An exploration into the factors that facilitate or hinder recovery from voice hearing

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Abstract

Background: Hearing voices is usually defined as an auditory hallucination with no originating external stimuli. Recovery from psychosis has traditionally been conceptualised as a biomedical disorder which is managed via symptom reduction. It is believed to be an organic disease which causes significant disruption and has a severe impact on the individual's life. In this study, we explore the idea that recovery from hearing voices is both possible and achievable and examine the idea that recovery from hearing voices is associated with psychosocial factors that mean that recovery, and/or living alongside voice hearing, is conceivable.

Methods: This study used Interpretative Phenomenological Analysis to interview seven voice hearers on their experience of voice hearing and examined what factors contributed or hindered voice hearing recovery.

Results: Five superordinate themes were found these were: (1) Voice hearing described as distressing and related to negative life events; (2) Religion and spirituality as both healer and iniquitous force; (3) Parenthood and a lack of agency vs. being parented; (4) Helpful vs. unhelpful systems; (5) Recovery linked to self-actualisation and wellbeing

Conclusion: Recovery from psychosis appears to be associated with various social and psychological factors that either hinder or contribute to the process of recovery.

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I dedicate this thesis to Uncle Patrick: May you Rest in Peace.

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1. Introduction

Chapter overview

This chapter aims to outline my personal and lived experience of this topic by providing a reflexive account of my research journey. It will then go onto to outline the literature base on hearing voices and the concept of recovery. Finally, I identify the research rationale making the claim that recovery from voice hearing is both possible and achievable.

1.1 Personal reflection

My research journey into those with ongoing voice hearing has been inspired by a deeply personal experience, which then facilitated my academic curiosity. As a voice hearer and survivor of ‘schizophrenia,’ I wanted to understand if there were ways that others had managed to live alongside their experiences, while still forging meaningful and fulfilling lives.

Delving into the literature revealed the prevalence of first episode psychosis, particularly on young people, and how much of the research focused on recovery for those individuals. However, the experience of living with voice hearing tends to go beyond a first episode, with many living alongside the condition for years, usually with minimal mental health support. I wanted to go beyond just highlighting the challenges and struggles; I wanted to illuminate the inspiring individuals I had met and read about, who had managed to move forward, grow and self-actualise either despite, or because of, their voice hearing experience. This for me felt like contributing to a change in the existing rhetoric of voice hearing being a death sentence.

My journey into accessing participants was a long and protracted one. As an NHS employee, I was inspired and encouraged to go through NHS systems and processes to access patients who had a diagnosis of schizophrenia and were accessing secondary mental health services. At first, this felt like the ‘right’ thing to do. It aligned with my university and personal ambitions. However, the deeper I went into the process of the IRAS application system, the more I realised that the process did not actually align with my own personal stance and counselling psychology ethos. I wanted to form an alliance with participants that was not hampered by bureaucracy and risk averse practices. The process of application became front and centre of the project; there was a risk of losing the essence of the project to medicalised and administrative ways. My aim had always been to work within an epistemology that put the participants front and centre of the research. In that way, I believed the voices of participants would reach the intended audience with more authenticity and clarity. For example, I am unsure if some of the critical feedback provided by participants in the study, in reference to mental health and NHS systems, would have occurred with such honesty if they had been made aware of my close affiliation with the NHS, while simultaneously being interviewed within an NHS setting.

Hence, my values and need to put clients at the forefront of the research became an ever-increasing internal pressure. Shortly after this reflection I found out that I had not received approval from IRAS, with some of the feedback being that I had no experience of the topic under investigation and oupled with the fact that much of the feedback centred on administrative issues; became the reason why halfway through the NHS research application I abandoned it. This felt freeing on many different levels; I now had agency to decide on who to approach, and how. Having worked at grass roots levels with several different organisations dedicated to helping those with various challenges, I was aware of the hearing voices network and its underpinning philosophy of engaging with the voice hearing experience that included normalisation, peer-support, and compassion. My plan was to contact various local groups and ascertain interest. At first, interest was slow, and it took several attempts before I was able to have the opportunity to speak with group members. However, my efforts paid off and feedback from one group leader said that my personalised email and follow-up phone call, which briefly drew upon my own personal experience as a voice hearer, made the difference between being considered just another detached NHS researcher, to someone that was keen to engage with clients in an authentic way.

I knew at the inception of the project that I would be using IPA. I considered other approaches, such as TA and discourse analysis, but I concluded that none brought voice to the participant in the way that IPA could. IPA is a double hermeneutic, hence, it’s about the participant trying to make sense of their social and personal world, while the researcher is trying to make sense of the participant making sense of their social and personal world. Making sense of the sense-making, was an interesting journey because complex shifts occurred throughout the life of the project in relation to the roles I was having to inhabit. For instance, during the analysis process, feedback from my supervisor would often require me to bracket and suspend judgement to facilitate the purity and authenticity of accounts, as opposed to bringing a prior knowledge to the process.

In addition, Levitt (2017) argues that qualitative research should bring about a sense of fidelity to the phenomena under investigation, and maintain allegiance to participants, the method selected, and data analysis. Reflecting on this, I believe I made attempts to stay faithful to participant accounts and of data collection. However, this was not a straightforward process and included several iterative back and forth processes to make claims as to the veracity of the data being grounded in the actual data captured. I found that some of the time, I was making interpretive claims outside of the actual ontological experience of participants and so would often re-read and revisit transcripts in order to represent a faithful account of participants' interviews. Hence, an idiographic approach was necessary to capture participants' subjectivity, which was then explored dynamically and individually. I therefore believe that the data produced is a faithful account of participants' voice hearing experience.

