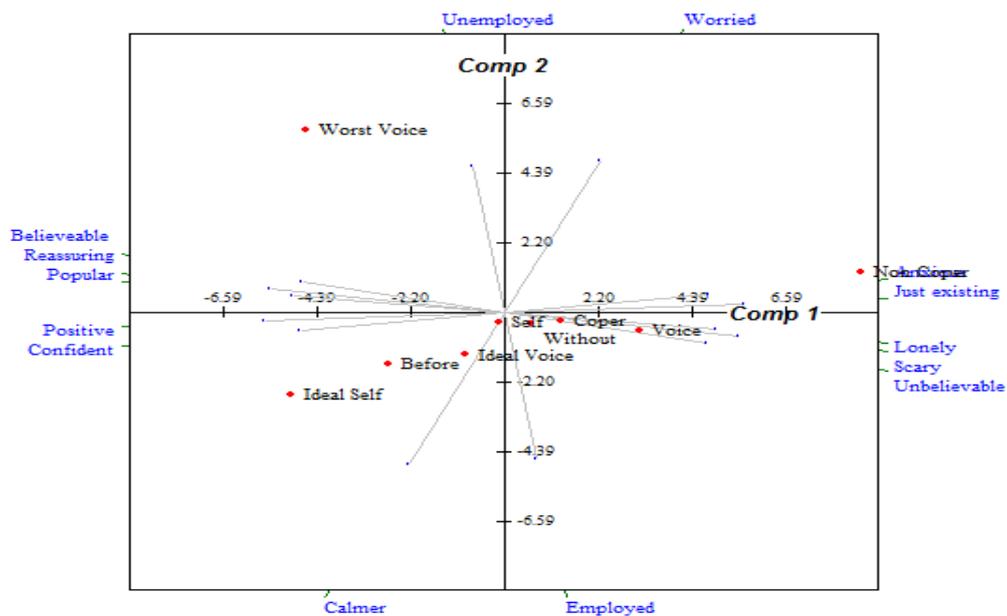


**Figure 14:** The Idiogrid representation of Lindsey's repertory grid

The 'self now' on Lindsey's repertory grid was plotted on the origin. This suggests that Lindsey views her 'self now' as less extreme than other elements, for example the 'ideal self' and the 'worst voice'. The grid shows that Lindsey's 'self now' has moved towards the construct poles 'just existing' and 'lonely' and away from the poles 'confident' and 'positive' before the voices. These construct poles were also closely associated with the 'ideal self'. It seems as though, the voice hearing experience has moved Lindsey closer towards the non preferred poles of her constructs, and suggests that she is wishing to be where she was before the experience. The 'dominant voice' was also closer to the 'ideal voice' than the 'worst voice', which makes sense because Lindsey chose to focus on the reassuring voice during the interview, although, even this voice she associated with the construct poles 'scary', 'lonely' and 'unbelievable'. Her worst voice was construed extremely and distanced

from any other element. In line with hypothesis 2a) the relatively close relationship Lindsey had with her dominant voice was associated with her engaging coping style.

### 4.7.4.2 Salience of the self and dominant voice

Lindsey construed the 'dominant voice' as more important in her view of the world than her 'self now', which is in line with a more pathological narrative of the voice hearing experience. This makes sense as Lindsey would say that her self-identity was governed by her experience as a voice hearer and a mental health patient. However, as an engager, this is not in line with hypothesis 3b) which suggested a link between salience of the self and engaging coping. For Lindsey salience of the voice was related to high levels of psychological distress, because although she said that she sometimes found the voices pleasant she still wished for a life without them.

From the repertory grid output, Lindsey had the highest salience score for 'self as non coper' (31.2%) followed by the 'worst voice' (22.95%). The least salient element was the 'self now'. So although, Lindsey construed herself as more similar to herself as a coper, she construed the 'self as a non coper' and the 'worst voice' as more important. This can help explain Lindsey's high levels of psychological distress, as she seemed fearful of a re-occurrence of the previous demanding voice because of the high level of distress it created for her and those close to her. Lindsey may have been compensating with this level of anxiety by being involved with Christianity, charities and support groups, and hence adopting an engaging coping style.

### 4.7.4.3 Tightness of construct system

Lindsey's grid seemed to indicate relatively loose construing, shown by the low percentage of variance accounted for by the first principal component (57.16%), when compared to the sample average. This can be explained by Lindsey's openness to different explanations for the voices, including psychopathology and spirituality. By adopting such a broad view of the voices, Lindsey was allowing herself to relate to and integrate the experience. For example, if she was open to viewing the experience as God, then within the church environment she was able to make sense

of the experience. This is in line with hypothesis 3c) which suggests that those who have a loose construct system will have an engaging coping style.

### 4.7.4.4 Analysis of constructs

The construct pole which accounted for the greatest percentage of variance was 'scary' (19.83%), and the least 'lonely' (10.84%). This shows that the construct 'scary—reassuring' was the most central to Lindsey's overall system. 'Scary' is an emotional construct pole in the CSPC, compared to 'lonely' which is an interpersonal construct pole. Sperlinger (1976, as cited in Winter, 1992) stated that individuals elaborated their construct systems in problem areas that were presenting them with particular difficulties. This may mean that Lindsey struggles most with emotional regulation and is more accepting of a relational framework for the experience. This could help explain her engaging coping style as well as her close relationships with others and her heightened levels of psychological distress. Fransella's (1972) view of the symptom as a way of life can also go some way to explain Lindsey's diagnosis of bi-polar disorder and borderline personality disorder, both of which are characterised by emotional dysregulation.

## 4.8 An example of a participant who adopted a resisting coping style and experienced both malevolent and benevolent voices and no mental health problems.

### 4.8.1 Background Information

Peter (which was not his real name) was a 45 year old White British male. Peter left school when he was 16 and worked in a DIY shop. Peter described having a breakdown in 1991 following what he described as bullying by his manager at work, which led to an admission to a psychiatric hospital and a diagnosis of depression with psychotic features. During this episode, Peter described hearing voices that called him names, as well as hearing noises in his flat from gangs and rapes. In 1997, Peter joined a hearing voices support group as he described having no quality of life following weight gain from his anti-psychotic medication and reduced social support.

Peter met his wife in the group and they married in 2000. Peter continued to experience two kinds of voices: those that he liked that told him he had special powers and reminded him to have a laugh, and those that he did not like that continued to call him names about his abilities and appearance.

Peter coped with this using the support of the group and his wife, and by walking and swimming. Peter said that he did not know why he heard voices, and believed that he never would, but he did say that he had lost the hatred for the experience and was enjoying supporting others. The dominant voice at the time of interview for Peter was the helpful voice.

### 4.8.2 Peter's questionnaire scores

**Table 9**: BAVQ-R, OQ45.2 and repertory grid scores and interpretation

| Measure | Sub-scale | Score | Interpretation |
|---|---|---|---|
| **BAVQ-R** | Malevolence | 13 | 13/18 (72%) |
| | Benevolence | 12 | 12/18 (67%) |
| | Omnipotence | 8 | 8/18 (44%) |
| | Resistance | 16 | 16/27 (59%) |
| | Engagement | 6 | 6/24 (25%) |
| **OQ45.2** | Symptom Distress | 0 | Lower than cut-off |
| | Interpersonal relations | 4 | Lower than cut-off |
| | Social Role | 6 | Lower than cut-off |
| | Risk | 0 | Lower than cut-off |
| | Total | 10 | Lower than cut-off |
| **Repertory Grid** | Salience of dominant voice | 7.29 | High |
| | Salience of self | 5.48 | Low |
| | Variance of component 1 (%) | 88.3 | Higher than average |
| | Distance between the 'self now' and the 'dominant voice' | 0.65 | Lower than individual element distance average |

The BAVQ-R scores in Table 9 show that Peter adopted a resisting coping style with the dominant voice. The voice was also classified as slightly more malevolent than benevolent. His scores on the OQ45.2 were lower than the cut off points, showing that Peter experienced little psychological distress.

### *4.8.3 Elicited constructs*

The constructs that were elicited from Peter:

1. In Control – Out of Control
2. Stable - Hyper
3. Unsure - Positive
4. Confident – In the Wars
5. Concerned about problems – Don't care about problems
6. Helpful - Unhelpful
7. Deathly – Happy

### *4.8.4 Idiogrid representation of Peter's repertory grid.*

#### *2.8.4.1 Distances*

Peter's Idiogrid graph (Figure 15) shows that he construed the 'self now' as identical to the 'ideal self', 'self without the voice', 'self as a coper' and the 'ideal voice'. These were all associated with the construct poles: helpful, positive, confident, happy, stable and careless, which could help explain Peter's reduced psychological distress scores, in comparison to the rest of the sample.

Interestingly, there was a large distance between the 'self now' and the 'self before the voice'. This fitted with Peter's story about how the experience of hearing voices changed his life. Peter had an active involvement with his hearing voices support group and also met his wife there. Before the experience, Peter described himself as someone with little social contact and few interests, whereas upon the time of meeting, Peter was a sociable and popular man.

The distance that Peter construed between his 'self now' and the 'dominant voice' was lower than the sample average, although, Figure 15 clearly shows that Peter construed the 'dominant voice' as dissimilar to all other elements. This could indicate that Peter has failed to integrate the voice into the rest of his construct system, which fits with him saying that he did not understand the experience. The distance between the voice and his self may explain his resisting style of coping.
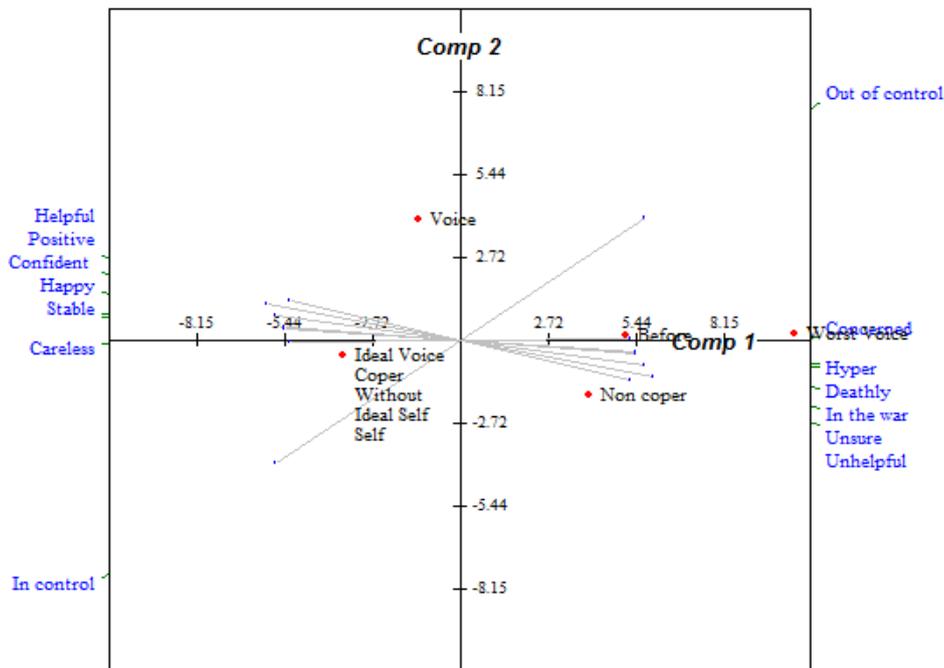
**Figure 15:** The Idiogrid representation of Peter's repertory grid

### 4.8.4.2 Salience of the self and dominant voice

The salience of the 'self now' was 5.48%, compared to the salience of the 'dominant voice' which was 7.29%, which suggests that Peter viewed his 'dominant voice' as more important than his 'self now'. The highest salience of all the elements was for the 'worst voice' at 44.42%. Peter therefore saw elements relating to the voice as more important than those relating to the self, and in particular may have been fearful of the re-occurrence of the 'worst voice' because of its derogatory content and because it was associated with the poles 'concerned about problems', 'hyper' and 'deathly'. This is in line with hypothesis 4b) which suggests that the salience of the 'dominant voice' will be associated with a resisting coping style. Peter's voices are clearly an important part of the view of his world, as without the experience he would not have met his wife or have the associated social identity that comes with being an active member of a support group.

