School of Psychology
Ysgol Seicoleg

A Systematic Review of Meaning-Making in the Voice Hearing Experience & An Empirical Study of the Experience of Voice Hearing in the Non-Care-Seeking Population

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CONTENTS

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For my grandparents, who I know would be immensely proud.

Preface

This thesis is comprised of two research papers: a systematic review and an empirical study. The systematic review explores how people from care-seeking and non-care-seeking populations who experience voice-hearing make meaning of their experiences. Following a systematic search of the qualitative literature, 10 relevant articles were identified. A thematic synthesis was carried out to assimilate the results of the studies and identify themes. The analysis identified five analytical themes: (1) Making sense of the VH experience; (2) Explanatory frameworks; (3) External influences on meaning-making; (4) Impact of voice-hearing on identity; and (5) Implications of voice-hearing. These themes are discussed and illustrated with supporting quotes from the research. Clinical implications and suggestions for future research are discussed.

The empirical study explores the experience of voice-hearing in people from the non-care-seeking population who do not experience distress associated with their voice-hearing. Relevant literature is discussed in relation to focus of the current research. Five participants were interviewed about their voice-hearing experiences. Interpretive phenomenological analysis was used to explore the data. The analysis generated three overarching themes summarising important aspects of the participants voice-hearing experiences: (1) Interpretation of the voice-hearing experience; (2) Managing the voice hearing experience; and (3) Valued aspects of the voice-hearing experience. The research is reflected upon with reference to previous research. Limitations of the study and implications for future practice are discussed.

Paper 1: Systematic Review

A Systematic Review of Meaning Making in the Voice Hearing

Experience

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Abstract

Aims: To conduct a systematic review of the qualitative literature investigating how voice-hearers from care-seeking and non-care-seeking populations make meaning of their voice-hearing experiences.

Method: PsycInfo, Scopus, CINAHL and MEDLINE electronic databases were systematically searched for relevant qualitative research. Ten primary research studies were identified and assessed as appropriate for inclusion and a thematic synthesis was carried out on the data.

Results: Five analytical themes were identified: (1) the meaning making process; (2) explanatory framework for voices; (3) external influences on meaning making; (4) influence on identity; and (5) implications of voice hearing.

Conclusion: The exploration of meanings of the voice hearing experience is important to voice hearers. This has implications for how they cope with the experience, the level of input required from services and the effectiveness of interventions. The personal meanings of the voices to the voice hearers should be explored in clinical services.

Keywords: voice-hearing, understanding, meaning, sense-making, qualitative.

Introduction

Voice hearing (VH) is an experience well-documented in various sub-groups of the population, including care-seeking (CS) and non-care-seeking (NCS) populations (Bevan, 2011) Historically, VH was predominantly conceptualised within the biomedical model of mental illness (Blackman, 2000), which views VH as a symptom of mental illness rather than as a meaningful experience. However, the VH experience (VHE) is increasingly viewed as existing on a spectrum of normal human experiences (Romme & Escher, 1989). As a result of this shift, VHE's are increasingly being considered, explored, and understood in a more diverse way. A growing evidence base highlights the complexity of the VH experience, with research recent acknowledging the importance of how the voice-hearer interprets their VHE. (Beavan, 2011).

The Hearing Voices Movement (HVM) represents a significant development in the departure from pathologising the VHE. The movement arose from the work of Marius Romme, Sandra Escher & voice hearer, Patsy Hedge, in partnership with a group of people with lived experience of hearing voices (Corstens et al., 2014). The movement advocates for the importance of exploration and meaning making in the context of the voice hearers life events. The fundamental principle of the movement is that VH is a meaningful human experience and part of the diversity of the human condition (Corstens et. al., 2014). The HVM encourages the incorporation of ideas about understanding the personal meaning and relevance of VH into clinical practice and policy making (Escher & Romme, 2012).

Romme & Morris (2007) assert that VH is a valid and meaningful experience and that, therefore, the meaning of the VHE to the individual requires exploration. Higgs (2020) reflected on the open-ended idea of 'meaning', suggesting that the concept encompasses a

range of beliefs. They acknowledged that research into the meaning of VH invokes an ecological framework, situating the voices in the culture, history, and life experiences of the voice-hearer. A growing evidence base increasingly highlights the therapeutic importance of exploring and accounting for the personal meaning of voices to the voice-hearer (Roxburgh & Roe, 2014; Jackson et al., 2011).

Several factors appear to influence the ways in which a voice-hearers understand their VH. There are significant cultural differences between perceptions of VH. Research suggests that non-western cultures are less likely to pathologise VH and more likely to assign credibility to the experience, therefore, people from non-western cultures may be more likely to openly discuss VH experiences. This may partly account for the higher rates of schizophrenia diagnoses in British African-Caribbean residents (Sharpley et al., 2001). Those from subcultures where spiritualism is commonplace often interpret their VH experience in accordance with the spiritual beliefs of the culture in which they are immersed. Roxburgh & Roe (2014) explored the anomalous experiences of mediums and found that finding a personal experiential framework or explanatory model in which the VH experiences are understood was an important feature of their VH journey. They also found that those who were not exposed to cultures that normalise and validate VH were more likely to attribute their VH experiences to a medical model of "illness". Heriot-Maitland et al. (2012) explored the 'out-of-the-ordinary' experiences of people from CS and NCS populations and found that a key difference between the groups was their ability to incorporate the experiences, into their personal and social worlds, indicating that levels of distress associated with the VHE may be moderated by cultural factors and by the response of people around them and influence the way in which they make meaning of the experience.

Traditional interventions to support those who experience VH-related distress are based on the medical 'illness' model (e.g., antipsychotic medication) and have shown poor efficacy in

enabling people to cope with voices (Bevan, 2011), which emphasises the need to develop more appropriate, effective methods of supporting people who require support regarding their VHE. An increasing evidence base indicates that exploring and understanding the VHE from the perspective of the voice hearer is fundamental in the development of effective approaches to clinical practice (Holt & Tickle, 2015). Clinical guidance issued by the British Psychological Society emphasises the importance of clinicians respecting an individual's construction of their own experiences of VH, rather than taking an "expert" position (British Psychological Society, 2000). Holt and Tickle (2016) reviewed literature exploring the experience of HV from a first-person perspective and concluded that clinicians should attend to the content of voices, the voice-hearers' understanding of the voices, and the meaning they make of their VH experiences. They argue that this approach is essential to providing person-centered care and effective, appropriate interventions for those who experience VH.

Romme & Escher (1989) were among the first to suggest that VH research should explore what the voices mean to the individual, yet research has historically overlooked the meaning of VH experiences, instead focussing on the nature and origin of voices, the cause of voices and potential methods of eliminating VH (Suri, 2011). Therefore, relatively little attention was given to the content and meaning of the experience for the individual (Holt & Tickle, 2014). The emergence of literature exploring these ideas increasingly indicates that VHE's are highly individualistic and differ qualitatively between voice hearers. Exploration of such experiences from the first-person perspective is valuable, and consultation with experts-by-experience is fundamental in developing an understanding of the most effective ways to support the population. Through developing an understanding of what the VHE means to people and how they make sense of and understand such experiences, appropriate theories and interventions can be developed to support those who experience VH-related distress and facilitate people living well with voices.

More recently, a small but significant evidence base has investigated how voice hearers understand the experience of VH (Clements et. al., 2018). Such research has begun to explore VH from the perspective of the voice-hearer, gathering in-depth, qualitative data into the experience. There has been an increase in the use of qualitative methods in recent years but for qualitative research to exert maximum influence it must be positioned within a wider context; the systematic review of qualitative studies is important in achieving this (Sandelowski et al., 1997).

Aims and Objectives

The current review will focus on qualitative research investigating how voice hearers from CS and NCS populations, make meaning of and understand their voices. The reviews aims to systematically locate and appraise qualitative research exploring how voice-hearers make meaning of their VHE's. The review will focus on published in peer-reviewed articles and will contribute to the understanding of how people in CS and NCS populations construct meaning of VH experiences. The aim is to explicate peoples experiences of meaning making in VH and to allow for conclusions to be drawn across studies, integrate findings and increase their influence.

Method

The aim of this synthesis was to identify, assimilate and integrate data from the existing qualitative literature about how voice-hearers make meaning of their VH experiences. Following development of the research question, databases were searched for relevant studies. A quality assessment of eligible articles was carried out, data was extracted, and a thematic synthesis completed by applying guidelines specified by Thomas & Harden (2008).

Literature Search

Relevant papers were identified by searching PsychInfo, MEDLINE, Scopus and CINHAL electronic databases in January 2021. Several search terms were used to identify empirical papers that reported on the meaning of voice hearing and that used qualitative methods of data-collection and analysis (See Table 1.). Search terms were applied using Boolean operators. Multiple electronic databases and a number of search terms were employed to optimise the search and account for the often-poor indexing of qualitative research (Shaw et al., 2004). No limits were placed on the date of publication. The search returned 914 results. Reference lists of the final 10 papers were hand-searched to identify any further relevant literature.

Voice Hearing	Meaning	Qualitative
Hearing voice*	Meaning*	Qualitative method*
Anomalous experience*	Experience*	Interpretative
Auditory hallucination*	Making sense	Phenomenological Analysis
Hallucinatory experience*	Sense making	Grounded Theory
Psychotic like phenomen*	Phenomenology	Thematic Analysis
Psychotic like experience*	Perception*	Content Analysis
	Perspective*	Narrative Analysis
	Attitude*	Unstructured
	Belief*	Semi structured
	Understanding*	Semistructured
		Focus group*
		Qualitative Interview*

Table 1. Literature search terms

Selection of Relevant Research

The process of selecting appropriate papers followed The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance, which provides a guide for the identification, selection, and critical appraisal of research (Liberati et al., 2009). A flowchart outlining the PRISMA process for the current synthesis is outlined in Figure 1.