### 4.8.4.3 Tightness of construct system

In the PCA of Peter's repertory grid, PC1 accounted for 88.3% of the variance. Peter's grid seemed to indicate relatively tight construing, shown by the higher than average percentage of variance accounted for by the first principal component. This is in line with hypothesis 4c) which suggests that those who have a tight construct system will have a resisting coping style. Peter appeared to be lost in the experience by failing to integrate it into his view of the world. Peter could be supported to explore different meanings to the experience (loosening) to enable him to find a personal meaning (tightening) which would allow him to work through the Creativity and Experience Cycle (Kelly, 1955).

### 2.8.4.4 Analysis of constructs

Construct poles associated with the 'dominant voice' included stable, positive, confident, helpful and happy. These construct poles mainly fit into the 'moral' and 'emotional' categories (Feixas et al., 2002). In the interview, Peter said that the dominant voice over the last week had been the more helpful voice, although his score for voice malevolence was still greater than benevolence.

The construct accounting for the highest percentage of the variance was 'out of control' (19.95%), which could be classified as 'relational' in the CSPC and the lowest 'concerned about problems', classified as 'personal' (11.42%).

Peter's self perception was positively altered because of the experience, but he still appeared to be struggling to engage with the experience which you might expect to be the aim of the support group. However, his low scores for psychological distress suggest that he may not wish for things to change. His high score for tightness may suggest that Peter is fearful of returning to his 'self before the voice' which he associated with the salient construct pole 'being out of control'. He may therefore be denying the voice as a way of remaining in control.

***4.9 An example of a participant who adopted a resisting coping style and experienced malevolent voices and increased psychological distress***

### *4.9.1 Background Information*

Calvin (which was not his real name) was a 46 year old White British male with a diagnosis of schizophrenia. Calvin first started to hear voices when he was 13 years old. At the time he understood the voice to be the voice of God and he said that he did not remember being too worried about it. The next experience was when Calvin was 23 years old, following 6 years of cannabis use. This experience was particularly distressing for Calvin as the voices reminded him of shameful events from his past (in particular the stress his drug use caused his parents). Calvin said that after this, it was 15 years until he told anyone about the voices because he said he was so afraid of what might happen. He first told a Community Psychiatric Nurse, following which Calvin received a diagnosis and was treated with anti-psychotic medication.

Calvin continued to hear voices and he said that his father believed the voices were a sign that he was a psychic because the voices often made comments about future events. Calvin said that instead he believed that he was ill, and the voices were a symptom of schizophrenia. Calvin also said that he would like to get rid of the voices because he felt that the experience was similar to being on an acid trip, and thus made him feel paranoid and mad. The voices continued to make critical comments about Calvin, for example, by saying things like 'stop making plans' and 'home wrecker'. Calvin coped with the voices by ignoring them and concentrating on other things. Because of the voices Calvin described having reduced social contact and higher levels of depression and social anxiety. Calvin was not employed because of the experience and did not have an intimate relationship, both of which he said were important to him.

*4.9.2 Calvin's questionnaire scores*

**Table 10:** BAVQ-R, OQ45.2 and repertory grid scores and interpretation

| Measure | Sub-scale | Score | Interpretation |
|---|---|---|---|
| **BAVQ-R** | Malevolence | 10 | 10/18 (56%) |
| | Benevolence | 4 | 4/18 (22%) |
| | Omnipotence | 15 | 15/18 (83%) |
| | Resistance | 21 | 21/27 (78%) |
| | Engagement | 3 | 3/24 (13%) |
| **OQ45.2** | Symptom Distress | 74 | Higher than cut-off |
| | Interpersonal relations | 26 | Higher than cut-off |
| | Social Role | 21 | Higher than cut-off |
| | Risk | 6 | Higher than cut-off |
| | Total | 121 | Higher than cut-off |
| **Repertory Grid** | Salience of dominant voice (%) | 12.24 | High |
| | Salience of self (%) | 1.48 | Low |
| | Variance of component 1 (%) | 83.90 | Higher than average |
| | Distance between 'self now' and the 'dominant voice' | 0.79 | Lower than individual element distance average |

The BAVQ-R scores reported in Table 10 show that Calvin adopted a resisting coping style with his dominant voice. The voice was also classified as omnipotent and malevolent. His scores on the OQ45.2 were also all higher than the cut off points, showing that Calvin experienced heightened psychological distress.

*4.9.3 Elicited constructs*

The constructs that were elicited from Calvin:

1. Nervous – Confident
2. Normal - Mad
3. Arrogant - Polite
4. Able - Confused
5. Resigned - Achieving

6. Negative - Kind

7. Positive – Threatening

### 4.9.4 Idiogrid representation of Calvin's repertory grid.

#### 4.9.4.1 Distances

The visual representation of Calvin's repertory grid (shown in Figure 16) shows that the 'dominant voice' was construed more similarly to the 'worst voice' than the 'ideal voice', which could help explain his high score for voice malevolence (in line with hypothesis 1c). The distance between 'the self now' and the 'dominant voice' was also large, which could help explain why Calvin adopted a resisting coping style (in line with hypothesis 2a).
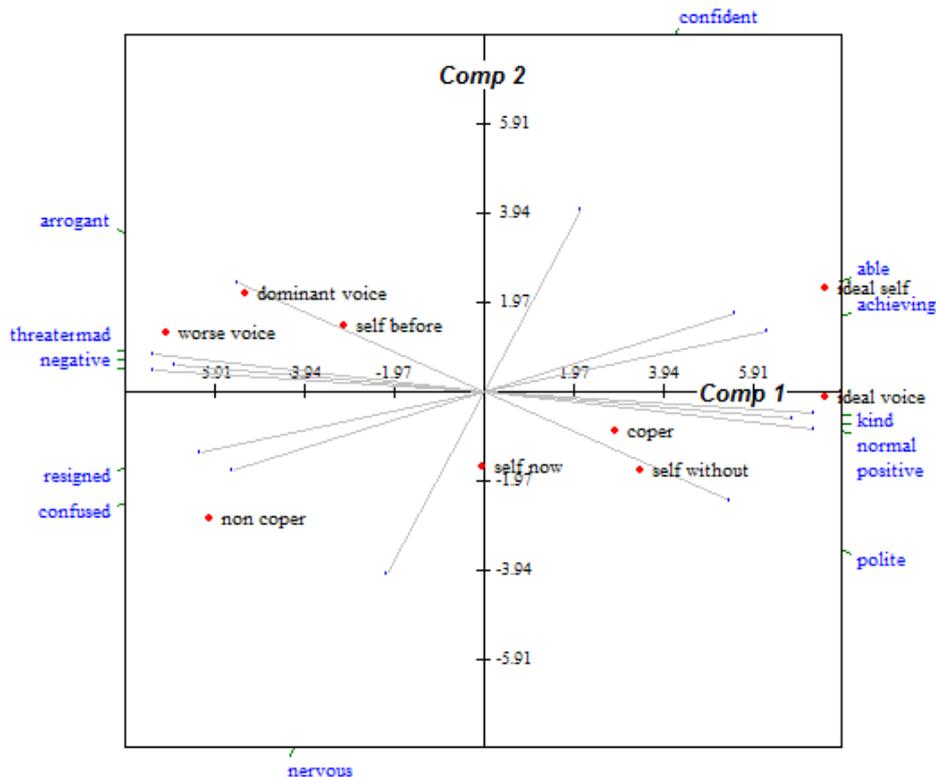


**Figure 16:** The Idiogrid representation of Calvin's repertory grid**.**

Calvin also construed his 'self now' as distanced from his 'ideal self', and construct poles associated with the 'ideal self' included being 'able' and 'achieving', which was

in line with Calvin saying that he felt the experience had prevented him from achieving his goals, for example, finding employment and having a family. This could also help explain Calvin's high scores for psychological distress. Also, interestingly, Calvin construed his 'self now' as distanced from his 'self before the voice' which he associated with the construct poles 'arrogant' and 'threatening', suggesting that the voice hearing experience has moved him closer towards his 'ideal self'. However, if it wasn't for the voice ('self without the voice') he would be even closer to his 'ideal self'.  This suggests that, based on the length of time in which Calvin had heard voices, as well as his age, he has moved on somewhat because of the experience.

### 4.9.4.2 Salience of the self and dominant voice

The element 'self now' made up only 1.48% of the variance of the grid, compared to 18.88% for the 'ideal self', and the 'dominant voice' made up 12.24%. This is in line with hypothesis 4b) which suggests that a more salient 'dominant voice' compared to 'self now' will be associated with higher scores of resistance. Calvin said that he had experienced the voices for so long that as much as he wished for a life without them, he could not imagine a life without them. He also described that he would feel lonelier without the voices.

### 4.9.4.3 Tightness of construct system

In the PCA of Calvin's repertory grid, PC1 accounted for 83.90% of the variance, indicating relatively tight construing. This is in line with hypothesis 4c) which suggests that those who have a tight construct system will have a resisting coping style. This links to Calvin's very strict view that his voices were a symptom of illness, and the associated narrative that there was little he could do about them.

### 4.9.4.4 Analysis of constructs

Calvin defined the dominant voice as 'mad', 'arrogant', 'negative' and 'threatening', which all linked to the high scores for voice malevolence and omnipotence. Calvin's

'ideal self' was very closely linked to the construct poles 'able' and 'achieving', which Calvin related to being in employment and having a more active social life.

The construct pole accounting for the highest percentage of the variance in Calvin's repertory grid was 'positive' (18.14%) and the lowest 'confident' (7.34%). 'Positive', fitted in the CSPC category 'optimist--pessimist' which is an emotional area. This is associated most with the elements 'ideal voice', 'self without the voice' and 'self as a coper', which suggests that the area that Calvin had most difficulty with was accepting the pessimism of his experience. As a result Calvin may feel stuck and unmotivated in the position of being ill preventing him from moving towards his ideal self, which he associates with being employed and more active. The length of time that Calvin has been in this position is also likely to make it harder to move on.

## 4.10 Synopsis of findings

Looking back across the chapter, Table 13 shows a synopsis of the study hypotheses.

**Table 13:** Summary table of hypotheses and findings.

| Hypothesis | Statistical analysis | Statistical conclusion |
|---|---|---|
| **1). Voice omnipotence, malevolence and benevolence:** | | |
| a. Construed salience of the dominant voice will correlate positively with omnipotence. | $r_s=0.63$, n=18, p<0.01 | Reject null hypothesis |
| b. Construed distance between the 'dominant voice' and the 'ideal voice' will correlate negatively with voice benevolence. | $r_s=-0.69$, n=18, p<0.01 | Reject null hypothesis |
| c. Construed distance between the 'dominant voice' and the 'worst voice' will correlate positively with malevolence. | $r_s=-0.56$, n=18, p<0.01 | Reject null hypothesis |
| **2). Relationships with voices:** | | |
| a. There will be a relationship between the closeness/distance between the hearer and the voice and their adopted coping strategy. | Resisting: $r_s=0.48$, n=18, p<0.05 Engaging: $r_s=-0.32$, n=18, p=0.19 | Reject null hypothesis Accept null hypothesis |
| b. Voice malevolence will be associated with distance between the 'self' and 'dominant voice'. | $r_s=0.55$, n=18, p<0.01 | Reject null hypothesis |
| **3).Engaging coping will be associated with:** | | |
| a. Reduced psychological distress. | $r_s=-0.06$, r=18, p=0.41 | Accept null hypothesis. |
| b. A more salient view of the 'self now' and reduced salience of the 'dominant voice' | $r_s=0.08$, n=18, p=0.38 $r_s=-0.61$, n=18, p<0.01 | Accept null hypothesis Reject null hypothesis |
| c. A smaller percentage variance accounted for by the first principal component | $r_s=0.-43$, n=18, p<0.05 | Reject null hypothesis |
| **4).Resisting coping will be associated with:** | | |
| a. Increased psychological distress. | $r_s=0.38$, n=18, p=0.06 | Accept null hypothesis |
| b. A more salient view of the 'dominant voice' and a reduced salience of the 'self now'. | $r_s=0.73$, n=18, p<0.01 $r_s=-0.17$, n=18, p=0.25 | Reject null hypothesis Accept null hypothesis |
| c. A larger percentage variance accounted for by the first principle component. | $r_s=0.61$, n=18, p<0.01 | Reject null hypothesis |
| **5). Other key findings:** | Voice benevolence was associated with reduced voice salience, and voice malevolence associated with increased voice salience. | |
| | There was no correlation between distance, salience, or tightness with measures of psychological distress. | |

# 5. Discussion

The discussion will begin with an overview of the demographics of the whole sample as well as engaging and resisting coping groups. Each hypothesis will then be presented in turn, including clinical implications and limitations of the finding. Overall methodological limitations will then be discussed leading to suggestions for future research and researcher reflections on the process.

## 5.1 Characteristics of the sample

The sample consisted of 18 participants (12 defined as resisting copers and 6 engaging copers). Similar to the Chadwick et al. (2000) study, the current study found large correlations of omnipotence and malevolence with resisting coping, and benevolence with engaging coping. It can therefore be assumed that the small sample size of 18 compared favourably on the dimensions of the BAVQ-R with a sample of 26 voice hearers in Chadwick et al.'s influential research.

The large and highly statistically significant negative correlation and median difference between the coping style of resistance and engagement, led to an assumption that the two variables were largely different from one another. This finding provides support for the grouping of the sample into engaging and resisting groups.

## 5.2 Voice Malevolence, benevolence and omnipotence

The more the voice hearer construed their dominant voice as similar to their worst voice, the more likely they were to view the dominant voice as malevolent, and conversely, the similarity between the dominant voice and the ideal voice was associated with viewing the voice as benevolent. In addition, there was a large positive correlation between a measure of construed salience of the dominant voice from the repertory grid and voice omnipotence from the BAVQ-R. The associations between the repertory grid and the BAVQ-R measures points to the convergent validity of the repertory grid's measure of salience of the dominant voice, and

distances between voice elements. The repertory grid has therefore shown itself to be a useful and alternative measure of voice benevolence, malevolence, and omnipotence.

This finding is important because, Fredrick and Killeen (1998) reviewed ten measures of auditory hallucinations and concluded that new instruments need to be developed that provide a more complete understanding of voices. In a review of the measures to assess auditory verbal hallucinations, Ratcliff et al. (2010) report that self report measures were acceptable to clients and generally easily completed. Future research could compare the repertory grid to other measures of voice hearing relationships, for example, the Voice and You Scale (VAY, Hayward, Denney, Vaughan & Fowler, 2008) which was specifically designed to examine the hearers' relationship with the dominant voice.

### 5.3 Psychological distress and its association to coping style

Resisting coping was associated with increased symptom distress, voice malevolence and omnipotence, and engaging coping was associated with increased voice benevolence. This may indicate that an engaging coping style is more favourable when coping with voices, which is in line with Romme and Escher's (1989) view that engaging with the voice is a better way of coping than resisting it. However, the very small negative correlations between engaging coping and psychological distress, and the mean OQ45.2 score being clinically significant for both resisting and engaging copers, suggests that even engaging copers experienced a heightened level of psychological distress. This was similar to the finding by Rudnick (2001) who found no difference in quality of life between those with schizophrenia adopting a problem or emotion focussed coping strategy. This could be explored further in future research with the inclusion of a control group.

#### 5.3.1 Clinical significance of the findings

The finding from the study suggested some evidence for the value in the use of coping style enhancement treatments aimed at adopting engagement with the experience. The finding of the study emphasised the need for professionals to

consider the engaging coping option as well as the often dominant professional narrative of resisting. What this might look like in clinical practice is discussed later in the chapter.

### 5.3.2 Limitations to this finding

Because of the correlational design, no direction of cause and effect could be determined. So although coping is often considered to be the response to an event (Lazarus, 1966), it can also be viewed as a causal factor to the experience. In other words, a person may respond to malevolent voices and symptom distress by resisting the experience, or conversely, this style of coping could contribute to the person being more likely to experience symptom distress and voice malevolence. The study suggested that engaging as a style of coping with voices was slightly more valuable than resisting, however, other research suggests that what is effective is enhancing peoples' natural self initiated coping strategies, which could include resisting. O'Sullivan (1994) found that almost four fifths of their participants described the coping strategies that were most useful as the ones they had devised themselves. For some, resisting the experience may be an adequate way of coping in order to preserve some kind of selfhood.

In addition, the length of time the voice had been heard as well as group attendance or previous psychological therapy was not controlled for. It seems safe to assume that those who have experienced voices for a longer amount of time would have had more opportunities to develop natural coping strategies, as well as support group attendees who would have learnt coping strategies from one another. It should also be noted that the 'symptom distress' and 'OQ45.2 total' measures did not capture solely the distress as a result of the voice hearing experience, and so the differences may not necessarily be a reflection of the distress associated with the voices. Finally, the small sample size made it difficult to report any firm conclusions.

## 5.4 Relationships with voices

A person who had a higher construed distance between the 'self now' and the 'dominant voice' was more likely to adopt a resisting style of coping, however, the

distance between the 'self now' and the 'dominant voice' was not associated with increased psychological distress, but was associated with voice malevolence.

Therefore, a person who viewed their dominant voice as malevolent and distanced themselves from the voice was more likely to resist the experience. This was similar to the finding by Hayward (2003), who used a modified version of Birtchnell's (2001) measure of the relating of married couples with voice hearers, and found a significant association between distance from the voice and the amount of negative voice content (malevolence). Vaughan and Fowler (2004) found that increased distance from the dominant voice was associated with increased emotional distress, although the current study and that by Hayward (2004) did not find the same relationship. Caution should be exercised therefore, before distancing oneself from the voice is pathologised and viewed as an unhelpful way of coping. This is especially so because distance from the voice was associated with voice malevolence, and for those experiencing malevolent voices, distancing oneself may be the preferred way of coping. An example of this from the current study was Peter. Peter's dominant voice was described as malevolent and he presented with a resisting coping style. Peter had distanced the voice from all of the self elements from the grid, yet he experienced little psychological distress. For Peter, resisting the experience and keeping himself separate from the voice enabled him to maintain a happy marriage and an active social life. He associated closeness to the voice with losing his relationships and his freedom.

Similarly, in his personal account of hearing voices, Benjamin Gray (2008) wrote 'better ignore the voice, repress it, soldier on, I thought. I had seen others screaming back at their voices, and it had left me with feelings of consternation, pity and fear....I learned several important lessons: never admit you hear voices; certainly never answer them' (p. 1006). Benjamin (1989) also studied these links and warned that the process of investment in a relationship with the voice could have detrimental psychological effects at the expense of other social relationships, which was also discussed by Chin et al. (2009) in their interpretative phenomenological analysis (IPA) study of the voice hearing experience.

### 5.4.1 Clinical significance of these findings

Benjamin (1989) was the first to investigate the notion of relationships to voices. Their research suggested that the relationship with the voice may serve an adaptive function. They concluded that treatment must 'confront on an individual basis, the function of the hallucination and provide more satisfactory social alternatives' (p. 308).

Benjamin (1989), and Birchwood and Chadwick (1997) both strongly believed that the way that individuals related with their voices was a reflection of their patterns of interaction in their social world. It was therefore likely that the way that an individual chose to relate to the voice depended on their previous experiences of social relationships (for example as close or distant). They suggested that this was more the case with identifiable voices as the person had a predetermined model for engagement. Hayward (2003) believed that perceived identity of the voice was an important consideration when exploring individuals' relationships with their voices. He found that voices that were not attributed an identity were related to from greater distance than those with an identity. It could be that the incognito voices triggered suspicion and led to the individual wishing to escape. Hayward suggested that, for unidentifiable voices, with a predominantly negative content, treatment may facilitate the individual to keep a safe distance from the voice. The detailed assessment of individual mediating factors, content and identity of the voice, as well as social relationship styles, is therefore paramount to arrive at a comprehensive and meaningful formulation and intervention.

Regarding psychological intervention, there have been two proposed ways of working: firstly, Birchwood et al. (2000) wrote about working on the level of social relating, including improving social status, perhaps through assertiveness training or group identification. Birchwood et al. (2000) felt that this intervention had the potential to improve the individual's relationship with the voice by modification of their social schemata and increasing self-esteem. Secondly, relating therapy (Birtchnell, 2002) aims to work more directly on the relationship with the voice, which could include support with identifying the voice to enable the person to relate to it more closely. Romme and Escher (2000) stated that the identity of the voice played a crucial role in the integration of the experience into one's reality by connecting past, present and future. Asking such questions as 'how did it start?' helps to begin to explore the

individual's narrative about the experience (Benjamin, 1989), as well as give clues to possible voice identities. In doing so it could allow the individual to correct any abnormalities in the internalisation process, which developmental accounts suggested were lacking. Fernyhough (2004) believed that in this way 'an alien voice might become a true inner dialogue, condensed, abbreviated, semantically transformed, and indistinguishable from normal inner speech' (p.65).

Hayward, Overton, Dorey and Denney (2009) stated that it was also important to enhance the awareness of the reciprocal nature of the relationship, especially those who experienced the voices as largely omnipotent, by enabling the individual to explore ways of relating to the voice differently. This concept was reflected by a quote from one of Hayward and Fuller's (2010) participants, 'I've been trying to run away from the voice all the time and I've learned to stand firm and fight back' (p. 369). Lastly, Perez-Alvarez et al. (2008) found that approaches such as mindfulness, acceptance, experiential role plays and re-authoring lives were all effective techniques aimed at changing a hearer's relationship with their voice. Furthermore, interventions should consider the changing and evolving nature of any relationship, albeit a partner or the voice. Relationships are influenced by a multitude of factors including emotions, stressors, and the environment as well as the length of time the relationship has evolved. Hayward et al. (2009) pose the question, can relationships with voices change? This could be addressed in future research by repeating hearers' repertory grids following an intervention.

### 5.4.2 Limitations of these findings

Lysaker and Lysaker (2004) were interested in the dialogue between the person and the voice. They stated that the voice did not invite the person into dialogue and similarly was not construed as something one could talk with or influence. During the experience of hearing a voice, the person may feel love, hate, fear or loathing for the voice, and they may debate with themselves and others the meaning of the voice (Leudar & Thomas, 2000). Voices were often described as focussed and singular, communicating things such as "you are a horrid person", but were often not influenced by the hearer's words. Although a lot of the research suggests that voice hearing relationships mirror other social relationships, the majority of voice hearers still reject the notion of a 'relationship' with their voice (Chin et al., 2009). Chin et al.

also found that participants preferred to implement boundaries and create a space between them and the voice, which they felt was an attempt to preserve selfhood. Social psychology describes the concept of 'othering', which is a tendency to differentiate self from other in such a way as to bolster and protect the self (Gillespie, 2007). In addition, by refusing to have a relationship with the experience, the hearer is avoiding the socially dominant narrative of madness. We should therefore be cautious before we make our own assumptions that voices should be viewed in a relational framework.

### 5.5 Salience of the self and voice

There was a large positive correlation between a measure of salience of the 'dominant voice' and resisting coping, but no association between the salience of the 'self now' and engaging coping. Also, neither salience of the 'self now' nor the 'dominant voice' was associated with psychological distress. In addition, salience of the dominant voice was positively associated with malevolence and negatively associated with benevolence. Therefore, individuals who experience malevolent voices also construe the voice as salient.

The first finding was consistent with Birtchnell's (1996, 2002) 'interpersonal octagon' theory of relating which suggested that 'voice upperness' (salience) was associated with the opposite pole of helplessness and submissiveness (resistance). However, the study found no association between the salience of the 'self now' element and engaging coping and psychological distress, indicating that a strong sense of self was not associated with reduced psychological distress or an engaging coping style.

#### 5.5.1 Clinical significance of these findings

The clinical significance of both the relationship and salience findings can be understood by re-visiting Birtchnell's (1996, 2002) inter-personal octagon. As described in Chapter 2, Birtchnell proposed that relating occurred along two intersecting axes: a horizontal one concerning the need for involvement with others versus a need for separation, and a vertical one concerning the need to relate from above or below. These four positions (distance, closeness, upperness and

lowerness) were said to carry advantages for the individual, and none of the four positions of the octagon were better or worse than the others. Individuals learn how to competently relate (positive relating) with successful maturation and one of the main goals of psychotherapy is to allow individuals who are said to negatively relate to move towards positive relating. Positive relating is associated with versatility. Vaughan and Fowler (2004) found that Birtchnell's negative relating style was applicable to the hearer's relationship with their voice, which also had significant implications for the hearer's level of distress. The horizontal axis of negative relating was associated with suspiciousness (distance) and fear or separation (closeness), and the vertical, pompous and boastful (upper) with helplessness (lower). Through the process of psychotherapy voice hearers can be facilitated to move towards a positive relating style in each of the four areas by:

- Showing an interest in the voices and getting to know them by giving the voices an identity (closeness).
- Bargaining with the voice about the need for privacy (distance).
- Leading and guiding the voice by giving it boundaries- taking back some control (upperness).
- Receiving selected helpful and protecting information from the voice (lowerness).