Papers were included in the synthesis if they met the following criteria: (1) they used a qualitative method of data analysis; (2) used an adult population; (3) investigated voice hearing from the first-person perspective; (4) used qualitative methods of data collection and analysis; (5) were published in a peer reviewed journal; (6) were written in the English language (7) placed sufficient focus on the meaning of the VH experience. Papers were excluded if: (1) the participants experience of voice hearing was related to an organic condition (e.g., dementia); (2) they focused solely on care-giver experiences; (3) they did not address the meaning of the VH experience; (4) they focussed solely or predominantly on other anomalous experiences (e.g., visual hallucinations); (5) if they focussed on a pre-determined meaning of VH (e.g., mediumship); (6) if they were review articles. Duplicate papers were removed. Those remaining were reviewed by title and abstract and those that were unsuitable were excluded. Some abstracts were unclear, or did not provide sufficient information so these, along with the other remaining papers were read in full to determine their suitability for inclusion. Ten papers remained at the final stage and hand-searching their reference lists identified a further four papers, which were screened out upon full-text reading, therefore 10 papers were included in the synthesis.
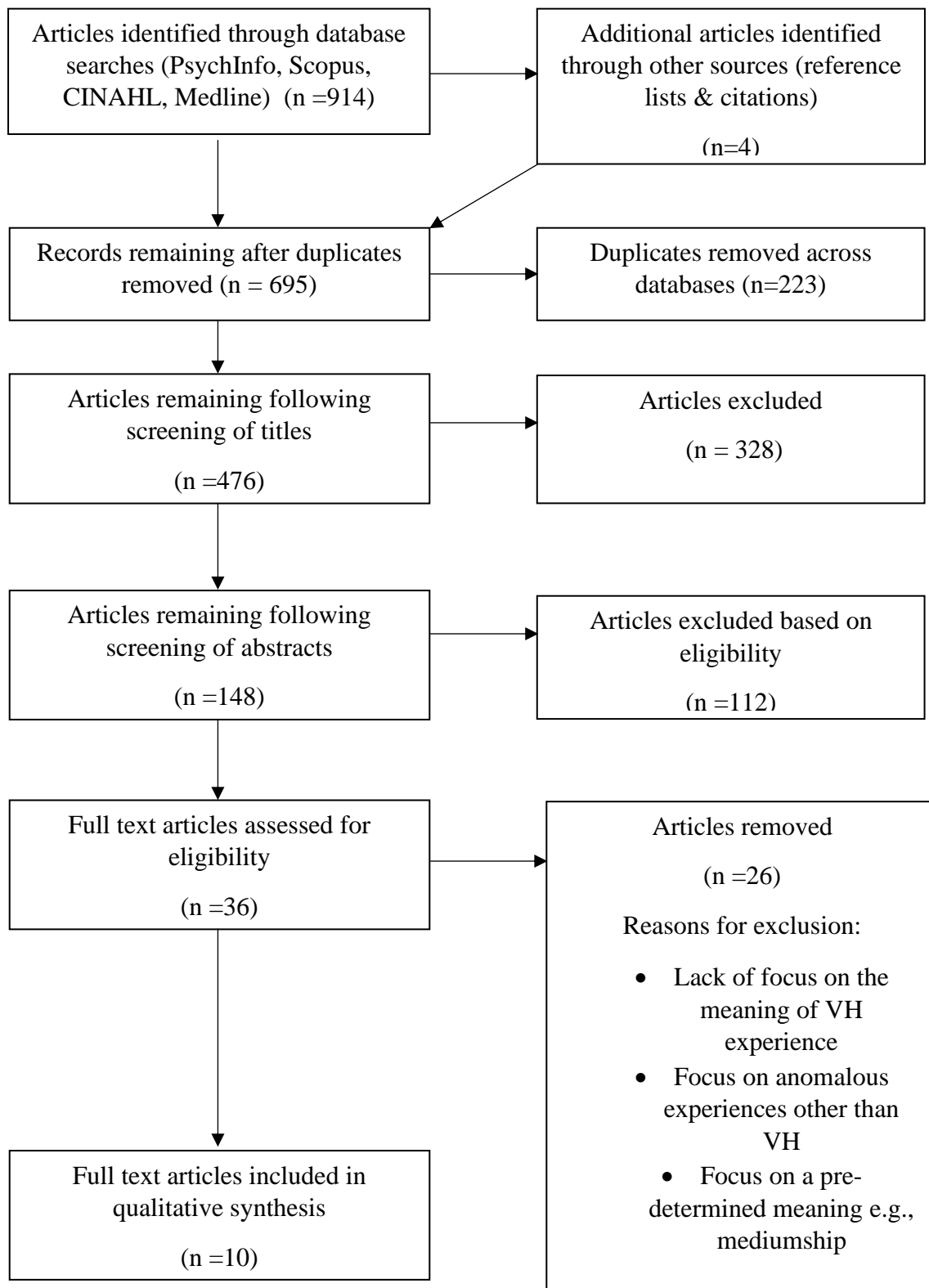
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│  Articles identified through    │          │  Additional articles identified │
│  database searches (PsychInfo,  │─────────▶│  through other sources          │
│  Scopus, CINAHL, Medline)       │          │  (reference lists & citations)  │
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│  Articles remaining following   │          │  Articles excluded based on     │
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│  Full text articles assessed    │          │  Articles removed               │
│  for eligibility                │─────────▶│                                 │
│                                 │          │  (n =26)                        │
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                │                             │                                 │
                │                             │  • Lack of focus on the         │
                │                             │    meaning of VH experience     │
                │                             │  • Focus on anomalous           │
                ▼                             │    experiences other than VH    │
┌─────────────────────────────────┐          │  • Focus on a pre-determined    │
│  Full text articles included    │          │    meaning e.g., mediumship     │
│  in qualitative synthesis       │          │                                 │
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│  (n =10)                        │
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Figure 1: PRISMA flow chart

Quality Appraisal

The Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research was used to appraise the quality of the studies included in the thematic synthesis. The tool is endorsed by Cochrane and the World Health Organisation for use in qualitative evidence synthesis and is considered to be a practical and user-friendly tool for researchers with little prior experience of synthesising qualitative research (Long et al., 2020). CASP encourages the consideration of three broad questions: are the results of the study valid, what are the results, and whether the results will help locally. The assessments were carried out by the author and ratings assigned. The evaluations were discussed during supervision with two Consultant Clinical Psychologists, one of whom was not affiliated with the review. To increase validity of CASP, a second reviewer who was independent of the current review, co-rated 30% of the final papers. There were two discrepancies between reviewers; ratings were discussed, discrepancies resolved, and agreed upon. Papers were included regardless of the CASP evaluation, as all articles contained valuable first-person perspectives about experiences of VH and were therefore valuable to the review. This decision was supported by the literature which suggests that exclusion of relevant articles at this stage may led to the omission of relevant and valid research for 'surface' reasons related to the write-up of that research (Dixon-Woods et al., 2005).

None of the articles except for Lewis et al. (2020), discussed the potential influence of the relationship between researcher and participants (Question 6), and reflexivity was also not discussed. Therefore, the extent to which the researcher's position may have led to bias in the formulation of research questions, sampling, data collection and analysis, could not be ascertained, which may affect the reliability of the results. Faccio et al. (2013) did not specify the method of analysis used, simply stating "qualitative analysis". These limitations were

considered during the analysis and interpretation of the findings and reflected upon in the discussion.

Data Extraction & Synthesis

The 'Findings' or 'Results' sections of each article were considered as data for the purpose of this review. Any conclusions drawn or theory development in the discussion section was not included in the analysis. The data were comprised of first order-constructs - verbatim quotes from participants and second order constructs - the authors' interpretation of the participant's speech. The data were read and re-read to promote familiarity and ensure full immersion. Following reading and annotation with initial ideas, data were entered into a table on a Microsoft Word document and grouped into meaningful sections.

Thematic synthesis (TS) is a method of synthesising qualitative data obtained in primary research, in accordance with principles traditionally endorsed in systematic reviewing (Thomas & Harden, 2008). The method uses techniques from thematic analysis to integrate the findings of multiple qualitative studies by identifying the most important or dominant themes. TS was selected for the purpose of this review as it meets the objectives of the review: to combine existing evidence and identify patterns within the data. The guidelines for conducting a TS are established and transparent and the outcomes are accessible (Thomas & Harden, 2008). Additionally, TS is "epistemologically-neutral" (Ritchie et al., 2013) and can therefore be applied to a the aggregation of data gathered from a range of research.

The TS was carried out according to the stages outlined by Thomas and Harden (2008). First-order constructs are used to support and exemplify the second-order constructs (Thomas & Harden, 2008). The process involves three stages: (1) line-by-line coding; (2) the development of descriptive themes; and (3) the generation of analytical themes. The articles were read several times to ensure immersion in the data. Verbatim quotes were entered into a

table created using a word processing document and initial 'free' codes (codes without a hierarchical structure) were developed inductively to capture the meaning and content of each sentence, which ensured fidelity to the primary data. Line-by-line coding allows for the translation of concepts from one study to another, which is a key stage in the synthesis of qualitative research (Thomas & Harden, 2008). This process was repeated for each study, with new codes being developed at the process progressed. Previous codes were checked at intervals to ensure consistency. The researcher examined the initial codes, grouping similar concepts together and contradictory concepts together. Descriptive themes were developed that captured the meaning of these groups of initial codes and provided context. The descriptive themes remained close to the original data. In the final stage of analysis, more abstract analytical themes were created by considering the descriptive themes in terms of the research question. Following this process, the analytical themes were discussed and finalised with the research supervisor.

	Clements et. al. (2019)	Holt & Tickle (2015)	Lewis et al. (2020)	Fenekou & Georgaca (2010)	Jones & Coffey (2012)	Fernandes & Zanello (2020)	Bohen-Johnston et al (2019)	Boumans et al (2017)	Faccio et al (2013)	Sinha & Ranganathan (2020)
Title	"I'm not telling an Illness Story. I'm Telling a Story of Opportunity": Making Sense of Voice Hearing Experiences	"Opening the Curtains": How Do Voice Hearers Make Sense of Their Voices?	"Maybe it's kind of normal to hear voices": The role of spirituality in making sense of voice hearing	Exploring the experience of hearing voices: A qualitative study	Voice hearing: A secondary analysis of talk by people who hear voices	Hearing Voices: From the Experience Qualification to the Possibility of Care	"It's a bit like a rollercoaster": a longitudinal qualitative study exploring a model of the phases of voice hearing	Coping with psychotic-like experiences without receiving help from mental health care. A qualitative study	Auditory hallucinations as a personal experience: analysis of non-psychiatric voice hearers' narrations	Living with voices: a thematic analysis of individuals' experiences of voice-hearing in India
Country	Australia	UK	UK	Greece	UK	Brazil	UK	Netherlands	Italy	India
Sample	5 attendees of a hearing voices group	8 voice hearers who were distressed by the experience	5 voice hearers from community mental health and early intervention in psychosis teams	15 voice hearers being treated by a local psychiatric hospital	20 voice hearers	10 voice hearers who had attended at least one hearing voices group	20 voice hearers from an early intervention in psychosis	18 voice hearers who answered a newspaper advert	10 voice hearers with no prior contact with mental health services	27 voice hearers and their carers in a private psychiatric hospital
Method of Data Collection	Semi-structured interviews	Semi-structured interviews	Semi-structured interviews	Semi-structured interviews	Semi-structured interviews. Secondary analysis of data collected for a previous study	Semi-structured interviews	Longitudinal mixed-methods design. Semi-structured interviews	Semi-structured interviews	Semi-structured interviews	Semi-structured interviews
Method of Analysis	Thematic analysis	Grounded theory	Interpretive phenomenological analysis	Abbreviated version of grounded theory	Thematic analysis	Content analysis	Thematic analysis	Software analysis (using MAXQDA) and narrative analysis	Not stated	Thematic analysis

Table 2: Characteristics of research included in the synthesis

Results

A thematic synthesis of the ten studies led to the generation of 48 initial codes, 29 descriptive themes and six analytical themes. (See Table 3.). Analytical themes are described below, citing primary and secondary evidence.

Descriptive Themes	Analytical Themes
Importance of exploring the meaning of the experience The medical model Voices conflicting/aligning with religious beliefs Mental health & traumatic experiences Frameworks of voice hearing and coping Response to voice hearing linked to explanatory belief The search for meaning The sense-making process	The meaning-making process
Integration of explanatory theories Exploring explanatory frameworks Ongoing sense-making Struggling with the voice hearing experience Distress linked to lack of control over voices	Explanatory frameworks for voices
Sharing with family Obstacles to sense-making Support in sense making/shared sense-making Positive influence of therapy Voice hearing and the community	External influences on meaning -making
Personal growth due to voice hearing Influence of VH on self-perception and identity Voice hearing and social worlds/communities Role of culture Relationship between voices and thoughts	Influence on identity
Labelling and stigma Voices feeling unmanageable Treatment by others following disclosure of voice hearing Fears about sharing voice hearing experiences Acceptance of voices Positive and negative experiences of voice hearing	Implications of voice hearing

Table 3: Descriptive and analytical themes

The Meaning Making Process

For many, the meaning-making process was integral to their VHE. Participants actively searched for meaning, which was a difficult and lengthy process for many; they asked questions of themselves and the voices as they attempted to identify who or what the voices were:

"I didn't know what it were [the voices] …I didn't understand what was happening. As time went on, it's my father's voice that I actually hear" (Holt & Tickle, 2015).

Many participants initially struggled to make sense of the voices, developing multiple theories and testing them out. Some were fearful and became more distressed and confused (Bogen-Johnston et al., 2019). Others ignored or denied their voices before finally accepting them (Sinha & Ranganathan, 2020). One participant described a lengthy sensemaking process:

"I have gone through everything that is not real, is imaginary or people believe to be true…you are trying to fit something in to explain it, to make it make sense…It's easy to just pick one and end up sticking with it because it explains it" (Jones & Coffey, 2012)

They found an explanation that was congruent with their world view and that of their community. The process involved "personal growth" (Clements et al., 2019), rediscovery and transformation.

Participants engaged in shared sense-making when they struggled to understand their VH through private enquiry, accessing online resources and hearing voices groups (HVG), which provided support and helped participants understand their voices. For some, their view changed over time e.g., changing from a belief that the voices were external to the being internal:

"they seem part of me now" (Bogen-Johnston et al., 2019)

This illustrates the acceptance that many described later in the sensemaking process. Participants made use of experiential information available to them to make sense of their VHE. One participant said:

"...my mum...I was introduced to her voices from an early age" (Lewis et al., 2020)

Highlighting the impact of early lived experiences on their own sense-making. Participants discussed the importance of sharing their VHE with others to help them understand the voices:

"...because to me I was going mad" (Lewis et al., 2020).

Although some experienced an internal struggle over whether to share the experiences, it had clarified their VHE.

Some continued with their sense-making journey, returing to questioning the origins of the voices:

"...whether it's a spirit that I hear, whether it's physically my mind that's become fragmented, or whatever...I don't know what they genuinely are" (Lewis et al., 2020).

As participants learned new information about VH it was integrated into their explanatory framework e.g., someone who learned of the link between VH and trauma believed that their childhood neglect was related (Clements et al., 2019). For some, the sense-making journey was on-going and was observed during conversation with the researcher, using that time to make links between questions asked and their own experiences (Holt & Tickle, 2015).

Explanatory Frameworks for Voices

Participants developed interpretive frameworks that facilitated understanding of their VHE. Medical models of VH were commonly endorsed; some believed that VH was a direct result of a mental health illness, identifying with a medical diagnosis and using medicalised language:

 "I am mentally schizophrenically ill" (Jones & Coffey, 2012).

Some believed that their VH had a genetic cause because family members had experienced VH:

"There is definitely something there genetically. It runs in the family" (Lewis et al., 2020),

Some believed that their VHE had a physiological cause:

 "...it's some kind of brain dysfunction" (Lewis et al., 2020).

Those who believed that mental illness was the cause of their VH were more likely to be fearful of their voices and withdraw from their environment

"I was scared...I was petrified that I was going mad...I try to bat the voices off and not interact with them" (Clements et al., 2019).

Some acknowledged the limitations of the medical model but made use of medical labels when helpful e.g., to facilitate access to interventions, but distanced themselves from ideas related to the model e.g., being 'a patient'. For some, HVG's had enabled them to move away from the medical model which had been helpful:

"I'm not telling an illness story, I'm telling a story of opportunity or learning" (Clements et al., 2019).

Some viewed their voices in a religious or spiritualistic framework e.g., communication with spirits or God, or a mediumistic gift, allowing them to externalise the source of the voices, facilitating a connection to their faith and a disconnect from the negative associations of mental illness. Consequently, some participants were reluctant to take medication and possibly reduce the voices:

"It would be like medicating god away" (Lewis et al., 2019).

Many believed that adverse life events and trauma (e.g., childhood abuse, bullying etc) had been a contributory factor to their VH:

"I was eleven when I was abused…I started to feel sadness…I had postpartum depression and my grandmother died days later…then came the voices" (Fernandes & Zanello, 2020).

Some believed that mental health difficulties maintained their VH (Holt & Tickle, 2015).

External Influences on Meaning Making

Many believed that mental health services (MHS) negatively impacted their meaning making, reinforcing their fear that VH signified "madness", which increased their distress. Many felt that MHS had dismissed their understanding of their voices. One participant attempted to explore their VHE's with a mental health professional but instead their medication was increased (Holt & Tickle, 2015), another was told that the voices *"should not be happening"* and was told to *"not pay attention to them"* (Sinha & Ranganathan, 2020). Participants felt that their lived experiences and views were *"rejected"* (Clements et al., 2019). Some believed that MHS could have supported their search for meaning if professionals had explored the experience with them:

"I feel they were pulling the curtains around it…you need to be able to [understand what is] underlying it, because it will just get worse and fester" (Holt & Tickle, 2015).

For others, MHS had supported their sensemaking journey. For one participant, their disclosure of VH to MHS had led to reassurance. Some felt that MHS had accepted their explanation of the voices., or they had gained clarification through exploration of the VHE with MHS:

"I used to feel…that there were spirits haunting me…obviously since having therapy I don't believe that anymore" (Lewis et al., 2020)

Many found psychological therapy helpful in understanding their VHE. Therapy had empowered them to gain control of the voices which facilitated coping.

"…it sort of made me think of my voice in a different way, which really helped because it sort of changed my outlook on the voice" (Bogen Johnstone al., 2019).

Reactions of family and friends to their VH had been significant in their sense-making. Some felt supported, others dismissed and ostracised:

"…they call me, crazy, complain about having to buy medicine" (Fernandes & Zanello, 2020).

Some shared their experiences with family and friends instead of MHS as VH was accepted within their community (Faccio et al., 2013). For others family interpretations were unhelpful e.g., believing their mother's belief about the voices being the devil, which led to distress (Bogen-Johnston et al., 2019).

Some sought support from religion in the meaning making process. One participant did not seek support from MHS because they relied on God:

"he's giving me really good advice" (Holt & Tickle, 2015).

Others received support from religious figures within their community e.g., a pastor, who had helped them develop an explanatory framework, linking the VH to life events.

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Participants discussed the positive impact of the VHG on their understanding of their VH and coping: "[I] began to see more and more, the links to trauma"; the VHG facilitated an understanding of "where the voices come from" (Clements et al., 2019). Their experiences and views of their VH were respected and they felt empowered, as opposed to feeling dismissed and disempowered by MHS.

The fear of being judged as "mad" had impeded participants' search for meaning e.g., someone experienced VH for 47 years before disclosing it to anyone, fearing being placed in an "asylum" (Holt & Tickle, 2015). Many acknowledged the importance of sharing their experiences in the sense-making process. Those without external support reported a decline in their mental health and worsened VH: "I had a hard time relating to people…I think it was helping all the voices" (Fernandes & Zanello, 2020).

Implications of VH

Many participants worries about the social consequences of a being labelled as someone who hears voices, evident in their resistance to diagnostic labels and the medical model of VH:

"I don't think that labels should be used…I think it's wrong to label people with schizophrenia…we are all just human beings" (Jones & Coffey, 2012).

Others believed that such labels afford advantages, such as access to treatment. However, they acknowledged that advantages are outweighed by the cultural weight carried by such labels. Some did not disclose their voices due to fear of mandated treatment. Some believed the label of *"mental health care patient" (Boumans et al., 2016)* carried additional stigma, and seeking support from MHS would lead to them being considered *"even more abnormal"* (Sinha & Ranganathan, 2020). Responses to such disclosures made them feel isolated so they not to share their VHE for fear of being rejected, or isolated from those important to them:

"I felt like I was on my own" (Clements et al., 2019).

Some worried about the potential implication feared being ostracised from their religious community:

"it's not a good thing I guess, from a Christian perspective" (Lewis et al, 2020).

Some believed that disclosing their VHE may lead result in a loss in connection with mainstream society, instead relying on a smaller sub-community e.g., a religious or spiritual community, where their voices were accepted. Participants fear of judgment was evident in them seeking reassurance from the researcher: *"Am I unusual?"* and "*it's bizarre, I know" (Lewis et al., 2020).*

Voice Hearing and Identity

Some participants had learned life lessons from their voices, which facilitated personal growth:

"The experience has helped me understand myself…and get in touch with what was important to me in terms of my values, what I want to create in myself and my life" (Clements et al., 2019).

Participants considered whether voices were part of them or a separate entity, examining the characteristics of the voice and its 'emotional quality' to decide whether it was separate to themselves. For some, the two had merged:

"…by now the voices have become something like…like thoughts" (Fenekou & Georgaca, 2010)

Belonging to a community of people accepting of VH facilitated positive feelings about their voices and encouraged them to identify as a voice hearer. HVG's allowed participants to move from a sickness model to a celebrated model of VH and those who held a religious

explanation for their VH, felt that hearing God's voice afforded him the respect of others at their church group (Clements et al., 2019).

Participants who believed that their VHE was a symptom of a biological/mental illness identified with diagnostic labels. The diagnostic label given to them had become part of their identity and was significant in how they understood themselves:

"I am schizophrenic" (Jones & Coffey, 2012).

However, some were aware of the stigma associated with being a "mental health care patient" (Boumans et al., 2016) and did not to identify with this. Some worried about the implications of VH on their religious identity, worrying that they meant they are a *"bad Christian"* e.g.,

"I went through a few weeks of talking with Satan"; *"a good Christian wouldn't think these things" (Clements et al., 2019).*

There was sense of guilt and shame as their Christian identity was challenged by their VH experiences. However, for others, their belief that their VH was of religious origin allowed them to retain a preferred identity; that of a "good Christian" rather than someone who hears voices due to mental illness (Lewis et al., 2020; Clements et al., 2019). It appeared that a participant's social context is a contributing factor in if/how they identified as a voice hearer (Faccio et al., 2013).

Discussion

This review contributes to the growing evidence base highlighting the importance of meaning in the VHE in CS and NCS populations. It is the first known attempt to synthesise qualitative research investigating the meanings people make of their VHE. The synthesis produced five analytical themes, generated from 48 initial codes and 29 descriptive themes. The analytical themes were: (1) Making sense of the experience; (2) Explanatory frameworks; (3) External influences on meaning making; (4) Influence on identity; and (5) Implications of voice-hearing. Any conclusions drawn from the results of the synthesis should be tentative, as only a small number of articles were included due to the lack of appropriate studies available.