The aim would be to encourage versatility, and prevent the hearer from being stuck in any one of the four positions.

The study also suggested that there was a relationship between the salience of the voice and its content. Although no direction can be determined, it can be assumed that if a voice hearer is encouraged to reduce the salience of their voice, by engaging in other activities, for example, hobbies, interests or new relationships, the salience of the voice could be weakened. A reduced salience of the voice was associated with benevolent voices, so although the voice hearer may not be able to get rid of the voices, they may be able to substitute malevolent voices with benevolent ones. This may also be facilitated by the use of anti-psychotic medication to help reduce the salience of the malevolent voice in the interim.

*5.5.2 Limitations of these findings*

As Birtchnell described, whether an individual related positively or negatively depended on their childhood attachments and experiences of relating. As Chapter 2 noted, research suggested a strong link between the development of hearing voices and childhood trauma, for example, sexual abuse. The current study did not control for previous history of trauma, but if it did it would be likely that, based on Birtchnell's work, those with a history of trauma would be less versatile with relating, experience more malevolent voices and be more stuck in the position of negative relating. History of trauma was not explored during participation, but based on the estimates presented in Chapter 2 it was likely that a large proportion of the sample experienced trauma at some point in their lives. Therefore, the current findings should also be applied to those in this category.

## 5.6 Tightness of the construct system

There was found to be a medium negative correlation between an engaging style of coping and a tight construct system, and a large positive correlation between a resisting style of coping and a tight construct system. Also, tightness was not associated with psychological distress. In addition, there was a statistically significant difference between male and female scores for the tightness of the construct system, whereby males had a tighter construct system compared to females. This would indicate that there may be a gender difference between men and women's construal of the world, which introduces important questions which would be interesting to explore further.

Therefore, resisting coping was associated with a fixed and narrow view of the world, compared to engaging coping, which was associated with a loose construct system. However, the study found that neither tight nor loose construing was associated with reduced psychological distress, and therefore neither can be concluded to be adaptive.

This finding is also in line with PCP research on the coping strategy, denial. Personal construct theory researchers have noted that individuals who tend to use denial frequently employ tight construing. What this means is that they tend to construe all situations as replicas of previous experiences, and ignore any changes (Catina et al.,

1992). Myers et al. (1999) conducted repertory grid research into repressive coping and self reports of parenting, and found that repressors were significantly tighter in construing than non repressors, as it enabled the individual to avoid anxiety provoking situations. This could be thought about in relation to Calvin. Calvin described a very fixed view of being 'ill', and as a result chose to ignore the voices and reject them with an individual and societal belief that this would help him get better and lead a normal life. When comparing Lindsey with Calvin, Lindsey, as an engaging coper, held a belief that her voices were not always a sign of madness, but instead attributed to them many other narratives including spirituality, a symptom of an illness, a sign for her to support others and her grandmother's comforting words. By viewing her experience so broadly, Lindsey was always able to make meaning from her experience, and be flexible with her thinking. She did not need to deny the voices, because they made sense for her. For Calvin, by construing the chaotic experience so narrowly, and individualistically, he may be denying or resisting the experience because of unconscious anxieties about becoming more unwell and not achieving his goals in life. As well as this he may be responding to a socially acceptable narrative of illness. In summary, it would seem that resisting copers may be protecting themselves from further distress and invalidation by adopting a fixed and narrow way of viewing the experience. However both Calvin and Lindsey scored highly on levels of psychological distress, indicating that neither of their strategies appeared to be adaptive.

Kelly (1955) suggested the ever changing, cyclical nature of construing. Winter (1992) wrote 'it may be more profitable, therefore, to view excessively loose or excessively tight construing, or exclusive use of strategies of dilation or constriction, in terms of an individual's failure to complete the Creativity and Experience Cycles' (p. 103). Kelly (1955) viewed the Experience Cycle as being central to reconstruction. McCoy (1981, as cited in Winter, 1992) also associated failure to complete this cycle with negative emotions. Therefore, excessively loose or tight construing may reflect strategies directed towards the optimal anticipation of events in the face of anxiety when living in an unpredictable world, but these strategies may have some negative consequences (Winter, 1992).

### 5.6.1 Clinical significance of these findings

Kelly (1955) regarded loosening as one of the main procedures of psychotherapy in some clients, for many reasons, including, allowing the individual to shuffle their ideas into new combinations, allowing some, otherwise ruled out, elements to come to one's attention, and releasing the person from a fixed construct system. Fransella (1972) found that only after an anorexic's construing had loosened considerably was she able to organise her thoughts. Loosening can involve techniques such as recounting of dreams, and uncritical acceptance. This would require the person communicating with the voice hearer to accept the voice as a real experience for the individual, rather than challenge it. Conversely, once a client's constructs have been loosened, and subsequently realigned, in order for the client to complete the Creativity Cycle they must then be re-tightened. Kelly (1955) believed that tightening allowed the individual to define their predictions, stabilise their psychological processes, and reduce confusion. Tightening can include techniques such as self monitoring of behaviours, voices or thoughts, practising new skills, and planning experiments to test out new hypotheses. These techniques are similar techniques as used in the evidence based CBT model for psychosis (Lewis, Tarrier, Haddock & Bentall, 2002). Kelly (1955) felt that for psychotherapy to be successful, a client was likely to pass through several Creativity Cycles, by weaving back and forth between tight and loose construing. This is important because, Sperlinger (1971, as cited in Winter, 1992) found that clinical improvement was associated with re-construction.

### 5.6.2 Limitations of these findings

The current study did not account for the length of time the individuals heard voices, or whether the hearer had received previous psychological therapy. Schwartz and Michelson, 1987, as cited in Winter, 1992, p. 152) wrote that 'cognitive change in therapy may require an increased frequency of coping thoughts until mastery is achieved and deeper cognitive structures are modified'.

### 5.7 Content analysis

Sperlinger (1976, as cited in Winter, 1992) stated that individuals elaborated their construct systems in problem areas that were presenting them with particular difficulties. This was then reflected in the large numbers of constructs they had available to them in that area. For example, Schaible (1990, as cited in Winter, 1992) found that agoraphobic women employed more constructs relating to interpersonal control than did other female clients. In the current study, when construing the dominant voice, the engaging group used constructs concerning moral and relational areas, compared to the resisting group, who used more emotional constructs. This suggested that the engaging group had difficulties in managing the interpersonal and moral value of the dominant voice, compared to the resisting group who may have had difficulties managing the emotional value of the voice. If the resisting coping group construed their voice as having a specific negative emotional character, then this may explain their resisting coping strategy and increased symptom distress. Clinically, if one can facilitate recognising the emotional characteristics of the voice, then the hearer could be supported with the emotional regulation of the voice, for example, relaxation techniques for angry voices.

In addition, the 'self as coper' element elicited constructs that were largely classified as 'emotional' for both groups. For the resisting group the largest category pole was 'balanced', and for the engaging copers 'specific emotions', including 'happy' and 'content'. This could be suggestive of a problem area in managing one's emotions when coping with the experience for both groups, and in particular remaining balanced and relaxed for those resisting the experience. The finding of increased levels of psychological distress across the whole sample could be suggestive of voice hearers' difficulties with managing their emotions and in particular finding it difficult to feel emotionally balanced. This finding suggests the significance of working psychotherapeutically with a hearer on an emotional level, i.e. with depression, anxiety or anger, as well as using techniques such as mindfulness and relaxation to facilitate more balanced emotions.

These findings were limited by the lack of a control group, as well as the small number of participants, in particular those in the engaging group. The experience of having two raters code the construct poles also brought to light that the coding system could be biased when different individual raters rated the same personal

constructs. For example, for some the construct pole 'friendly' may be regarded as being classified as emotional ('warm'), whereas others may classify it as relational ('pleasant'), depending on the 'individual versus relational' lens the rater viewed the world through. This, along with the very small construct poles rated 1 or 7 for engaging copers', made it very difficult to report any firm conclusions from the content analysis. Fransella et al. (2004) suggested that in order to overcome some of the flaws associated with construct classification researchers should create their own verbal categories for their own purposes.

## 5.8 Methodological limitations of the study

Nayani and David (1996), in a phenomenological study, found that environmental cues and mood states influenced the voices and the degree of control of the voice. The current study, although to some respect controlled the environment by using quiet, suitable rooms, the study did not measure or control for individuals' current mood state. This could have been measured using simple rating scales.

The study was correlational in design and therefore did not allow any inferences to be made regarding the direction of cause and effect. Although previous studies found that coping strategies depended on meaning making (Takai, Vematsu, Kaiya, Inoue & Ueki, 1990), it should not be dismissed that a person's tendency to draw on particular coping styles may influence the voice in a corresponding way. For example, a person who coped with difficult experiences using interpersonal support, and who may be more naturally inclined to adopt an engaging coping style, may be more likely to adopt a relational attribution to the experience. This could be investigated further by studies that also assessed the individual's trait coping styles, drawing on previous experiences of difficulties. For example, the Coping Checklist (Rao & Subbakrishna, 1989) covers a wide range of cognitive, behavioural and emotional responses that are used to handle stress, including problem solving, denial, positive distraction, negative distraction, acceptance, religion/faith and social support seeking. This kind of measure would allow a more comprehensive understanding of an individual's learnt coping strategies. In addition, Lazarus and Folkman (1991) emphasised that there was both stability and change in coping (as cited in Large & Strong, 1997), and coping should therefore not be considered a stable measure.

### 5.8.1 Limitations of the sample

Other than the small and unevenly spilt sample size, the study was also open to potential sample biases from those who participated. All participants were happy to give their time and participate, indicating that participants needed to be motivated and to some extent, organised. In addition, the entire sample had accessed mental health care for their voice hearing experience. This selection bias may have meant that the two extremes of the voice hearing population were missed. Future research should include those who have not accessed any form of mental health care provision, as well as those who are struggling to lead a life in the community because of their voices. This is important as Romme and Escher (1989) found that a third of those who heard voices in Holland did not access mental health care.

Research has consistently suggested that there was a process that hearers went through depending on the length of time they had experienced the voice. Romme and Escher (1993) proposed a model based on three phases: the 'startling', 'organisation' and 'stabilisation' phases. At each of these phases the individual had a different relationship with their voices and a different way of making sense of the experience. It was thought that approximately 12 months after the initial episode the hearer reached the stabilisation phase, which was associated with a consistent manner in which the voice was dealt with. Larkin (1979) found that hallucinatory content in psychosis changed from threatening and isolating in the acute phase to socially focussed during remission.

Although the current study did not record the length of time the hearer experienced voices a guess could be made that this ranged from less than a year to more than 20 years. Future studies should focus on one of the three phases in order to remain consistent and reliable. It would also have been interesting to repeat the grids of those who may have still been in the organisation phase once they had reached the stabilisation phase to increase our understanding of the cognitive processes involved in moving between the stages.

### 5.8.2 Limitations of the OQ45.2

The OQ45.2 presented with three main limitations. Firstly, and importantly, the measure was developed in the US and therefore the norms supplied were only for the

US population. Secondly, the measure placed a lot of emphasis on employment and education with questions such as 'I feel stressed at work/ school'. A large majority of the sample were not in employment or education (although this was not formally recorded) and so for these this question was meaningless. For this kind of population a measure that identified social role performance other than employment and education would have been more suitable. Thirdly, the measure was designed as an outcome measure, and not as a one off tool.

### 5.8.3 Limitations of the BAVQ-R

The manual for the BAVQ-R did not contain any research on test-retest reliability. Experience of using the questionnaire would suggest that such research would be interesting, as participants often had to consciously select which voice they would view as their dominant voice over the last week, and even this depended on voice frequency, intensity, and importance. One participant did not ever hear a singular voice because the voices were always communicating with each other, meaning that selecting just one was very difficult. Most research in the area asks participants to select just one voice, which may not be capturing an accurate reflection of the experience. It is important that future research and test design take into account multiple voices.

The study also chose to define people into groups based on the BAVQ-R group scores of resisting and engaging coping. Although there was a clear rationale for doing this, categorisation in this way could be considered arbitrary. Group definition could merely depend on one point, which was likely to be influenced by environmental and emotional issues, and as such the reliability of the classification was likely to be poor. Nevertheless, this kind of classification into groups based on a questionnaire score is common place in clinical and research settings.

### 5.8.4 Limitations of the repertory grid

The use of the repertory grid in a very wide range of research areas (Fransella et al., 2004) indicates its flexibility, and so a discussion of the technique is important.