The search for meaning in the VHE was important to voice-hearers, and peoples lived experiences were foundational to the meaning they constructed of their VH. The way in which people were supported to make sense of their voices, or not, had significant implications for how the VHE progressed and the associated level of distress experienced by the voice hearer. This provides support for Romme & Morris' (2007) assertion that VH is a meaningful experience, and that exploration of the experience and their perception of it is an important aspect of supporting those who hear voices. Such findings highlight the utility of using a psychological formulation-based approach in working with voice-hearers, enabling the development of a shared understand of their VHE's, informed by personal meanings, lived experiences and systemic influences. Accordingly, Jackson et al (2012) reported on the therapeutic importance of exploring and accounting for the way in which voices are set in the personal framework of the voice hearer, indicating the utility of psychological formulation in supporting those who experience VH.

The results indicated that the response of others to disclosures of voice-hearing can influence the voice-hearers perception and evaluation of their VHE, which has been illustrated in previous research (e.g., Roxburgh & Roe, 2014; Luhrmann et al., 2015). The acceptance of voices by those around them and the wider culture is associated with a less distressing VH experience, as seen in non-western cultures and spiritualist communities. Such evidence illustrates the role of systemic influences on the meaning a voice-hearer makes of their experiences and the moderation of associated distress (Heriot-Maitland et al., 2012).

Bevan (2011) stated that the concept of VH as a variation on normal human experience implies that there may be characteristics of the experience that are similar across voice hearers, including those in CS and NCS populations. The findings of the current synthesis provide evidence for this, with similarities noted between the VH experiences in CS and NCS populations within and across studies.

Strengths & Limitations

These results provide support for the movement away from a reductionist medical model of voice hearing focussed on distress and deficits and towards a model that validates lived experience, exploration, meaning making and the voice hearer taking an active role in therapeutic work.

The review included studies from across the world, including western and non-western countries. This enables the inclusion of data from different cultures which indicated that there are differences and similarities in the way voice hearers from different cultures view the VH experience, which provides support for previous research illustrating the impact of the voice hearers cultural background on the way they experience their VH and their experience of seeking support of attitudes to VH (e.g., Roxburgh & Roe, 2014; Heriot-Maitland et al., 2012).

There is a lack of primary qualitative research investigating the accounts of voice hearer's understandings of their VHE, in CS and NCS populations. The studies included in the review were of varying quality, and had methodological limitations, as previously discussed (see Method section). It is significant that nine of the 10 articles included did not explore or reference the researcher's position, their relationship to the participants, and the possible impact of this on the research. This can lead to a lack of clarity about the extent to which authors interpretations were influenced by their background and theoretical stance.

To maintain an acceptable level of quality, the inclusion criteria required that articles included were published in a peer reviewed journal, however, this may have led to the omission of relevant grey literature. This is a particularly pertinent consideration in reviewing qualitative research, which is more likely than quantitative research to be reported in grey literature. Holt & Tickle (2014) have suggested that discounting grey literature may lead to the exclusion of minority voices, which are not equally represented in the peer-review process. For this reason, any future reviews may wish to include grey literature. Furthermore, there is a lack of consensus regarding methods of judging the methodological robustness of qualitative research, because, among other reasons, qualitative research is taken from different ontologies and epistemologies, additionally there is little consensus about what constitutes quality (Long et al., 2020). This should be considered when comparing and synthesising a range of qualitative studies, as in the current review. The CASP is a subjective tool; although an attempt to mitigate for this was made by using a co-rater in 30% of the articles included in the synthesis, this should be considered.

The review may have benefitted from a second reviewer reading full text articles that were considered for inclusion and the Confidence in the Evidence from Reviews of Qualitative Research (CERQual) tool could be used in addition to the CASP to increase the reliability of the analysis.

In synthesising qualitative studies, there is the difficulty of differentiating between first and second-order constructs, because the data extracts included are selected by authors and may not be representative of the participants reporting of their experiences. They may also be subject to bias, in line with the authors theoretical stance (Atkins et al, 2008). Discussions were held with the research supervisor about the process of the thematic synthesis and the emerging results. The descriptive and analytical codes were also reviewed by the research supervisor, increasing the reliability of the synthesis.

There is a continued interest in various aspects of the VHE in different populations. There is a need for more methodologically robust studies into the first-hand accounts of voice-hearers to develop understanding of the range of experiences across the VH continuum. The current review highlights that voice hearers are a heterogenous group; it would be advantageous to gain further understanding into their frameworks for understanding VH and the sense-making and experiences that lead them to that.

Clinical Implications

The current results highlight the importance of the exploration of a persons' voices in clinical practice, without assuming or offering an explanation for those voices, medical or otherwise. The positive and negative experiences of MH services reported illustrate their significance in the meaning-making journey and in how people understand their VHE's, illustrating the importance of developing services that are person-centered and psychologically informed.

Those working with voice hearers should facilitate discussion of the content of voices and explore the personal meanings of the experience for the voice hearer. Considering this evidence, there may be benefits to using a psychological formulation-based approach to explore voice hearer's experiences and to inform and guide interventions. Evidence has found that voice-hearers want to explore the content and meaning of their voices with professionals,

and professionals believed that they were providing this, indicating that there is a gap between the service-user and staff perceptions of support provided (Coffey et al., 2008). Such evidence illustrates the need for further staff training and for staff to engage in regular reflective practice, to ensure that service provisions meet the needs of the population

Some voice hearers are reluctant to seek support from MH services, and those that did often had negative experiences, where their experiences and invalidated and approached in a reductionist way. These findings highlight the need for change in the way MH services interact with and support voice hearers. How they experience their first point of contact with MH services is critical in fostering feelings of safety, validation, and acceptance, which requires professionals to communicat a respectful curiosity about the person and their voices. This approach is more likely to facilitate meaningful engagement in therapeutic interventions to reduce distress and enable them to live well with their voices. Implementing this approach in settings where the medical model of VH is dominant may create tensions. The sharing of knowledge is key in developing psychologically-informed services; clinical psychologists are in a position to facilitate such changes by leading team formulations and through providing consultation and training to colleagues.

In each of the studies, participants were concerned about the societal stigma attached to VH and to accessing services for VH. This continues to present a challenge to those voice hearers and those working with them; changes are gradually occurring, with the growth of the continuum model of psychosis and organisations such as the HVN normalising the experience, but a significant shift is needed. Professional can support this movement by validating and normalising peoples voice hearing experiences, and by challenging pre-conceptions about voice hearers. They can also provide support to voice hearers who wish to share their experiences with friends and family, formulating a way for them to do so that feels safe for them.

Conclusion

This synthesis of 10 studies offers insight into the meanings that voice-hearers from CS and NCS populations, make of their experiences. Constructing meaning was important to people, and external influences either helped or hindered this process. They understood their VH through frameworks of religion and spirituality, mental health difficulties and trauma. Voice-hearing was connected to their identity, with some embracing the identity of being a voice hearer. The societal stigma attached to the VHE was significant to people and impacted on their support-seeking and coping behaviours. The review highlights the heterogeneity of the ways in which people understand their VHE. Results illustrate the need for services to validate and support people in exploring and understanding their VH experiences in the context of their lived experiences, beliefs and culture, and the importance of developing individualised and person-centered services and interventions.

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Paper 2: Empirical Study

An Empirical Study of the Experience of Voice Hearing in the Non-Care-Seeking Population

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Abstract

Aims: This research aimed to explore the first-person accounts of voice-hearing in people from the non-care-seeking population who do not experience distress related to their voice-hearing.

Method: A qualitative approach was employed to gather rich, in-depth data. Semi-structured interviews were carried out with five participants recruited from the general population via social media. An interpretive phenomenological analysis was carried out on the data.

Results: Three superordinate themes and nine subordinate themes were identified. The superordinate themes included: (1) interpretation of the voice hearing experience; (2) managing the voice hearing experience; (3) and valued aspects of the voice hearing experience.

Conclusion: Perceived control of the voices was important in mediating the voice-hearing experience and preventing voice-hearing related distress. Clinical and research implications are discussed.

Keywords: voice-hearing, voices, non-care-seeking, distress, experience, interpretative phenomenological analysis.

Introduction

Historically voice hearing (VH) was considered synonymous with poor mental health (Taylor & Murray, 2012). The dominant medical model dichotomised experiences as non-pathological or pathological, with anomalous experiences, such as VH falling into the latter category (Bevan, 2010). However, the notion that not all who hear voices are distressed by the experience has gained traction in the field since Strauss (1969) proposed the first continuum model of psychosis, which promoted normalisation of anomalous perceptual experiences. Romme & Escher (1989) further developed this theory, considering VH as a valid experience rather than as a symptom of a mental health diagnosis. Subsequently, VH in the non-care-seeking (NCS) population has been the subject of much research and VH is increasingly considered to be a variation of normal human experience (Romme & Escher, 1989).

Prevalence estimates of VH in the NCS population vary significantly. Bevan at al. (2011) report that between five and fifteen percent of the general population may experience VH and Krackvik et al. (2017) suggest that one to two percent of the general population experience repeated and complex VH (cited in Alderson-Day et al., 2017). Other estimates indicate that the prevalence is between 4.8% and 27% (Verdoux et al., 1998; Posey & Losch, 1983, respectively. As cited in Lawrence et al., 2010). The variance in these estimates may be attributable to variation between definitions of VH, methodologies and study designs (Laroi, 2012). Additionally, diagnostic measures and criteria used to determine the presence of VH may not be sufficiently sensitive for a NCS population, leading to an underestimation of prevalence rates (Hill & Linden, 2013).

Sommer at al. (2010) investigated the phenomenology of VH in a NCS population using the Psychotic Symptom Rating Scale (PSYRATS; Haddock et al., 1999) and found that 91%

were not distressed by their voices and 55% were able to stop their voices if they were distressed by them.

Evidence suggests that voices are less negative in content and provoke less distress in the NCS population (Hill & Linden, 2013). Cognitive models of voice hearing suggest that the appraisal of the voice rather than the content of the voices determines whether they are experienced as distressing (Morrison, 2001). Chadwick and Birchwood (1994) proposed that beliefs about VH may be a mediating factor between voices and the affective and behavioural response. They reported that belief about the malevolence of the voice dictates whether it is resisted or engaged with, which predicts distress. They identified three key elements in the VH experience: perceived power, intent, and emotional and behavioural responses. Peters et al. (2011) investigated these elements and found that beliefs about voice power were the strongest predictor of distress, and this should therefore be a target for psychological interventions in reducing distress.

Comparison studies investigating the VH experience in the care-seeking (CS) and NCS populations have explored predictors of distress. Andrew et al. (2008) compared the VH experiences of a care-seeking (CS) population to a NCS population identifying as mediums. They found no between-group differences regarding the perceived origin of the voice, but the CS population were more likely to experience negative voices, voice-related distress, and less likely to feel in control of their voices. They were also more likely to perceive their voices and malevolent than the NCS group, finding support for the cognitive model. The NCS group may have experienced less voice-related distress due to the mediumistic framework though which they interpreted their voices. Such findings support Romme & Escher (1989), the first to propose that control over the VH experiences was linked to distress.

Interpretation of voices is influenced by culture, and previous research has illustrated that there are significant cultural differences in beliefs about VH. In western cultures VH has been linked to trauma, distress and illness but in non-western cultures it is often considered a normal or positive experience (Talseth et al., 2012). Morrison (2001) suggested that the when the voice-hearer appraises the experience in a way that is considered unacceptable in their culture, then they are more likely to experience associated distress. Accordingly, VH-related distress levels have been found to be higher in social contexts where VH is considered a symptom of mental health difficulties (Powers et al., 2017; Vilhauer, 2017; as cited in Vilhauer & Sharma, 2018). Laroi et al., (2014) carried out a review of research investigating the role of culture in auditory and verbal hallucinations, finding that culture plays a significant role in shaping the hallucinatory experience and associated distress.

People who identify as mediums or clairvoyants belong to a western subculture that values VH experiences. Powers et al. (2017) compared VH in clairaudients to voice-hearers from the NCS population, voice-hearers from a CS group and a matched control group. The clairaudients were more likely to receive a positive reaction from others when disclosing VH whereas the clinical group was more likely to receive a negative reaction which disrupted their social relationships. The clairaudients also had a more positive affective response and more control over the voices than then other groups. The voices were similar in characteristic, frequency, and content, suggesting that the, appraisal that voice hearers and those around them make of their voices may predict distress. Powers et al., (2017) suggest that a predictor of distress is the intentionality of the VH experience, which is closely linked to control and may illustrate why those in spiritualist communities experience less voice-related distress A sense of control in the VH relationship can enable voice-hearers to exert independence and choice (Jackson et al., 2011).

Vilhauer & Sharma (2018) found that although negative voices are more frequent in voice-hearers with mental health diagnoses, approximately half of voice-hearers without a mental health diagnoses also experience negative voices, highlighting that VH is not a dichotomous experience and a positive or negative VH experience should not be presumed based on whether someone experiences mental health difficulties. In the current study NCS voice hearers are defined as those who do not experience voice-hearing related distress and do not currently access mental health support specifically for their VH.

Enhancing understanding of VH experiences in the NCS population is integral to formulating a thorough understanding of the VH continuum and to provide insight into the development of etiological models and interventions for voice-hearers in the CS population, to decrease distress and reliance on the NHS in those with severe and enduring mental health difficulties. Distress levels are a determinant of whether someone requires the support of MHS, and the presence of distress is an ethical guideline for the requirement of psychological intervention. Additionally, research has indicated that voice-hearers from the NCS population are more likely to develop severe mental health difficulties (Sommer at al., 2008). Studying this population may provide an understanding of factors that are protective in the VH experience, and what helps prevent or relieve distress.

VH is a complex and multifaceted experience. However, much research investigating VH in a NCS population has applied quantitative methodology, resulting in a lack of qualitative, first-person accounts about the experience. Most studies of VH in the NCS population have taken a narrow focus, investigating VH symptomology rather than the experience (Lawrence et al., 2010), which has led to a lack of in-depth exploration of VH in this population. Much qualitative research carried out within NCS populations has been comparative, rather than focussing solely on the NCS population. Qualitative methodologies have grown in popularity

due to the recognition that, unlike quantitative methodologies, they capture meanings and the experiential and interpretative elements of healthcare (Collingridge & Gantt, 2008).

Aims & Objectives

The aim of the current research is to gather in-depth insights into the VH experiences of those in the NCS population who do not experience VH-related distress. The study will gather first-person accounts from those who feel neutral or positive about their voices. The findings of this study will contribute to the evolving qualitative evidence base about VH in the NCS population. Developing a comprehensive understanding of these experiences will facilitate the development of effective support and interventions for those who do experience VH-related distress. Exploring how voice-hearers cope with the experience and live well with their voices has implications for the way in which clinical psychology supports those in distress and seeking care.

Methodology

Design

The aim of the research was to understand experiences of VH in the NCS population through gathering rich, in-depth data, therefore a qualitative design was used. Data was collected using semi structured interviews. Qualitative methods are considered appropriate when addressing research questions that focus on the experience, meaning and perspective of the participant (Hammarberg et al., 2016). Interpretative phenomenological analysis (IPA), a structured framework proposed by Smith et al., (2009), was used to explore the data.

Ethical Considerations

Ethical approval for the research was granted by Cardiff University School of Psychology Ethics Committee. As the participants being recruited were from the NCS population and did not experience distress associated with their voice hearing, no additional ethical safeguarding

was required. This research was conducted during the COVID-19 pandemic, therefore changes to the original procedure were necessary. Interviews took place virtually using a video platform rather than face-to-face, to ensure the physical safety of the participants and researcher.

Participants contacted the researcher via email or social media message to express their interest in the study and the researcher confirmed that they met the inclusion criteria. Potential participants were sent an information sheet (See Appendix 1) detailing the purpose of the research and what would be involved should they choose to participate. Participants were informed that interviews would be carried out online. Upon agreeing to participate they were sent a consent form (Appendix 2) which they completed using an electronic signature and returned to the researcher. Verbal consent was also recorded during interviews. Participants were informed that the audio recording of their interview would be deleted following transcription, the transcription will be anonymised and transcripts would be stored electronically on a secure Cardiff University system for five years, as stipulated by Cardiff University School of Psychology.

Recruitment & Participants

Recruitment took place on social media. Previous research has found support for the online recruitment of NCS samples of voice hearers (Lawrence et. al., 2010). The recruitment 'poster' (See Appendix 3) was circulated by the researcher and research supervisor on Twitter and Facebook. The information was shared in several voice-hearing community groups on Facebook. People voiced their interest by contacting the primary researcher by email or sending them a social media message. The contact information of the research supervisor was also included on the recruitment poster.

Purposive sampling was employed, to select participants based on their experience with the focus of empirical inquiry (Shaw, 1999). The inclusion criteria stipulated that participant should be over 18 years old, have had experience of voice hearing that they were not distressed by and that they had not accessed support specifically for their voice-hearing within the last two years. VH was defined as hearing a voice/voices that other people cannot hear (Ohayon, 2000). People who accessed mental health support for other reasons were not excluded from participation. As the interviews were taking place over video platform, there were no geographical constraints on where the participant was from.

Seven participants were recruited, however, during two interviews it became apparent that the participants were currently accessing support to manage their voices from MHS. Following discussion with the research supervisor, a decision was taken to exclude these interviews from the analysis as they did not fit the inclusion criteria.

The five remaining participants were aged between 24 and 60 years, one man and four women. Three participants were from the UK and two from the USA. Two practised Shamanism, one was a Christian, and two did not practice spirituality or religion. Historically, participants had had varying levels of contact with mental health services for various presentations: two had seen counsellors, one for low mood and another for anxiety and trauma; one had experienced an episode of psychosis and been hospitalised (12 years ago); another received medication for an episode of psychosis (7 years ago) and one was currently taking an unspecified psychiatric medication.

Participants were given the opportunity to ask questions at the beginning and end of interview. They were told that they could contact the researcher or the research supervisor if they had any further questions. Participants were sent a £10 voucher to thank them for their time and participation.

Data Collection

The researcher referred to an interview schedule to guide the interviews (see Appendix 4) and explore participant experiences of voice-hearing. The schedule was designed with reference to Smith et al. (2009), which provided guidance regarding the interview structure and the topics covered. The schedule included open-ended questions and prompts to facilitate further elaboration. The use of a schedule allowed the conversation to progress naturally and for the researcher to follow any conversational trajectories that emerged during the interview, but also that data specific to the research question was gathered. Clear, accessible, neutral, and inclusive language was used, and leading questions were avoided. The research supervisor was involved in the development of the interview schedule. The schedule was refined after the first interview and questions that did not elicit information that addressed the research question were removed. The interviews were recorded via Dictaphone and transcribed verbatim by a professional transcriber. Transcripts were anonymised and any information that may have identified the participant was removed.

Data Analysis

IPA is a qualitative methodology that seeks to understand experiences from the perspective of the individual. IPA was selected as method of analysis because it is concerned with the examination of personal lived experience, the meaning of the experience and how people make sense of that experience (Smith, 2010). It allows an 'insider's perspective of an experience or event, which is then interpreted by the researcher (Larkin et. al., 2006). The theoretical roots of IPA are rooted in phenomenology; it is concerned with an individual's lived experience and gaining proximity to that experience, particularly those experiences that are significant to us and constitute our lived world (Smith et al., 2009).

Through a dynamic process of interpretation, the researcher takes an active role in eliciting the participant's experiences (Smith & Osborn, 2004). Because the analysis is based on detailed case exploration, the researcher can make statements about individual participants (Smith et. al., 1995). IPA is informed by hermeneutics. It is an interpretive endeavour and involves the researcher making sense of the participant making sense of their experience. The process is dynamic, with the researcher taking an active role (Smith et. al., 2009). It is an ideographic approach, concerned with the particular rather than the population, and focus on details is maintained, with in-depth consideration of data sets (Smith, 2010). Small sample sizes are typical in IPA studies because the primary concern is in-depth examination of individual experience, therefore IPA studies typically include between three and six interviews (Smith et al., 2009).

IPA was selected as an appropriate method of data analysis because the aim of the current study was to explore the voice-hearing experiences of people from the NCS population, and gain insight into their world. It allowed the researcher to focus on the unique elements of individual participant experiences whilst also exploring meaning across participant experiences (Smith et al., (2009).

The analysis was carried out by the primary researcher. Extracts and themes were checked by the research supervisor. Smith at al. (2009) step-by-step approach to conducting IPA was employed, as outlined below:

	Description of Analysis
Stage 1: Reading and re-reading	The researcher ensured immersion in the data by reading and re-reading the data to ensure that the participant remained the focus of the analysis and to encourage active engagement with the data. The researcher recorded any preliminary thoughts, observations and possible connections within the transcript and reflected on their observational notes from the accompanying interview.
Stage 2: Initial noting	The researcher explored the transcript paying close attention to the semantic content and language, noting anything of significance or interest. The notes became more interpretive, considering the how and why the participant held theses viewpoints or concerns, and consideration was given to psychological terms and concepts. The researcher maintained a phenomenological focus and remained close to the participant's meanings and how they made sense of their lived experiences. At this stage, the notes included descriptive comments, linguistic comments and conceptual comments, while remaining close to the original transcript. Following Stage 1 & 2, the researcher had a comprehensive set of notes on the data.
Stage 3: Developing emergent themes	The analysis moved from the original transcripts to the comprehensive set of notes produced in the previous stages of analysis. The researcher mapped the relationships, patterns, and connections between exploratory notes to identify emergent themes. This stage of the analysis is a demonstration of the hermeneutic circle, whereby the whole interview becomes a set of parts as the researcher focusses on discrete sections, before coming together as a new whole upon completion of the analysis. The researcher constructed concise statements summarising what is important about sections of the transcript/notes. The themes reflected the participants original words and the researcher's interpretation.
Stage 4: Searching for connections across themes (within a transcript)	The researcher mapped the ways in which the themes fit together in a way that highlights the most interesting and important aspects of the participants account. This involved abstraction: identifying patterns between emergent themes and grouping them together under a newly developed superordinate theme; subsumption: making an emergent theme as superordinate themes and bringing together a set of related emergent themes together underneath that; and numeration: nothing the frequency with which a theme occurs. At this stage some emergent themes were discarded e.g., those that did not address the research question. If any themes did not fit the emerging picture, the researcher returned to the transcripts and earlier notes to re-evaluate and assess the importance of themes, or comment on any disconformity within themes.
Stage 5: Moving to the next case	Stages 1-4 were repeated with the next transcript and each remaining one. To maintain the ideographic commitment of IPA, the researcher attempted to bracket their thoughts and ideas that had emerged in the analysis of the previous transcript/s. However, it is acknowledged that the researcher will inevitably be influenced to some extent by their previous findings.
Stage 6: Looking for pattern across cases	The researcher lay out the themes generated from each transcript during Stages 1-4, and accompanying illustrative quotes, to look for connections across them. This involves considering how one theme may illustrate a different case, and which themes were particularly compelling. Here the analysis become more theoretical: themes from certain cases that represent examples of higher order concepts shared by other cases, are identified.