Feixas et al. (1992) studied the reliability and convergence validity of several measures of cognitive structures derived from a repertory grid, including percentage of variance accounted for by the first component and self-other discrepancy. Their results indicated that the majority of scores showed impressive test re-test reliability.

One issue posed was the wording of elements. Substantial effects have been related to the use of specific elements in the grid (Stringer, 1979, as cited in Neimeyer, 2002). Mitso (1958, as cited in Wright & Lam, 2002) found that when participants were re-tested on their constructions of supplied role elements versus specific names of friends, the group with role titles produced significantly more identical constructs.

Finally, the current study chose to use elicited constructs over supplied constructs in order to obtain a more true reflection of the experience from the participants. Webber (2004) found a significant correlation between construct rankings and participants' degree of confidence in their own self evaluations across both supplied and elicited constructs. They found that participants using elicited constructs expressed significantly more confidence than did those given supplied constructs. This would indicate favourability towards elicited over supplied constructs. Although, using elicited constructs prevented comparisons to be made across individual's grids, which could have been a further source of information. A focus group of voice hearers could guide any future research that chooses to provide constructs, and may for example, choose to provide construct poles such as 'in control—out of control', and 'ill—well'. However, what must be considered is that well reported cognitive deficits in psychosis may influence responding on self report measures through limiting the ability to concentrate, to mentally synthesise the material before responding, to keep motivated and to make abstract judgements (Tandon et al., 2008).

### 5.9 The importance of culture

The current study found a significant difference between those defined as associated to a Western culture (White British and European) and those defined as associated to an a non Western culture (Black African, Black Caribbean and Asian) on voice omnipotence from the BAVQ-R. This suggests that there may be a difference in the nature of the voice between those coming from a narrative based on individualism and pathology with those from cultures that emphasise collectivism and spirituality.

The finding was similar to that of Schwab (1977, as cited in Al-Issa, 1995) that Black-Americans reported a higher frequency of voices compared to White respondents. Schwab (1977) found that the difference was associated with religious affiliation in the Black American group, and so future research in the area should include religious beliefs as an additional measure. Nevertheless, it appeared as though the voices described by those from a Western philosophy were viewed as more omnipotent than those from non-Western philosophies, although this difference did not expand to salience of the voice from the repertory grid. Differences between non-Western and Western philosophies was discussed by Tamaka-Matsumi and Marsella (1976, as cited in Winter, 1992), who found that when understanding depression, Causicans tended to refer to internal mood states such as sadness and despair, while the Japanese tended to refer to external objects such as storms and mountains. Button (1983) stated that relationships between predominant constructions within a certain cultural context and the type of symptom typically presented by a member of that culture provided support for the influence of culture on the development of psychological problems.

Another explanation for the difference from the current study may be that the measures used were not culturally sensitive and some questions may have been unfamiliar to those from different ethnic groups. Berthoud and Nazroo (1997, as cited in Johns et al., 2002) found that measures which were outside of a culture's boundaries were less reliable as some of the ideas may have been unfamiliar. Future development of measures, as well as diagnostic tools, to assess those who hear voices should therefore consider their cultural sensitivity and appropriateness. Future research could also address how a person from a non-Western cultural background coped with the experience of hearing voices living in a Western society. The reduced voice omnipotence in those from non-Western cultures in the current study could be reflecting different mediating factors between the experience and coping, including cultural beliefs and cultural acceptance.

### 5.10 Suggestions for future research

As mentioned in chapter 2, the Mental Health Foundation (2000) found that NHS patients wanted more opportunities for organising self help groups. This also linked to the growing involvement of mental health consumers in research (Trivedi & Wykes,

2002). Because voices are so individual and unique to the hearer it makes it very difficult for those on the outside to truly understand the experience. The first hand knowledge of voice hearers provides invaluable information on the development of measures. Future repertory grid studies may wish to facilitate a focus group of voice hearers to capture meaningful elements and constructs. In addition, given the extensive support for a continuum model of psychosis (Strauss, 1969; van Os et al. 2000) it would be interesting to compare these findings to a non voice hearing sample.

Qualitative research exploring individuals' relationship with their voices as well as coping strategies has already been undertaken (Knudson & Coyle, 2002). A narrative analysis of a qualitative interview would be helpful in beginning to view relationships and coping with voices as an evolving, dynamic, and changing experience, associated with a past, a present and a future.


### 5.11 Conclusions

The research carried out with voice hearers compared resisting and engaging copers on dimensions such as the relationship with the voice, salience of the voice and tightness of construing in order to expand on the well researched mediating factors between the experience of voice hearing and coping. The study found that resisting coping was associated with an increased distance from the voice, increased salience of the voice and a tight construct system. Resisting coping was associated with increased symptom distress, although engaging coping was not associated with reduced psychological distress. Caution was therefore exercised before engaging coping was considered a more helpful way of coping. Throughout, the study pointed to the usefulness of the repertory grid as a comprehensive, user friendly, clinically significant measure of the voice hearing experience.


### 5.12 Researcher reflections

Since other researchers have discussed the experience of pleasant voices (Nayani & David, 1996), which is also indicated by the user led Hearing Voices Network, I was struck by the majority of participants in the current study who experienced extreme

difficulties in making sense of and coping with their experience as well as experienced high levels of psychological distress. This was also reflected in O'Sullivan's (1994) findings that the vast majority of voice hearers (87.5%) reported some unpleasant experiences, and a significant minority (32.5%) reported some pleasant experience. In O'Sullivan's study, all of those, including those who heard pleasant voices, still wished for a life without voices. He felt that the voice's mere presence, although not insulting or threatening, was distressing and associated with abnormality and madness. Karlsson wrote, following his focus group study of voice hearers, 'voices are strong and powerful experiences that sometimes convey memories from the past or difficulties that the voice hearer would prefer to forget but in fact has had to confront' (2007, p. 365).

What also struck me was the diversity of views, models, explanations and meanings attached to the experience. In addition, it seemed rare that an agreement between the individual, the voice, the family, the professional system and society was negotiated. For psychological work to be effective these conflicts between the different levels of context must be addressed as well as the ever more significant issue regarding stigma.

According to Marius Romme (2007) schizophrenia is a harmful label. He believes that it conceptualises experiences in a way that makes it impossible to resolve the problems that lie at the roots of an individual becoming unwell. He believes that it silences the perspectives, voices, and experiences of those it diagnoses as 'schizophrenic'. Japan recently decided on a new diagnostic term to replace 'schizophrenia'. They named it 'Togo Shitcho Sho' (Integration disorder) (Sato, 2006), as a term that aimed to reduce stigma, emphasise the biopsychosocial approach and imply recovery. So although Integration Disorder still ultimately pathologises the experience as a 'disorder', the change in name goes some way towards a more modern understanding of the experience and away from the original Greek translation of schizophrenia as a 'splitting of the mind'.

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# APPENDICES

# PARTICIPANT INFORMATION SHEET

## (NHS)

## Title of the study: The personal constructs of coping for people who experience hearing voices.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

**One of our team will go through the information sheet with you and answer any questions you have.**

Please take some time to read this fully and think about any questions you may have.

Part 1 of this sheet outlines the purpose of the study and what will happen to you if you take part, and Part 2 gives you more detail on the conduct of the study.

Please ask us if there is anything that is not clear.

**Why are we doing the study?**

We are conducting a study looking at how people cope with the experience of hearing voices. The study looks at how people view themselves and how people view their voices. I am also interested in whether the type of voice and the relationship the individual has with the experience influences how the individual chooses to cope.

**Why have I been chosen?**

You have been chosen because your care coordinator told us that you experience hearing voices.

**Do I have to take part?**

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

**What will happen to me if I take part?**

Our meeting will be a one off and will last about 2 hours. The meeting will be as convenient for you as possible. During the meeting we will complete 2 questionnaires and one highly structured interview. Meetings will not be taped.

**Will I be reimbursed for my time?**

We cannot offer financial reimbursement for your time, but every effort will be made to make the meeting convenient for you

**What are the disadvantages of taking part in the study?**

Participation will require about 2 hours of your time. The nature of the study may also trigger some difficult thoughts and feelings for you.

**What are the advantages of taking part?**

We cannot promise that the study will help you, but the information we get from the study will help improve the treatment of individuals who hear voices.

**What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2

**Will my taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

**If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.**

<u>PART 2</u>

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

If you wish to withdraw from the study either during or after our meeting all your information will be destroyed and this will not affect your treatment elsewhere.

**What are the advantages of taking part?**

On many occasions we have heard people express that their experience of hearing voices is meaningful and different for each person. If you choose to participate in the study you will help to add to professionals and other voice hearers understanding of the experience.

As well as this because the study is focussing on individual coping strategies participation may provide you with an increased understanding of your experience and your coping strategies. This may also enable services to tailor their interventions depending on the individuals experience and preferred ways of coping.

**What will you be asked to do if you take part in the study?**

You will be asked you to complete 2 standard questionnaires.

1. A questionnaire which asks questions on the nature of your voices and the ways you chose to cope with them.
2. A short questionnaire which asks questions related to your general mental health and well being

The majority of the meeting will then be taken up completing a structured interview using a written grid. You will be asked to think about ways in which you and your voices are similar or different. Once words have been chosen you will be asked to think about how well these words describe you and the voices. This interview will use a technique known as the repertory grid. All of these measures will be analysed using computer software. The computer software provides a useful diagram showing how individuals view their world. If you wish you can receive a copy of this to help you understand your experiences.

The meeting is highly structured and will not be taped.

**Where will they be held?**

Meetings will be held in an NHS clinic that is accessible for you. This might either be the place where you see your care co-ordinator/ group or a local G.P surgery. It may also be a university building if this is more suitable.

**Who will be at the meeting?**

Catherine Marshall will undertake the meeting with you.

**What if the researcher has any concerns?**

I may need to speak to your care coordinator if I am worried about anything that is said in the meeting. I will of course speak with you first before I do this.

If a disclosure about previous or potential harm to either yourself or another person is made during our meeting then I will be obliged to contact the police.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (07834 593560). If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service on 0800 376 0775 (freephone). Details can be obtained from pals@cpft.nhs.uk

**Harm**

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Cambridgeshire and Peterborough NHS Foundation Trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

**Will my taking part in this study be kept confidential?**

Both questionnaires and your repertory grid will be anonomised with a coded reference number. Only the researchers will be able to identify personal information from participants. All personal information will be kept securely in locked filing cabinets or password protected computer files.

When all the results have been collected they will be written up. No confidential information will be used in the write up of the study, as this ensures that no participants can be identified. All patient identifiable information will be destroyed following completion of the research.

**Involvement of your G.P**

Your care coordinator and G.P. will be informed of your participation in the study and given a brief summary of your results. This can be discussed in the meeting with you if you have any concerns with this.

**What will happen to the results of the study?**

Results will be kept securely by the researcher 5 years after the research has been completed. Results will be used and written up as part of a Doctoral Programme of Clinical Psychology at the University of Hertfordshire.

If you agree to take part in the study, and are interested in the results when the study is finished, a summary can be provided on request. Participants will not be identifiable from the write up of the study.

**Who is organising and funding the research?**

My name is Catherine Marshall and I am a Trainee Clinical Psychologist at the University of Hertfordshire.  The study will be supervised by Professor David Winter, Programme Director and Chartered Clinical Psychologist and Dr Tim Sporle, Charted Clinical Psychologist.

The study is sponsored by Cambridgeshire and Peterborough NHS Foundation Trust.

**Who has reviewed the study?**

The clinical psychology research lead at the University has reviewed the study.

The study has also been approved by the NHS ethics committee. All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by North Essex Research Ethics Committee.

**Further Information and contact details**

If you would like further information, or to take part in the study, I may be contacted on c.marshall6@herts.ac.uk

University *of* Hertfordshire **UH**

# PARTICIPANT INFORMATION SHEET

(Rethink and Family Action Plus)

## Title of the study: The personal constructs of coping for people who experience hearing voices.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

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**Why have I been chosen?**

You have been chosen because you experience hearing voices.

**Do I have to take part?**

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

**What will happen to me if I take part?**

Our meeting will be a one off and will last a maximum of 2 hours. The meeting will be as convenient for you as possible and can be conducted on the phone if this is easiest. During the meeting we will complete 2 questionnaires and one highly structured interview. Meetings will not be taped.

**Will I be reimbursed for my time?**

We cannot offer financial reimbursement for your time, but every effort will be made to make the meeting convenient for you

**What are the disadvantages of taking part in the study?**

Participation will require about 1-2 hours of your time. The nature of the study may also trigger some difficult thoughts and feelings for you.