Table 1: Summary of stages in data analysis (based on guidance by Smith et al., 2009)

Quality Assurance

Quality assurance is important to ensure integrity and rigour. In qualitative research integrity is defined by trustworthiness, credibility, applicability, and consistency (Leininger et al., 1994). The ways in which the current research will aim to meet these criteria are stated in Table 2.

Trustworthiness	A report of a qualitative study should contain the same robust procedural description as any other study. The purpose of the research, how it was conducted, procedural decisions, and details of data generation and management should be transparent and explicit. A reviewer should be able to follow the progression of events and decisions and understand their logic because there is adequate description, explanation and justification of the methodology and methods.
Credibility	Qualitative research can only be defined as credible when results presented with an adequate context are recognisable to those who share the experiences described and to those who care for them. Several methods can be used to defend the credibility of the research including reflexivity, triangulation, and a thorough description of the methods used to interpret the data.
Applicability	A study is found to be applicable when its findings can fit into contexts other than the situation first researched, and when clinicians and researchers find use in applying the findings to their own experiences.
Consistency	A consistent study is one which is reliable, and where other researchers, with the same data, would find similar patterns.

Table 2 – Quality assurance in qualitative research (Leininger et al., 1994)

The researcher met regularly with the research supervisor to discuss and reflect on the research and discuss any queries or issues that emerged. A member of research staff who was not directly affiliated with the research was also consulted during the research process. The research supervisor checked a selection of coding and listened to the audio recording of the first interview to provide the researcher with feedback. They also checked the themes generated from the data following analysis.

Reflexivity

Bracketing, the process of the researcher reflecting on and attempting to suspend their beliefs about the research subject, is an important step in phenomenological research (Bevan, 2010). The researcher enters the research process with their own experience, views and perceptions which should be acknowledged and reflected upon during the research process, to maintain transparency and reduce bias. The researcher kept a reflective diary and engaged in supervisory discussions throughout the process to encourage self-awareness and transparency. This process supports quality assurance in qualitative research.

Laroi et al., (2014) reflected on the importance of the researcher reflecting on their cultural background when researching VH, as the perception VH varies between cultures. The researcher considered how they may influence the research process.

The researcher is a 36-year-old, Welsh-British, middle class, white, cisgender woman. They are working in the role of Trainee Clinical Psychologist and the research is a requirement for completion of their doctoral training programme. They have worked in adult, older adult and forensic mental health settings with adults who experience voice hearing, all of whom described the experience as distressing. This may have led to pre-conceptions about the nature of VH, or the aetiology underlying the experience of VH. The research supervisor has experience of carrying out research with people in the general population who experience VH. The dominant western culture that the researcher had been exposed views voice-hearing as being linked to serious and enduring mental health difficulties, with a significant societal stigma attached. The researcher held this information in mind and aimed to take a position of respectful curiosity during the research process.

Results & Analysis

Data analysis led to the development of three superordinate themes and nine subordinate themes, which are presented in Table 3. Themes will be discussed with accompanying quotes to illustrate findings. An extract of the analysis illustrating the progression from coding to final themes is included (Appendix 5).

Superordinate Theme	Subordinate Themes
1.) **Interpretation of the Voice Hearing experience**	• Rejection of the medical model • Personal meanings • Voices as self or other?
2.) **Managing the Voice Hearing Experience**	• Control over the voices • Evolution of the voice-hearing experience • Developing mastery over the VH experience
3.) **Valued Aspects of the Voice Hearing Experience**	• Voices providing support • Voices having a purpose • VH as an interesting experience

Table 3: Summary of themes

1.) Interpretation of the Voice-Hearing Experience

Rejection of the medical model

Most participants did not identify with the traditional medical model of VH. Some felt that it did not fit with their experiences of VH, which led to them exploring explanations that held personal meaning for them.

"I found that the concept of what was happening to me was a biological illness didn't really fit and didn't make sense" (Participant 4)

Participant 5 believed that their VHE was distinct from their mental health difficulties had worried that others would not see this distinction. They did not their valuable VHE reduced to a symptom:

"I'm really very careful because…I have other problems that people can conflate with [voice-hearing] being mental illness…but [the voices] came to me at a time when I was at my strongest and most happy".

Some participants chose not to engage with the healthcare system because of the pathologising way in which professionals framed VH. They worried about being labelled 'a patient' and the negative connotations and stigma associated with this. However, some used medicalised or reductionist language to describe other voice-hearers and mental health patients. They appeared to have internalised the negative narrative they worried about others attributing to them, attributing it to other voice hearers, in a 'them vs us' narrative. They did not identify with people in many voice-hearing communities, choosing to distance themselves from others with VH experiences. Participant 4, for example, referred to them as *"these people",* asserting that their voices are *"radically different"* to their own. They did not

acknowledge that elements of the experience were shared, as though that may introduce fear into their personally constructed experience. Participant 1 explicitly acknowledged this fear and avoided contact with VH communities:

"it makes me very spooked to talk to people with a lot worse symptoms…I don't know what kind of coincidence kept me from getting that far…but, sometimes it's kind of a scary reminder".

Although Participant 1 subscribed to the medical model of VH e.g., describing the cause of their VH as a "glitch in the brain", using medicalised language and taking medication they were unhappy that prescribed medication had reduced their voices, and chose to minimise their dosage to reintroduce the voices. They selected aspects of the medical model that suited their needs and rejected those that did not e.g., the objective of eliminating voices:

"[the lower dose] seems to make hallucinations more likely to happen".

Personal meanings

Participants understood their VH through their lived experience, assimilating new information into this understanding over time. These personally constructed meanings facilitated autonomy over the experience. Spiritualist beliefs had allowed some an alternative understanding of their VH, one which was less threatening and provided feelings of safety and belonging to a community:

"... it helped me have an understating of psychosis that wasn't looking at it as a diseased brain, which, of course, is very frightening" (Participant 4)

Most reflected on significant events and emotional responses; they discussed their voices as a representation of their subconscious and a means of processing experiences that were too

challenging to deal with consciously e.g., trauma or extreme stress. This led to the acceptance of a psychological explanation that fit with their lived experience:

"seeing it as my psyche healing itself from things that I hadn't dealt with in my life was much more…empowering way of…viewing the narrative of my life" (Participant 4)

Participants repeatedly emphasised the influence that the individual has over their VHE, and suggested it is this construction of personal meanings that differentiate between the voice-hearers who experience distress, and those who do not:

"that lake of fire is not there unless you create it for yourself – if you feel the need to be purified by fire then you will be burned" (Participant 5).

Voices as self or other?

Most participants appeared uncertain of whether voices were a part of them or existed separately within them:

"these spirits or these pieces of my imagination or whatever they are" (Participant 5)

Those who explicated a belief contradicted themselves in the language they used e.g., switching between "I"; "they"; "we"; "these guys" when referring to their voice/s and some gave a tentative opinion on the source of the voices:

"I am more inclined to believe that they…are simply being generated inside my head. But I…I haven't really tried to test that and to explore that" (Participant 3)

Others had mixed experiences, sometimes hearing what they believed was an internal voice and sometimes the voice of others, which may have contributed to their uncertainty. People rationalised the voice must be external because of its abstract nature and complexity. Some participants engaged in active exploration of these ideas during the interview, with some appearing to seek confirmation or disconfirmation of their theories from the researcher:

"I don't think my mind could have created a complexity of this scale…but I also understand that the voices are often coming out of my own mind, my own subconscious, my own thoughts?" (Participant 1)

Participants used analogies to explain their VHE to the researcher e.g., a radio or background chatter. They normalised VH, suggesting that everyone hears voices in their head to some extent, whether it is an internal narrative or self-talk. Participant 4 compared various types of internal voices to highlight this:

"*we all hear the voice in our head that says, oh, you forgot to leave the stove on, or, you know, that voice of criticism.*".

2.) Managing the Voice-Hearing Experience

Control over the voices

The concept of control over VHE was central to participant accounts; they all had a degree of control over the experience which was important in mediating their VHE. The language participants used to talk about the voices demonstrated their deliberate assertion of control e.g., "I choose to"; "I let them"; "I allow it" (Participants 1, 2, 3, 4 & 5), indicating that this was something they consciously practiced in their VHE. Those with more control over the voices had more consistently positive experiences, made a concerted effort to hear the voices and spoke about them with self-assurance:

"*it's on my terms and I can stop them if I want"; "I'm very much in control of the experience. I usually don't…hear voices unless I kind of want to hear them, or tap into that meditative state" (Participant 4)*

"*when I'm depressed or sad, I tend to…not have those experiences…I tend to say, you know, I don't want to talk to anybody right now, and they go away." (Participant 5)*

Others were less confident in their control over the experience. Although Participant 1 and 2 spoke as though they felt in control of their voices, they were reluctant to say this explicitly, as though they might "tempt fate" and they could lose that control, or the VH could return to how it had been in the past, indicating that, despite their positive experiences with the voices, there remained an element of apprehension:

"*I wouldn't make the mistake of saying I'm in control just because it feels like these guys don't like me tempting fate. But…it definitely feels a lot better than what it has been in the past*" (Participant 1)

Participant 1 spoke favourably of their voices and the friendships they had created with them. However, there was apprehension that the voices could disappear, which made them feel helpless, and highlighted that they did not have as much control over the experience as they might like. There was a sense that they could stop them, or exert control over them when they occurred, but they could not instigate them:

"*I can't seem to trigger it if want them to happen…if I needed to make them happen or if they stopped happening…I don't think there's a thing I could do about it and that would be really sad for me*" (Participant 2)

Developing mastery over the voice-hearing experience

Over time participants developed skills, techniques and rules to gain control of the voices and to facilitate a neutral or positive VHE. Some had learned ways to harness their voices in a way that was fulfilling and pleasurable, and make the most of the experience:

"*I did like a six-month Shamanism training workshop. And through that kind of learnt just how to get in touch with [positive voices] I guess, so I sort of see these voices as three separate animals and I can sort of go in and have chats with them*" (Participant 4).