**What are the advantages of taking part?**

We cannot promise that the study will help you, but the information we get from the study will help improve the treatment of individuals who hear voices.

**What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2

**Will my taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

**If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.**

<u>PART 2</u>

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

If you wish to withdraw from the study either during or after our meeting all your information will be destroyed and this will not affect your treatment elsewhere.

**What are the advantages of taking part?**

On many occasions we have heard people express that their experience of hearing voices is meaningful and different for each person. If you choose to participate in the study you will help to add to professionals and other voice hearers understanding of the experience.

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**What will you be asked to do if you take part in the study?**

You will be asked you to complete 2 standard questionnaires.

1. A questionnaire which asks questions on the nature of your voices and the ways you chose to cope with them.
2. A short questionnaire which asks questions related to your general mental health and well being

The majority of the meeting will then be taken up completing a structured interview using a written grid. You will be asked to think about ways in which you and your voices are similar or different. Once words have been chosen you will be asked to think about how well these words describe you and the voices. This interview will use a technique known as the repertory grid. All of these measures will be analysed using computer software. The computer software provides a useful diagram showing how individuals view their world. If you wish you can receive a copy of this to help you understand your experiences.

The meeting is highly structured and will not be taped.

**Where will they be held?**

Meetings will be held in either an NHS clinic, a university building, where you meet your group or over the telephone. This will be based on whatever is most suitable for you.

**Who will be at the meeting?**

Catherine Marshall will undertake the meeting with you.

**What if the researcher has any concerns?**

I may need to speak to your G.P if I am worried about anything that is said in the meeting. I will of course speak with you first before I do this.

If a disclosure about previous or potential harm to either yourself or another person is made during our meeting then I will be obliged to contact the police.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (07707 684828). If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service on 0800 376 0775 (freephone). Details can be obtained from pals@cpft.nhs.uk

**Harm**

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Cambridgeshire and Peterborough NHS Foundation Trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

**Will my taking part in this study be kept confidential?**

Both questionnaires and your repertory grid will be anonomised with a coded reference number. Only the researchers will be able to identify personal information from participants. All personal information will be kept securely in locked filing cabinets or password protected computer files.

When all the results have been collected they will be written up. No confidential information will be used in the write up of the study, as this ensures that no participants can be identified. All participant identifiable information will be destroyed following completion of the research.

**Involvement of your G.P**

If you wish your GP and/ or care coordinator can be informed of your participation and given a brief description of your results. This can be discussed in the meeting with you.

**What will happen to the results of the study?**

Results will be kept securely by the researcher 5 years after the research has been completed. Results will be used and written up as part of a Doctoral Programme of Clinical Psychology at the University of Hertfordshire.

If you agree to take part in the study, and are interested in the results when the study is finished, a summary can be provided on request. Participants will not be identifiable from the write up of the study.

**Who is organising and funding the research?**

My name is Catherine Marshall and I am a Trainee Clinical Psychologist at the University of Hertfordshire.  The study will be supervised by Professor David Winter, Programme Director and Chartered Clinical Psychologist and Dr Tim Sporle, Charted Clinical Psychologist.

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**Further Information and contact details**

If you would like further information, or to take part in the study, I may be contacted on c.marshall6@herts.ac.uk

University *of* Hertfordshire **UH**

**Centre Number:**

**Patient Identifiable number:**

# Consent Form (NHS)

## The personal constructs of coping for people who experience hearing voices.

**Name of researcher:** Catherine Marshall, Trainee Clinical Psychologist, University of Hertfordshire

|  | **Please Initial Box** |
|---|---|
| I confirm that I have read and understand the information sheet dated 01.07.10 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. |  |
| I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. |  |
| I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals involved in the research (those named on information sheet) I give permission for these individuals to have access to my records. |  |
| I agree to my GP and care coordinator being informed of my participation in the study. |  |
| I agree to take part in the above study. |  |

_____     _____     _____

Name of Patient                        Date                               Signature

_____     _____     _____

Name of Person                        Date                               Signature

Taking consent

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

University of Hertfordshire UH

**Centre Number:**

**Participant Identifiable number:**

# Consent Form

## (Rethink and Family Action Plus)

## The personal constructs of coping for people who experience hearing voices.

**Name of researcher:** Catherine Marshall, Trainee Clinical Psychologist, University of Hertfordshire

| | Please Initial Box |
|---|---|
| I confirm that I have read and understand the information sheet dated 01.07.10 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | |
| I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. | |
| I agree to take part in the above study. | |

_____     _____     _____

Name of Patient                    Date                          Signature

_____     _____     _____

Name of Person                    Date                          Signature

Taking consent


When completed: 1 for participant; 1 for researcher

# **Debriefing Sheet**

Thank you for taking part in this study.

The study is looking at how people cope with the experience of hearing voices by looking at how people view themselves and how people view their voices. It has long been recognized that different people cope with the experience in different ways and that some ways of coping work better for some people than for others. For example, some people chose to ignore their voices and others prefer to communicate back to them. It is hoped that by researching what works for what kind of person individuals can be better supported in living with the experience of hearing voices and can be helped to work towards recovery.

If you need to talk to somebody about things that are difficult for you, or worries that you have then some of the information below might be useful for you.

**In a crisis**

1. If it is office hours then in the first instance contact your care coordinator or duty worker on then number that they have provided you with.
2. If it is out of hours and you feel that you are at crisis then please attend your local A&E for the necessary support.
3. Otherwise, recommended support lines are provided below:
   o The Samaritans: 08457 90 90 90 (24/7)
   o NHS Direct: 0845 46 47

**Other mental Health support**

Other agencies exist that provide useful information and support on mental health problems

1. MIND
   o Info Line: 0845 766 0163
   o www.mind.org.uk (to find your local MIND support centres)

2. ReThink (charity supporting those with severe mental illnesses)
   - o Info Line: 0845 456 0455
   - o www.rethink.org

**Hearing Voices support**

1. The Hearing Voices Network (working with those who hear voices)
   - o Enquiries and Info: 0114 271 8210
   - o Email: info@hearing-voices.org
   - o Website: www.hearing-voices.org
   - o Offers information, support, people stories, blogs and information on local support groups.
2. Intervoice (the international community for hearing voices)
   - o Website: www.intervoiceonline.org
   - o Provides information, resources, people's stories, and online blogs.

If you would like to know the results of the study, please write you name and email address, or postal address below. Information will then be forwarded to you when the study is complete.

Catherine Marshall

Trainee Clinical Psychologist

# Do you hear voices?

## Would you be interested in participating in a research study?



My name is Catherine Marshall, I am a Trainee Clinical Psychologist at the University of Hertfordshire.

My research is looking into how people who hear voices cope with the experience. It aims to make links between an individual's relationship with their voices and their preferred method of coping.

Participation will involve completion of 1 highly structured interview and 2 questionnaires and will take approximately 1-2 hours. This can be done on the phone or face to face.

If you are interested or you would like further information please contact either myself on c.marshall6@herts.ac.uk or Dr. Tim Sporle on timothy.sporle@sept.nhs.uk.

Alternatively you can phone me on 07707 684828

**National Research Ethics Service**

**Essex 1 Research Ethics Committee**

East of England REC Office 1
Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Tel: 01223 597693
Fax: 01223 597645

02 November 2010

Miss Catherine Marshall
Trainee Clinical Psychology
Cambridgeshire and Peterborough NHS Foundation Trust
DClinPsy, University of Herts
College Lane Campus
Hatfield
AL10 9AB

Dear Miss Marshall

**Study title:** **The personal constructs of coping for people who experience hearing voices.**
**REC reference:** 10/H0301/33
**Amendment number:** AM 01
**Amendment date:** 11 October 2010

The above amendment was reviewed by the Sub-Committee in correspondence.

**Ethical opinion**

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved documents**

The documents reviewed and approved at the meeting were:

| Document | Version | Date |
|---|---|---|
| Protocol | AM 01 | 11 October 2010 |
| Notice of Substantial Amendment (non-CTIMPs) | AM 01 | 11 October 2010 |

**Membership of the Committee**

The members of the Committee who took part in the review are listed on the attached sheet.

**R&D approval**

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
*The National Research Ethics Service (NRES) represents the NRES Directorate within*

**R&D approval**

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

| 10/H0301/33: | Please quote this number on all correspondence |
|---|---|

Yours sincerely
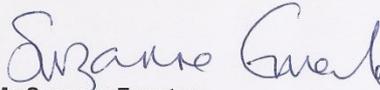
**Ms Suzanne Emerton**
**Committee Co-ordinator**

E-mail: suzanne.emerton@eoe.nhs.uk

Enclosures:    List of names and professions of members who took part in the review

Copy to:       Miss Natercia Godinho
               Cambridge & Peterborough NHS
               Foundation Trust , R&D Office
               Douglas House
               Trumpington
               Cambridge  CB2 8AH

               Professor John Senior

## North Essex Partnership NHS
### NHS Foundation Trust

Trust Headquarters
Stapleford House
103 Stapleford Close
Chelmsford • Essex
CM2 0QX

Telephone: 01245 546400
Fax: 01245 546401
www.nepft.nhs.uk

Catherine Marshall
Trainee Clinical Psychologist
University of Hertfordshire
College Lane Campus
Hatfield
AL10 9AB

19th November 2010

Dear Catherine

**Study: the personal constructs of coping for people who experience hearing voices**

I apologise for the delay in replying to your request for approval to conduct the above named study.

I am pleased to confirm that based on the documents submitted by you to the Trust approval has been granted for the proposed study to be conducted with the Trust's patients as outlined in this study design. At a later stage you may be contacted by our newly appointed R&D Manager about the progress of this study.

I will ask that you be issued a letter of Access for Research. This will be sent under separate cover from our HR dept.

I wish you all the best with your study and look forward to hearing about the results.

Yours sincerely

**Malte Flechtner MD MRCPsych**
**Medical Director**

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**SEPT**

21st July 2010

Miss Catherine Marshall
Trainee Clinical Psychologist
School of Psychology
College Lane Campus
Hatfield
AL10 9AB

Research Governance for Bedfordshire and Luton
South Essex Partnership Trust
Disability Resource Centre
Poynters House
Poynters Road
Dunstable, LU5 4TP

Chair: Lorraine Cabel
Chief Executive: Dr Patrick Geoghegan OBE

Dear Miss Marshall

Re: *The personal constructs of coping for people who experience hearing voices.*

Thank you for submitting your research proposal to the Research Governance Approvals Group
(RGAG). The group considered the above study on the 15th July 2010 and are happy to grant
approval. One of the RGAG members was unable to attend the meeting in person but emailed a
number of comments for your consideration which I have enclosed.

If you make any changes to your proposal please inform the group of these. If they are substantial
changes you will need to resubmit your full proposal for review.

In receiving this letter you are accepting that your study must be conducted in accordance with the
research governance framework and in line with health and safety and data protection guidelines. If
you are unsure about your obligations in relation to these three areas, please contact me
immediately. Throughout the course of you research you will be sent monitoring forms and audits.
It is important that you fill these in and return them. A failure to do so may result in your approval
being withdrawn.

Additionally, brief details of your project (title, aim and project lead), may be posted on our internal
website to give other staff a flavour of the research currently taking place in the organisation. Details
of research funded by pharmaceutical companies will not be added but all others may be used,
unless you notify me of your objection.

Please inform me of any amendments to the approved research proposal / protocol, participant
information sheet or consent form and use the usual incident reporting channels to report any
adverse events relating to your study.

www.SEPT.nhs.uk

South Essex Partnership University **NHS**

At the end of your study, please forward a copy of the final report to me, together with presentations or publications relating to the project so that I can keep an accurate record of the outcomes of research in our area.

I look forward to hearing about the progress of your proposal,

Best wishes,

Nicole Stokoe
Research Officer to
**Prof G A Kupshik**
Chair of Research Governance Approvals Group


Cc

Dr Timothy Spoorle, SEPT, Robin Pinto Unit
Professor David Winter, University of Hertfordshire

# North Essex Partnership NHS
## NHS Foundation Trust

Miss Catherine Marshall,
D.Clin.Psy.,
School of Psychology,
University of Hertfordshire,
College Lane Campus,
Hatfield,
Hertfordshire,
AL10 9AB

Trust Headquarters
Stapleford House
103 Stapleford Close
Chelmsford  Essex
CM2 0QX

Telephone:  01245 546400
Fax: 01245 546401
www.nepft.nhs.uk

18th April 2011

Dear Miss Marshall,

**Letter of Access – The personal constructs of coping for people who experience hearing voices**

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that such checks as are necessary have been carried out by your employer and that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. This letter confirms your right of access to conduct research through North Essex Partnership NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on Monday 18th April and ends on Wednesday 31st August unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to North Essex Partnership NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through North Essex Partnership NHS Foundation Trust you will remain accountable to your employer Cambridgeshire & Peterborough NHS Foundation Trust but you are required to follow the reasonable instructions of the Research & Development Manager (Mr Kieran Wing) within this NHS organisation or those given on his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with North Essex Partnership NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with North Essex Partnership NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on North Essex Partnership NHS Foundation Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with

Essex County Council

patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

North Essex Partnership NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Lisa Mellor
**Lisa Mellor**
**Associate Director of HR**

cc:    **Paul Roberts**, Cluster 3 CLRN Research Office, Building 2, Spencer Close, St. Margaret's Hospital, Epping, Essex, CM16 6TN
       **Sue Moncrief,** Business Manager – Recruitment & Training, Kingfisher House, Huntingdon, Cambridgeshire, PE29 6FH.

Essex County Council

20 August 2010

9th Floor
Charter House
Alma Street
Luton
Bedfordshire
LU1 2PJ
Tel: 01582 528809
Fax: 01582 700151

Miss C Marshall
Trainee Clinical Psychologist
67a St Agnells Lane
Hemel Hempstead
Hertfordshire
HP2 7AY

Chair: Lorraine Cabel
Chief Executive: Dr Patrick Geoghegan OBE

Dear Miss Marshall

**Letter of access for research**

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is responsible for ensuring such checks as are necessary have been carried out. This letter confirms your right of access to conduct research through SEPT for the purpose and on the terms and conditions set out below. This right of access commences on 20 August 2010 and ends on 30 September 2011 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to SEPT premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through SEPT, you will remain accountable to your employer University of Hertfordshire but you are required to follow the reasonable instructions of your nominated manager, Sue Moncrief, Business Manager – Recruitment & Training Admin, in this NHS organisation or those given on her behalf in relation to the terms of this right of access. Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with SEPT policies and procedures, which are available to you upon request, and the Research Governance Framework.

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You are required to co-operate with SEPT in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on SEPT premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

SEPT will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

**Steve Graham**
**Associate Director of Workforce & Organisational Development**

cc:    Nicole Stokoe, R&D office at SEPT
       Sue Moncrief, Business Manager – Recruitment & Training Admin, Kingfisher House, Huntingdon, Cambs  PE29 6FJ

'stronger together'

Hello Catherine

Thank you for getting back to me with the amendments, I am pleased to tell you that we have now approved your application and we are happy for you to recruit study participants through Rethink. We have a number of options:

1. **Rethink website** – on the research webpages, under 'Get involved'. The advert would need to include: a brief description about the study, who can get involved, what involvement will involve, contact details for the research team and a closing date for people to get in touch with you. We can also place a link to another website.

2. **Facebook** – we can place an advert on our Facebook site. For this we would need a couple of sentences and we would then place a link to a web page (either the Research pages or your website, if you have one). Something that will entice people to look further, and any more text can go on the website.

3. **Twitter** – we can place an adverts on our Twitter site – similar to the Facebook advert, the only difference is that you only have a 140 characters limit

4. **Involvement Mailing** - The monthly Involvement mailing is sent to activists in Rethink e.g. Rethink group co-ordinators and links, media volunteers and RC members. This mailing is sent to active members of Rethink to help them stay up to date with what's happening in Rethink and the mental health world. Below are a list of dates for information deadlines and date of mail outs. Advert should be no longer than 1 side of A4.

5. **Activist Mailing** – a monthly mailing similar to the Involvement Mailing. This is sent to Activists only. Advert should be no longer than 1 side of A4.

6. **Rethink services** - I can email PA's to area services managers about the study with your contact details and posters etc, but it would be up to them to take the promotion of the study any further

7. **Rethink groups** - similarly, I can email group coordinators but it would be up to them to take the promotion of the study any further

Just let me know how you would like to proceed, and send me through any relevant promotional materials, that would be great.

Many thanks,

Craig
---------------------------------------------------------------------------
*Craig Weeks*
*Research Officer*
*Rethink*

*Working together to help everyone affected by severe mental illness recover a better*

**From:** Sally Breach
**Sent:** 26 November 2010 14:37
**To:** 'C3'
**Subject:** FW: Voice hearing research

Hello Catherine,

Response from Catherine McLaughlin here, let me know if you need more.

Best wishes,

Sally

**Sally Breach**

**Community Recovery Team Co-ordinator**

Family Action Community Recovery Team

26 Suffolk Road

Lowestoft

NR32 1DZ

**01502 531 789**

**Family Action has been a leading provider of services to disadvantaged and socially isolated families since its foundation in 1869.** We work with over 45,000 families a year by providing practical, emotional and financial support through over 100 services based in communities across England. A further 150,000 people benefit from our educational grants and information service.

**Charity Awards success!** Family Action has been awarded the prestigious Effectiveness Award by the Charity Awards Foundation.

Registered charity no: 264713.

Registered company limited by guarantee in England and Wales no: 01068186.

---

**From:** Catherine McLaughlin
**Sent:** 24 November 2010 16:54
**To:** Sally Breach
**Subject:** RE: Voice hearing research

Having discussed this with my boss Howard Jones, I can confirm that we are happy to accept the Ethics Committee approval for Catherine Marshall's research. Will this email suffice or will they want letter?

Thanks,

Appendix

# BAVQ–R

There are many people who hear voices. It would help us to find out how you are feeling about your voices by completing this questionnaire. Please read each statement and tick the box which best describes the way you have been feeling in the *past week*.

If you hear more than one voice, please complete the form for the voice which is dominant.

Thank you for your help.

Name: . . . . . . . . . . . . . . . . . . . . . . . . .

Age: . . . . . . . . . . . . . . . . . . . . . . . . .

| | | Disagree | Unsure | Agree slightly | Agree strongly |
|---|---|---|---|---|---|
| 1 | My voice is punishing me for something I have done | | | | |
| 2 | My voice wants to help me | | | | |
| 3 | My voice is very powerful | | | | |
| 4 | My voice is persecuting me for no good reason | | | | |
| 5 | My voice wants to protect me | | | | |
| 6 | My voice seems to know everything about me | | | | |
| 7 | My voice is evil | | | | |
| 8 | My voice is helping to keep me sane | | | | |
| 9 | My voice makes me do things I really don't want to do | | | | |

| | | Disagree | Unsure | Agree slightly | Agree strongly |
|---|---|---|---|---|---|
| 10 | My voice wants to harm me | | | | |
| 11 | My voice is helping me to develop my special powers or abilities | | | | |
| 12 | I cannot control my voices | | | | |
| 13 | My voice wants me to do bad things | | | | |
| 14 | My voice is helping me to achieve my goal in life | | | | |
| 15 | My voice will harm or kill me if I disobey or resist it | | | | |
| 16 | My voice is trying to corrupt or destroy me | | | | |
| 17 | I am grateful for my voice | | | | |
| 18 | My voice rules my life | | | | |
| 19 | My voice reassures me | | | | |
| 20 | My voice frightens me | | | | |
| 21 | My voice makes me happy | | | | |
| 22 | My voice makes me feel down | | | | |
| 23 | My voice makes me feel angry | | | | |
| 24 | My voice makes me feel calm | | | | |
| 25 | My voice makes me feel anxious | | | | |
| 26 | My voice makes me feel confident | | | | |

When I hear my voice, *usually* …

| | | Disagree | Unsure | Agree slightly | Agree strongly |
|---|---|---|---|---|---|
| 27 | I tell it to leave me alone | | | | |
| 28 | I try to take my mind off it | | | | |

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| | | Disagree | Unsure | Agree slightly | Agree strongly |
|---|---|---|---|---|---|
| 29 | I try to stop it | | | | |
| 30 | I do things to prevent it talking | | | | |
| 31 | I am reluctant to obey it | | | | |
| 32 | I listen to it because I want to | | | | |
| 33 | I willingly follow what my voice tells me to do | | | | |
| 34 | I have done things to start to get in contact with my voice | | | | |
| 35 | I seek the advice of my voice | | | | |

## Scoring Guidelines

All items have a four-point response range, Disagree (score 0), Unsure (score 1), Agree slightly (score 2) and Agree strongly (score 3).

The questionnaire has three scales measuring meaning given to the voice:

Malevolence (items 1, 4, 7, 10, 13, 16)
Benevolence (items 2, 5, 8, 11, 14, 17)
Omnipotence (items 3, 6, 9, 12, 15, 18)

These three scales therefore have a range of possible scores 0–18.

Following the original BAVQ, the questionnaire also measures Resistance and Engagement, two ways of relating to voices. Resistance and Engagement both contain emotional and behavioural items.

Resistance
- Emotion (items 20, 22, 23, 25): range 0–12
- Behaviour (items 27, 28, 29, 30, 31): range 0–15

Engagement
- Emotion (items 19, 21, 24, 26): range 0–12
- Behaviour (items 32, 33, 34, 35): range 0–12

Emotion and behaviour scores can either be totalled to give one overall score for Resistance (range 0–27) and Engagement (range 0–24), or looked

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| Therapist: _____ | Name/initial: _____ |
| Session # _____ | NHS # _____ |
| Date: _____ | Age: _____yrs.  Sex: M ☐  F ☐ |

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire "work" is defined as employment, school, housework, volunteer work, and so forth. Please do not mark the large boxes on the right.

|  |  | Never | Rarely | Sometimes | Frequently | Almost Always | DO NOT MARK SD IR SR |
|---|---|---|---|---|---|---|---|
| 1 | I get along well with others | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 2 | I tire quickly | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 3 | I feel no interest in things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 4 | I feel stressed at work/school | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 5 | I blame myself for things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 6 | I feel irritated | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 7 | I feel unhappy in my marriage/significant relationship | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 8 | I have thoughts of ending my life | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 9 | I feel weak | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 10 | I feel fearful | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 11 | After heavy drinking, I need a drink the next morning to get going. (If you don't drink, mark "never") | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 12 | I find my work/school satisfying | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 13 | I am a happy person | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 14 | I work/study too much | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 15 | I feel worthless | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 16 | I am concerned about family troubles | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 17 | I have an unfulfilling sex life | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 18 | I feel lonely | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 19 | I have frequent arguments | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 20 | I feel loved and wanted | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 21 | I enjoy my spare time | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 22 | I have difficulty concentrating | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |

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## Outcome Questionnaire (OQ©-45.2)

| | | Never | Rarely | Sometimes | Frequently | Almost Always | DO NOT MARK SD IR SR |
|---|---|---|---|---|---|---|---|
| 23 | I feel hopeless about the future | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 24 | I like myself | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 25 | Disturbing thoughts come into my mind that I cannot get rid of | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 26 | I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never") | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 27 | I have an upset stomach | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 28 | I am not working/studying as well as I used to | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 29 | My heart pounds too much | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 30 | I have trouble getting along with friends and close acquaintances | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 31 | I am satisfied with my life | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 32 | I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never") | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 33 | I feel that something bad is going to happen | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 34 | I have sore muscles | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 35 | I feel afraid of open spaces, of driving, or being on buses, subways, …etc. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 36 | I feel nervous | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 37 | I feel my love relationships are full and complete | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 38 | I feel that I am not doing well at work/school | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 39 | I have too many disagreements at work/school | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 40 | I feel something is wrong with my mind | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 41 | I have trouble falling asleep or staying asleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 42 | I feel blue | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 43 | I am satisfied with my relationships with others | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | |
| 44 | I feel angry enough at work/school to do something I might regret | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| 45 | I have headaches | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |

Subscale totals =

Total =

Repertory Grid

| Emergent / Construct Pole | Self Now | My Ideal self | Self before the voice | Self without the voice | Self as coper | Self as non coper | My dominant voice | My ideal voice | My worse voice | Implicit Pole |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

1. Take 3 elements
2. Some important way in which two of them are alike and different from the third (emergent pole).
3. What is the opposite of this? (implicit pole)
4. Scale 1-7 (where 1 relates to construct pole on left)

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**SPSS Output**

## 1. Comparison to Chadwick sample

**Correlations**

| | | | Malevolence | Resistance |
|---|---|---|---|---|
| Spearman's rho | Malevolence | Correlation Coefficient | 1.000 | .843[**] |
| | | Sig. (1-tailed) | . | .000 |
| | | N | 18 | 18 |
| | Resistance | Correlation Coefficient | .843[**] | 1.000 |
| | | Sig. (1-tailed) | .000 | . |
| | | N | 18 | 18 |

[**]. Correlation is significant at the 0.01 level (1-tailed).