"Anyone can learn Shamanism. All you have to do is to want to…and be open to things happening differently than you expect" (Participant 5)

They explored their VHE and attempted to make sense of the experience in a way that facilitated a positive interpretation of VH, and in doing so felt an affiliation with spiritualism. The practice of Shamanism had enabled them to appreciate their VH in a different way and taught them techniques to implement boundaries which facilitated a more structured VHE:

"[the shaman] told me… that I should always be in control and have good boundaries and be the one in charge" (Participant 4)

Participant 3 was sometimes amused or interested by the content of their voices but was usually disinterested in their VHE. They were content to live with the voices, having learned that if they did not interact with or explore the voices, the voices would not interfere with their daily life. This suggests an avoidant coping technique, and they were the only participant not to have explored their voices or developed a relationship with them, as others had, but they had lived a full life that was not overshadowed by the VHE:

"I know it's better to just let them be and not – not listen to them, which is what I tend to do, which is what I'm doing… it's not something that is a problem for my life. It only would become a problem if I started listening to what they had to say" (Participant 3).

Evolution of the voice-hearing experience

Participants VHE's evolved over time. Some had previously experienced distressing voices, or they had been distressed by their current voices. They spoke of these experiences as consuming and unmanageable, which was distinctly different to how they described their current VH experiences:

"...that was more of an alarming experience…this kind of really negative presence or voice that I found to be quite mean and alarming…I didn't really have any understanding of what was happening" (Participant 4)

A lack of understanding about what was happening contributed to their distress. This was a reoccurring theme in most accounts. Familiarity with voices led to the participant developing confidence, and permitted a choice in how they responded:

"I think once [I knew] there could be nicer ones I could chose to ignore the mean one".

Most participants developed relationships with their voices over time, becoming familiar with the voice's presence, how they sounded, what they might say and when. The skills participants had learned in managing the voices had been crucial in the evolution of the experience. Developing a sense of control over the voices had changed the dynamic of the relationship, and empowered the participants and, facilitating the autonomous experience of VH that had developed over time:

"I am hearing them all the time, but I'm not listening to them; I think that's the difference" (Participant 3).

"I still hear voices every day, all day, but it's on a much more even keel and it's much more sort of respectful" (Participant 2).

3.) Valued Aspects of the Experience

Voices providing support

Some participants relied on the voices for emotional support when required, or a source of strength that they could access when they felt vulnerable. They trusted the voices and acknowledged that the voices knew them well enough to provide good advice and support:

"I can speak to my voices to various friends, to my immediate family" (Participant 1)

"it definitely helps me feel more resilient and able…to face difficulties that inevitably occur in life…I have these guides, or allies" (Participant 4).

Some referred to the voices as though they were long-time friends or siblings, referring to them using playful banter. Others spoke about their voices as parental figures and of themselves as embracing the role of the child, highlighting the protective role of the voices. For others, the voices scaffolded support when they lacked confidence in their skills e.g., giving them reminders or suggestions on how they could complete a task.

"I feel like they are there to protect me in some sense…one or a couple of them will come and check on me" (Participant 2)

"…sometimes it's not what I want to hear, or… it's not always the easy answer; sometimes it's the hard answer and I, yeah, don't necessarily always fully listen to them. But usually it was the better one" (Participant 4)

Voices having a purpose

Most participants referred to the voices having an essential purpose or function that was meaningful, amounting to more than their usual day-to-day interactions with them. For Participant 2 this was related to ideas about religion and theology, encouraging them to develop an academic understanding of religious works, which has provided a context for their VHE's and an overarching meaning to the experience, which comforted them:

"[the VHE] was to bring me closer to these sources [Bible/Koran] and it was to bring me closer to these ideas". Despite never having been religious, they believed that their VHE had been *"a cleansing activity from God".*

Some believed the voices had allowed them to connect with themselves on a deeper emotional and spiritual level emotionally, encouraging an awareness of their subconscious and shaping their identity:

"that's a part of myself that I can connect with that, you know, brings me something that I find important" (Participant 4)

"because of these experiences I'm a really different person. So, even if I never hear another voice again, it's like, well, I heard what I needed to hear" (Participant 5)

Some spoke of the voices encouraging an awareness of their values and helping them take committed action to act in accordance with those values. Participant 1 discussed how their voices influence their ethics, which were central to their career, an important aspect of their identity:

"it's made me a better person, because I have no choice but to be very honest about what's going on in my mind…[it's] a question of keeping me morally conscious".

Voice-hearing as an interesting experience

All participants spoke of being interested in their voices. They were "fascinated" by VH and curious about why they experienced it. Their curiosity was evident as participants actively questioned and challenged their views during the interviews, proposing ideas and considering evidence for them in the moment. Many appeared receptive to new theories or ideas about their VH, and researched new information presented to them by others, illustrating their curiosity in the experience. They associated VH with learning and development:

"I've learned something important and [I'm] grateful for the interaction and fascinated, absolutely fascinated" (Participant 5).

Some participants intellectualised their VHE, talking about the academic enquiry they had engaged in relation to their VH, or had exploring VHE with regard to religious, theological and philosophical literature:

"I find it very interesting… it's just very fun to be someone who really likes psychology in a wacky brain that can still understand a textbook" (Participant 1)

"I have become quite educated, I've seriously studied the Old Testament and the Koran and the Gospels and God and academic commentary on the Bible and the idea of miracles and theology" (Participant 2).

The intellectualising of their experiences may be a coping technique, allowing them to distance themselves from the VHE, perhaps permitting a feeling of safety from an experience that has caused them distress in the past. This also highlights that the attribution of meaning and value to their VHE's, may also support coping.

Participants 3 had not decided on an explanation for their VHE's, which increased their interest: *"I'm still rather baffled by it…I find them fascinating"*, however, despite their interest, they remained reluctant to explore it, maintaining their avoidant coping style. Possibly indicating how tentative their control over the VHE of the voices is, and that the participant may have been more fearfu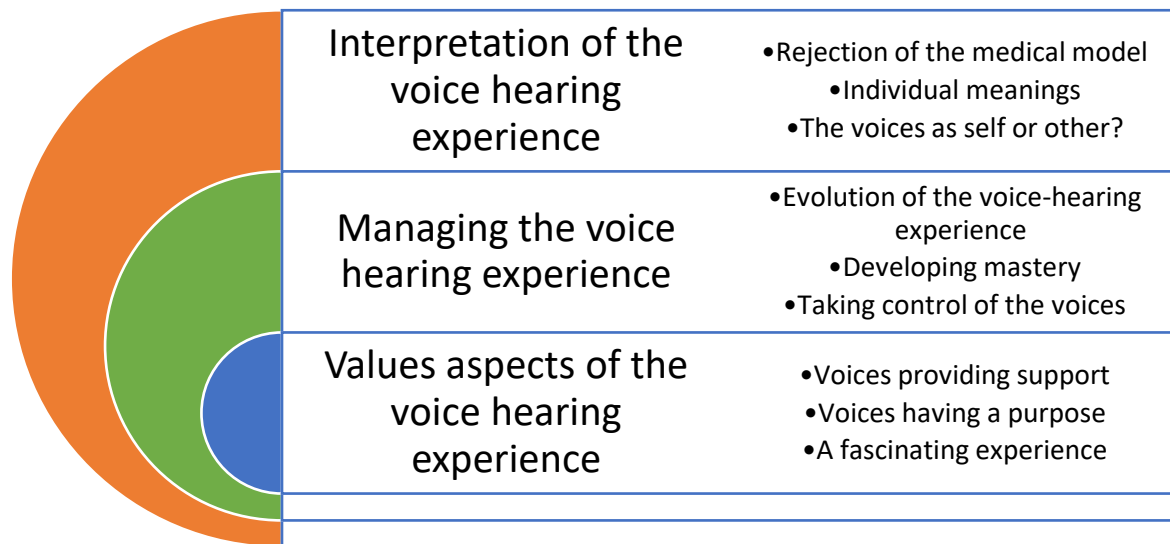l of the voices than they were consciously aware of. Others were eager to know more and continued to explore their experiences:

"I don't completely understand but…I am understanding more and more as time goes on" (Participant 2).

Most reflected on the knowledge and insight they had gained from their voices and VHE's. They spoke about this with gratitude and appeared to feel fortunate to have such experiences, despite the earlier VH-related difficulties some had encountered. For some, the VHE had

changed the way they thought about life and the lessons they had learned underpinned their

life philosophy:

"*there's more to life and death than life and death and if we're open and use a little bit of*

critical thinking, we can have amazing experiences" (P5).

Interpretation of the voice hearing experience	•Rejection of the medical model •Individual meanings •The voices as self or other?
Managing the voice hearing experience	•Evolution of the voice-hearing experience •Developing mastery •Taking control of the voices
Values aspects of the voice hearing experience	•Voices providing support •Voices having a purpose •A fascinating experience

Figure 1: Graphic representation of relationships between themes

Discussion

The aim of this study was to explore the VH experiences of those from the NCS population who did not experience related distress. Analysis of the data generated three superordinate themes: (1) Interpretation of the voice hearing experience; (2) Managing the voice hearing experience; and (3) Valued aspects of the experience. These were explored through nine subordinate themes. Findings indicate that making personally relevant meanings from the VH experience was important, as was learning skills to promote mastery over the voices and feel in control of the experience. The positive aspects of the VH experience were also prominent and illustrated how the VHE may be valued by voice-hearers. The results provide evidence that those who experience distress related to their voice-hearing can be supported to develop coping techniques that facilitate a manageable, neutral and perhaps positive VH experience.

Results contribute to the existing evidence base of research examining potential moderators of distress in those who hear voices. Previous research has highlighted the importance of the voice hearers' perceived degree of control over the voices, and the association of this with the level of voice hearing related distress they experience, suggesting that those with more control over the VE report experiencing less distress than those who lack control over the experience (e.g., Romme & Escher, 2004; Jackson et al., 2011). Anthropological research carried out with shamans in small societies has found that they channel "metaphysical powers", which allow them to maintain control over the VH experience (Laroi et al., 2014). This was reflected in the current findings, where the participants who practiced shamanism applied rules and guidelines to their VH experiences that afforded them control over the voices and facilitated positive VH experiences. The intentionality underlying such experiences appears to be associated with positive experiences VH, as opposed to the passivity associated with the experience in others, suggesting that passivity may be associated

with distress. This provides additional support for the important role of control in mediating VH related distress.

Chin et al (2009) explored how voice-hearers from the CS population related to their voices. They found that people developed strategies in coping with the voices that included setting boundaries about when they would communicate with or listen to the voice; this finding was reflected in the sample of NCS voice-hearers in the current study, where participants discussed setting rules maintaining boundaries, and how these techniques had allowed them to nurture a healthier relationship with their voices and a more manageable experience of VH.

Ambiguity regarding the origin of voices, as reflected in the 'Voice as Self or Other' subtheme, has been identified in previous research. Holt & Tickle (2013) acknowledged the discrepancies between evidence regarding the status of voices, thoughts and inner dialogue: previous research has reported that half of voice hearers describe voices as coming from 'inside the head' and half from 'outside the head' (Hoing et al., 1988, as cited in Holt & Tickle, 2013) and another study found that they identified the voice both as 'other' and as dialogue with the self (Leudar et al., 1997, as cited in Holt & Tickle, 2013). Such discrepancies appear to be linked to the way in which the voice hearer relates to their voices and an uncertainly about the mechanisms underlying the VH experience; despite many of the participants having searched for and settled on an explanation for the voices, this was something of which they remained uncertain. David (1999) suggests that a perceived disparity between the content of the voice and the expected content of the VH's own inner speech may determine their belief about the origin of the voice; this was observed in several participant accounts in the current study, where they were reluctant to believe that their mind could have created such elaborate or intricate experiences.

The positive aspects of voice hearing are increasingly gathering attention in literature. Valavanis et al. (2019) carried out a review of research exploring the positive aspects of voice-hearing and found that the valued elements included support and protection, guidance, personal growth, and increased connection to spiritual belief systems. These findings reflect those of the current study, where participants reflected on the valued aspects of their VH experiences and their appreciation of the support, insight, and development opportunities they had been afforded because of their voice-hearing. These findings highlight the importance of clinicians maintaining remaining objectivise when working with voice-hearers, and not making assumptions about how the person experiences their voices. It also indicates the need for a nuanced approach to models of voice hearing, as experiences are not necessarily dichotomised as positive or negative.

Garety et al (2007) state that there are several risk factors that influence the transition from someone experiencing a 'psychotic-like experience' i.e., VH without associated distress, to clinically significant psychosis. These include: a biopsychosocial vulnerability, the use of a dysfunctional cognitive appraisal or causal attribution and heightened negative affect and arousal. These risk factors are widely acknowledged to be present in voice hearers from the CS population (Andrew et al., 2008) but they are also more likely to be present in the NCS voice hearing population compared to control groups. Although this may be due, in part, to a 'dose-response' relationship, those in the current study had learned to cope with their VHE in a way that minimises the disruption to their lives or enables them to transform the experience into a positive one.

The current results provide support for previous research indicating that some voice-hearers are dissatisfied with the limited therapeutic approaches of MH services to voice hearing, such as medication and the overreliance on the medical model (Coffey & Hewitt, 2008). Participants in the current study rejected the medical model for fear of their VH being

pathologised and because it did not resonate with them and their experiences. Voice hearers'

dissatisfaction with the limited services available to them may be a reason for the rise in

popularity of hearing voices groups: people are meeting the perceived gap in services by

accessing groups where VH experiences are shared, normalised and valued and meaning

making is supported (Corstens et al., 2014).

Strengths and Limitations

The inclusion criteria specified that participants should not currently be experiencing voice-

related distress or have accessed support for their voices within the last two years. Those who

were receiving support from mental health services for reasons other than their VH were not

excluded. This may differ from the inclusion criterion in other studies investigating VH in

NCS populations. However, existing evidence indicates that the voice hearers cannot be

categorised into dichotomous groups; it is likely that many voice-hearers who do not

experience VH-related distress experience other MH difficulties, especially as they are more

likely to present with associated risk factors (e.g., Garety, 2007). This is considered to be a

strength of the study, as selecting only those who conform to a pre-existing definition of what

a voice-hearer looks like, in CS or NCS populations, will impede an understanding of the

complete range of experiences. Additionally, not allowing the participation of people based

on their mental health status, for a presentation or diagnosis which may be unrelated to their

experiences as a voice-hearer, may be considered unethical and exclusionary.

The recruitment method may have led to an inherent bias in the participant sample, not only

towards those who are computer literate and who access social media, but also towards those

who openly identify as a voice hearer, because the social media groups/pages were publicly

visible to any social media user. Respondent validation was considered as a technique to

increase the validity of the data. However, this was decided against because Smith et al.

(2009) challenged the use of the technique in IPA. They argued that that doing so creates a 'triple hermeneutic', whereby the participant is making sense of the researchers sensemaking, who is making sense of the participants experiences.

Although the participants experience of this research was held central to the design and execution, consultation with an NCS voice-hearer as an expert-by-experience at the design and analysis stages would have ensured that the language used was appropriate and respectful, data collection was clear and that the topic was relevant to people from the NCS voice-hearing community (Mawson et al., 2011).

Clinical Implications

The management and reduction of distress is an ethical and professional priority for clinical psychologists, and other healthcare professionals. It is essential in facilitating well-being and managing risk. The results of the current study contribute to a wider evidence base that has implications for guiding clinical practice.

There is a clear need for MH services to expand the way in which they consider voice hearing, and to ensure that staff who work with voice hearers receive training informed by the current evidence base, with a focus on exploration of the voice hearers understanding of their voices and developing coping skills to maintain control over the experience. As evidenced throughout the current paper, research emphasises the VH populations dissatisfaction with the medical model of VH: clinical practice should be informed by the knowledge of experts by experience, from CS and NCS populations, to develop services that meet the needs of those they support. The possible link between a person's voices and their view of themselves, others and the world is a further reason to prioritise exploration of the content and meaning underlying the experience for the person.

This study highlights the importance of skills to manage the experience of VH, and to empower voice hearers by facilitating a sense of control over their voices. The relationship the person has with their voices was a key determinant in the VH experience evolving and improving, and participants in the current study reflected on the role of acceptance of voices in this. This suggests that an approach such as Acceptance and Commitment Therapy (ACT) may be valuable, with the focus on changing the person's relationship with their voices rather than attempting to eliminate the voices, psychological flexibility, and living a values-led life (Thomas et al., 2013). Research has found that ACT significantly reduced distress associated with symptoms of psychosis compared to controls (Gaudiano & Herbert, 2006). Davies et al. (2019) carried out qualitative research looking the effectiveness of ACT in a forensic population; they found that the intervention helped normalise voice hearing experiences and encouraged psychological flexibility in how people responded to them. Given the focus on how a person manages their voices, the approach may be particularly helpful for those who experience enduring distress related to VH. This was investigated by Shawyer et al. (2017) in a randomised control trail investigating the effectiveness of ACT for psychosis for those with a diagnosis of 'medication resistant psychosis'. They found that the ACT group were more satisfied with therapy and reported greater subjective benefit than a comparison group who received a befriending intervention.

It is important that we acknowledge the positive or helpful aspects of VH, as such experiences are valuable to the voice hearer, and in neglecting to do so we are at risk of impeding a move away from the medical model of VH and of diminishing the experience.

Future Research

The results of the current study contribute to existing research to provide a platform for future research and further theoretical developments in the field. Research has highlighted the need

for qualitative investigation into the phenomenon of voice hearing, to understand the range of experiences. Future research should further investigate the underlying mechanisms of control over the VH experience, and how these can be fostered in those who experience voice-related distress. The evolution of participant's VH experiences highlights a need for longitudinal research, monitoring the change in the experience over time and factors associated with it.

Conclusion

This study offers a contribution to the literature about the VH experiences of those from the NCS population, and do not experience associated distress. The results contribute to the evidence base about managing distress in CS populations of voice hearers, who are distressed by the experience. The exploration of personal meanings, development of skills to manage the experience and maintain a feeling of control and acknowledgement of the positive aspects of the voice hearing experience may be significant in managing and reducing voice hearing related distress.

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Participant Information Sheet

The Experience of Voice Hearing in the General Population

Thank you for your interest in this research. Before you decide to take part, it is important that you understand what it is about and what it will involve. This information sheet will provide you with details on what will happen if you decide to participate.

Our research is looking at the experiences of people in the general population who hear voices but are not distressed by them, and do not seek psychiatric support for them. You may view the voices you hear as life enhancing or beneficial. We want to hear about your experiences of voice hearing and what it means to you.

If you do decide to take part, you will be asked to sign a consent form to say that you are happy to be involved. The researcher will contact you to arrange a date and time for your interview that suits you. The interviews will take place over an online video platform and will last for around an hour. An audio recording of the conversation will be made and destroyed after the interview is written up.

You will remain completely anonymous: when writing up the research, your name or any other identifiable details will not be used, so no one will be able to identify you.

The research has been approved by the Cardiff University School of Psychology Ethics Committee. We do not think that participating in this research will cause you any disadvantages or discomfort, and we hope that you will enjoy chatting to our researcher. However, you will be able to change your mind about participating if you wanted to.

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Participant Consent Form

Study: The experience of voice hearing in the non-care-seeking population

Researchers: Hannah John-Evans & Dr Heledd Lewis

If you consent to participating in the above study, please read each statement below; if you agree with the statements, please initial each box and sign in the space provided at the bottom of the sheet.

1. I have read and understood the participant information sheet (Version 3). I have had the opportunity to consider the information provided, ask the researcher questions, and have received a satisfactory answer to any questions.

2. I understand that my participation in this study is entirely voluntary and that can withdraw my participation at any time, without giving reason. If I choose to withdraw from the study, there will be no adverse consequences.

3. I understand that my participation is anonymous, and my responses will be transcribed without any identifiable information.

4. I understand that my discussion with the researcher will be recorded and that once transcribed, this recording will be destroyed.

5. I understand that quotes from my discussion with the researcher may be used in the write up of the study but that they will be anonymous.

6. I agree to take part in the above study

_____   _____
_____

Name of Participant   Date   Signature

_____   _____
_____

Name of Researcher   Date   Signature

Appendix 3: Recruitment Poster

Research participants needed: voice hearing in the general population

Hearing voices is something that lots of people experience. The experience is different for everyone – some people find it distressing, but others do not, and may even find it life-enhancing or beneficial.

We would like to speak to people who are not distressed by the voices they hear. We would like to hear about your experience of voice hearing.

You will chat with our researcher over the internet for around an hour. You will receive a £10 Amazon voucher as a thank you for your time and participation.

If you are 18 and over and have experienced repeated voice hearing that you are not distressed by, then you are invited to take part. If you would like to know more, please email us at:

John-EvansH1@cardiff.ac.uk

Or find us on Twitter **@voices_research**

Thank you for your interest.

CARDIFF UNIVERSITY
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Hannah John-Evans
Trainee Clinical Psychologist

Dr Heledd Lewis
Consultant Clinical Psychologist/Senior Clinical Tutor

Appendix 4: Semi-Structured Interview Schedule

1.) Can you tell me about the voices that you hear?

- What are the voices like?
- Can you tell me about a recent time when you heard the voices?
- What were you doing?
- What did they say/do?
- Talk me through it, if you can, step by step.

2.) Tell me about how and when it started?

- Can you remember the day they started?
- What were you doing?
- What was going on in your life?
- What was your reaction?
- What sense did you make of them at this time?
- Why do you think you began to experience the voices at that time in your life?

3.) What is your understanding of them? What sense do you make of them since?

- Do you discuss your experience of VH with other people?
- Do you interact with the voice?
- What does VH mean to you?

4.) How do you feel about the voices?

- How do you feel after hearing the voice/s?
- How would you feel if you stopped hearing the voices?
- What impact do they have on your life
- How have the experiences affected you as a person?

PROMPTS

Why?
How?
Can you tell me more about that?
Tell me what you were thinking…
How did you feel?

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