**Correlations**

| | | | Resistance | Omnipotence |
|---|---|---|---|---|
| Spearman's rho | Resistance | Correlation Coefficient | 1.000 | .832[**] |
| | | Sig. (1-tailed) | . | .000 |
| | | N | 18 | 18 |
| | Omnipotence | Correlation Coefficient | .832[**] | 1.000 |
| | | Sig. (1-tailed) | .000 | . |
| | | N | 18 | 18 |

[**]. Correlation is significant at the 0.01 level (1-tailed).

**Correlations**

| | | | Omnipotence | Malevolence |
|---|---|---|---|---|
| Spearman's rho | Omnipotence | Correlation Coefficient | 1.000 | .745[**] |
| | | Sig. (1-tailed) | . | .000 |
| | | N | 18 | 18 |
| | Malevolence | Correlation Coefficient | .745[**] | 1.000 |
| | | Sig. (1-tailed) | .000 | . |
| | | N | 18 | 18 |

[**]. Correlation is significant at the 0.01 level (1-tailed).

**Correlations**

| | | | Benevolence | Engagement |
|---|---|---|---|---|
| Spearman's rho | Benevolence | Correlation Coefficient | 1.000 | .703** |
| | | Sig. (1-tailed) | . | .001 |
| | | N | 18 | 18 |
| | Engagement | Correlation Coefficient | .703** | 1.000 |
| | | Sig. (1-tailed) | .001 | . |
| | | N | 18 | 18 |

**. Correlation is significant at the 0.01 level (1-tailed).

## 2. Distance between the 'self now' and 'dominant voice'

**Correlations**

| | | | Distance | Resistance |
|---|---|---|---|---|
| Spearman's rho | Distance between the self and voice | Correlation Coefficient | 1.000 | .480* |
| | | Sig. (1-tailed) | . | .022 |
| | | N | 18 | 18 |
| | Resistance | Correlation Coefficient | .480* | 1.000 |
| | | Sig. (1-tailed) | .022 | . |
| | | N | 18 | 18 |

*. Correlation is significant at the 0.05 level (1-tailed).

**Correlations**

| | | | Engagement | Distance |
|---|---|---|---|---|
| Spearman's rho | Engagement | Correlation Coefficient | 1.000 | -.323 |
| | | Sig. (1-tailed) | . | .096 |
| | | N | 18 | 18 |
| | Distance between the Self & Voice | Correlation Coefficient | -.323 | 1.000 |
| | | Sig. (1-tailed) | .096 | . |
| | | N | 18 | 18 |

## Hypothesis Test Summary

| | Null Hypothesis | Test | Sig. | Decision |
|---|---|---|---|---|
| 1 | The distribution of Self_Voice is the same across categories of Style. | Independent-Samples Mann-Whitney U Test | .160 | Retain the null hypothesis. |

Asymptotic significances are displayed. The significance level is .05.

3. **Salience of the dominant voice (% Sum Of Squares Voice) and self (% SOS Self)**

**Correlations**

| | | | % SOS Voice | Resistance |
|---|---|---|---|---|
| Spearman's rho | % SOS Voice | Correlation Coefficient | 1.000 | .732** |
| | | Sig. (1-tailed) | . | .000 |
| | | N | 18 | 18 |
| | Resistance | Correlation Coefficient | .732** | 1.000 |
| | | Sig. (1-tailed) | .000 | . |
| | | N | 18 | 18 |

**. Correlation is significant at the 0.01 level (1-tailed).

**Correlations**

| | | | Engagement | % SOS self |
|---|---|---|---|---|
| Spearman's rho | Engagement | Correlation Coefficient | 1.000 | .078 |
| | | Sig. (1-tailed) | . | .380 |
| | | N | 18 | 18 |
| | % SOS self | Correlation Coefficient | .078 | 1.000 |
| | | Sig. (1-tailed) | .380 | . |
| | | N | 18 | 18 |

## Hypothesis Test Summary

| | Null Hypothesis | Test | Sig. | Decision |
|---|---|---|---|---|
| 1 | The distribution of percent_SOS_Voice is the same across categories of Style. | Independent-Samples Mann-Whitney U Test | .035 | Reject the null hypothesis. |
| 2 | The distribution of percent_SOS_self is the same across categories of Style. | Independent-Samples Mann-Whitney U Test | .640 | Retain the null hypothesis. |

Asymptotic significances are displayed. The significance level is .05.

## 4. Tightness of the construct system (% of first principle component)

**Correlations**

| | | | Resistance | % of first principle component |
|---|---|---|---|---|
| Spearman's rho | Resistance | Correlation Coefficient | 1.000 | .612[**] |
| | | Sig. (1-tailed) | . | .003 |
| | | N | 18 | 18 |
| | % of first principle component | Correlation Coefficient | .612[**] | 1.000 |
| | | Sig. (1-tailed) | .003 | . |
| | | N | 18 | 18 |

**. Correlation is significant at the 0.01 level (1-tailed).

**Correlations**

| | | | % of first principle component | Engagement |
|---|---|---|---|---|
| Spearman's rho | % of first principle component | Correlation Coefficient | 1.000 | -.427[*] |
| | | Sig. (1-tailed) | . | .038 |
| | | N | 18 | 18 |
| | Engagement | Correlation Coefficient | -.427[*] | 1.000 |
| | | Sig. (1-tailed) | .038 | . |
| | | N | 18 | 18 |

## Hypothesis Test Summary

| | Null Hypothesis | Test | Sig. | Decision |
|---|---|---|---|---|
| 1 | The distribution of Eigenvalue_Percent_tightness is the same across categories of Style. | Independent-Samples Mann-Whitney U Test | .061 | Retain the null hypothesis. |

Asymptotic significances are displayed.  The significance level is .05.

# Construct analysis frequency tables

**Table a:** The frequency of each category for the construct poles given an extreme rating (1 or 7) to the element 'dominant voice' for the group of engaging copers.

| Area | Code | Pole | Freq | Pole | Freq | Area Total |
|---|---|---|---|---|---|---|
| **Moral** | 1A | Good | | Bad | 2 | **Moral (4)** |
| | 1D | Respectful | | Judgemental | 1 | |
| | 10 | Moral other | 1 | | | |
| **Emotional** | 2D | Balanced | 1 | Unbalanced | | **Emotional (2)** |
| | 2E | Specific emotions | 1 | | | |
| **Relational** | 3A | Extroverted | 1 | Introverted | | **Relational (4)** |
| | 3F | Dependent | 1 | Independent | 1 | |
| | | Peaceable | 1 | Aggressive | | |
| **Personal** | 4A | Strong | 1 | Weak | | **Personal (2)** |
| | 4H | Mature | | Immature | 1 | |
| **Intellectual/ operational** | 5D | Focussed | 1 | Unfocussed | | **Intellectual/ operational (1)** |
| **Values and Interests** | 6A | Ideological values | 1 | | | **Values and Interests (1)** |
| **Total** | | | | | | **14** |

**Table b:** The frequency of each category for the construct poles given an extreme rating (1 or 7) to the element 'dominant voice' for the group of resisting copers

| Area | Code | Pole | Freq | Pole | Freq | Area Total |
|------|------|------|------|------|------|-----------|
| **Moral** | 1A | Good | | Bad | 1 | **Moral (7)** |
| | 1B | Altruist | 1 | Egoist | | |
| | 1F | Sincere | | Insincere | 4 | |
| | 1O | Moral other | 1 | | | |
| **Emotional** | 2A | Visceral | 1 | Rational | | **Emotional (27)** |
| | 2B | Warm | | Cold | 1 | |
| | 2C | Optimist | | Pessimist | 6 | |
| | 2D | Balanced | | Unbalanced | 7 | |
| | 2E | Specific emotions | 12 | | | |
| **Relational** | 3A | Extroverted | 1 | Introverted | 2 | **Relational (13)** |
| | 3B | Pleasant | | Unpleasant | 1 | |
| | 3D | Tolerant | | Authoritarian | 2 | |
| | 3E | Conformist | | Rebel | 1 | |
| | 3F | Dependent | 1 | Independent | | |
| | 3G | Peaceable | | Aggressive | 2 | |
| | 3H | Sympathetic | | Unsympathetic | 1 | |
| | 3I | Trusting | | Suspicious | 2 | |
| **Personal** | 4A | Strong | 2 | Weak | | **Personal (10)** |
| | 4D | Organised | | Disorganised | 4 | |
| | 4E | Decisive | | Indecisive | 1 | |
| | 4I | Self acceptance | 2 | Self criticism | 1 | |
| **Intelligent/ operational** | 5D | Focussed | | Unfocussed | 1 | **Intelligent/ Operational (2)** |
| | 5O | Others | 1 | | | |
| **Existential** | 0A | Purposeful | 2 | Purposeless | 1 | **Existential (5)** |
| | 0B | Growth | | Stagnation | 1 | |
| | 0C | Fulfilment | | Emptiness | 1 | |
| **Total** | | | | | | **64** |

**Table c:** The frequency of each category for the construct poles given an extreme rating (1 or 7) to the element 'self as coper' for the group of engaging copers

| Area | Code | Pole | Freq | Pole | Freq | Area Total |
|---|---|---|---|---|---|---|
| **Moral** | 1E | Faithful | 1 | Unfaithful | | Moral (2) |
| | 1F | Sincere | 1 | Insincere | | |
| **Emotional** | 2B | Warm | 1 | Cold | | Emotional (5) |
| | 2E | Specific emotions | 4 | | | |
| **Relational** | 30 | Others | 1 | | | Relational (1) |
| **Personal** | 4A | Strong | 1 | Weak | | Personal (3) |
| | 4C | Hard working | 1 | Lazy | | |
| | 4I | Self acceptance | 1 | Self criticism | | |
| **Intellectual** | 5A | Capable | 1 | Incapable | | Intellectual (2) |
| | 5D | Focussed | 1 | Unfocussed | | |
| **Values and Interests** | 6A | Ideological | 1 | | | Values and Interests (1) |
| **Existential** | 0A | Purposeful | | Purposeless | 1 | Existential (1) |
| **Total** | | | | | | **14** |

**Table d:** The frequency of each category for the construct poles given an extreme rating (1 or 7) to the element 'self as coper' for the group of resisting copers

| Area | Code | Pole | Freq | Pole | Freq | Area Total |
|------|------|------|------|------|------|------------|
| **Moral** | 1B | Altruist | 1 | Egoist | | Moral (3) |
| | 1F | Sincere | 2 | Insincere | | |
| **Emotional** | 2B | Warm | 1 | Cold | | Emotional (12) |
| | 2C | Optimist | 2 | Pessimist | | |
| | 2D | Balanced | 5 | Unbalanced | | |
| | 2E | Specific emotions | 4 | | | |
| **Relational** | 3A | Extroverted | 3 | Introverted | | Relational (7) |
| | 3B | Pleasant | 2 | Unpleasant | | |
| | 3D | Tolerant | 1 | Authoritarian | 1 | |
| **Personal** | 4A | Strong | 1 | Weak | | Personal (5) |
| | 4D | Organised | 2 | Unorganised | | |
| | 4I | Self acceptance | 2 | Self Criticism | | |
| **Total** | | | | | | 27 |

# Literature Search Strategy

To complete a comprehensive literature search the major psychology, medical and social sciences databases were selected, including PsychINFO, PubMed and ScienceDirect over a period of approximately 16 months. In addition to this specific journals were searched included '*The Journal of Constructivist Psychology', 'Clinical Psychology and Psychotherapy'* and *'Schizophrenia Bulletin'.* Furthermore, relevant literature was also sought out following academic and clinical discussions, through the Hearing Voices Network website (and other specialist hearing voices websites including RufusMay.com and Intervoice), Google Scholar, and reference lists of relevant research papers and books.

Key search terms for the experience under investigation were identified as '*Hearing Voices', 'Voices', 'Auditory Hallucinations', 'Auditory Verbal Hallucinations', 'Positive Symptoms', 'Psychosis'* and *'Schizophrenia'.*

Other relevant search terms were *'Personal Construct Psychology', 'Repertory Grids', 'Coping', 'Cognitive' and 'Relationships'.*