The terms and language used in the study were also something I had considered. Language is a currency we all live by, and it can have powerful connotations and consequences. The language in this study evolved, and my own reflections and the feedback received from university staff included encouragement away from a medicalised understanding of psychosis to one that tended to embody lived experience. This was difficult to achieve because much of the language used in peer review journals uses medicalised language. For example, the terms "schizophrenia" and "psychosis" are readily used in peer reviewed journals and in the DSM-5.

I found the term 'schizophrenia', a term coined by Eugen Bleuler which stems from the Greek word shcizo (split) and phren (mind), problematic. Many people today think of the phrase as meaning 'split personality'. This is a misunderstanding of the condition and only serves to perpetuate unhelpful and out-of-date thinking. Hence, I settled largely for the term ‘psychosis’ or ‘the hearing voice experience’, preferring the latter. The term ‘hearing voices’ or ‘an individual who hears voices’, is more akin to IPA’s idiographic and very important, rich, and descriptive approach to language. This is perhaps still unsatisfactory in many ways as this ‘new’ way of thinking about the condition at times felt clumsy and conscious. I was also not consistent in my efforts to co-create language with the interviewee, and I would oscillate between the old terms, asking, not asking, and co-creating language, or not. This for me demonstrates how far we must go in terms of reconceptualising the thinking around those who hear voices.

In my role as survivor as a voice hearer, and the benefits that education, employment and living in the UK bring, I reflect on these demographics and wonder if my choice to choose to focus on growth and recovery after, or alongside, voice hearing was actually a reflection of where I was personally situated in life. Did my ‘positives’ in fact blind me to the very real struggles that those who hear voices experience and are we yet ready to talk about voice hearing from the construct of positive psychology, when so many are currently struggling just to get through the day? From this standpoint, I felt my position as researcher somewhat placed me as an ‘outsider’ to those I was interviewing. I had happened to ‘recover’ and was, in that respect, not struggling with acute voice hearing like some of the participants. Therefore, did my intersectionality of educated woman and trainee psychologist become more of a barrier to the people I interviewed as opposed to putting us ‘on the same page’. This privilege may have fed into the participants’ sense that they were not quite understood and were apart and different from me. This, for me, shows the diversity in those who hear voices - we are unique, and no two individuals will be the same. Constructs of oppression, privilege and advantage come in many forms and can either serve to bring together or alienate.

Even with this difference, I acknowledge that the choice to interview Hearing Voices Network (HVN) participants was a powerful one; there was a positionality both physically and literally in the research process. Meeting participants on their own terms, in their own environments and in their own worlds of the HVN, meant power was handed back. I believe this sense of physicality helped participants to ‘open up’. Thought was also given to the presence that a researcher would have on their wellbeing, and I strived to be as non-intrusive as possible, whilst still trying to bridge the gap of our difference. This included self-disclosure on research forms that I too was a voice hearer, and hence someone experiencing the struggle. I do believe this physical positionality of literally entering their social world and literal self-disclosure allowed for data that was rich, co-created and grounded.

Looking back, I do not believe that I held very conscious assumptions about what I would encounter with those who heard voices. I hoped for a level of diversity in experience, which is what I received, and I hoped for discussions surrounding the challenges and potential benefits that being a voice hearer had. In terms of the trauma experienced by participants, my assumptions were that they would again be diverse. However, I did not anticipate the amount of growth seen. Even for those who were clearly still struggling, growth and recovery was evident. Trauma can be considered a subjective phenomenon, but I was not prepared for the levels of trauma discussed (from sexual abuse, loss and drug abuse). This may have been a naïve assumption on my part, but more importantly, reflects and supports not only the resilience of participants, but provides meaningful contributions to the wider and more modern way of thinking of those who hear voices which are based in the traumatic suffering of the human experience, with the voice hearing experience being a manifestation of that suffering.

If anything, I held an overly optimistic view of the voice hearer, likely influenced by own ‘happy place’. This, however, reinforced my preconceived ideas that voice hearers can, and do, grow from their struggles and via relational humanity can not only survive, but flourish from their experience.

Adding to the literature base on those who hear voices was first and foremost borne out of personal reflexivity and subjectivity. Being a researcher of the hearing voices movement and, at one time, a participant, it felt apt to research a movement that had played a fundamental role in my own recovery journey. I wanted to add to the debate surrounding the medicalisation of hearing voices and add my voice to the growing number of activists (Dillion, 2013; Longdean et al., 2012; Romme and Escher, 1989; 2000; Cooke, 2020; and Johnstone et al., 2018) who understand that a medicalised explanation, and its subsequent treatment, is too dominant in the field of psychiatry and psychology, and at times a real blockade to engagement with what is primarily a psychological and human reaction to negative life events. Therefore, using my voice to redress the balance will hopefully add and strengthen the existing literature base which argues for voice hearing to be considered a deeply normative, challenging, and understandable reaction to human suffering.

1.2 Literature Review

This literature review looks to explore the lived experience of those who hear voices. It will make the case that current diagnostic and medical frameworks are problematic when it comes to the management and treatment of psychosis and considers whether a different approach is needed. The latter half of this review focuses on recovery from psychosis and the factors that facilitate such a process. It ends with an outline of the hearing voices network and how this organisation has been instrumental to the lives of many voice hearers.

1.3 A definition of voice hearing and its prevalence

The experience of auditory hallucinations is often defined as a person hearing a voice in the absence of external stimuli (Farrugia & Greech, 2023). Voice hearing according to the dominant discourse is related to schizophrenia and other psychotic disorders (Valavanis, Thompson & Murrary, 2010). The experience of voice hearing can vary from person to person. It is a relatively common human experience (Johns & Van Os, 2001). Voices can vary in frequency, tone, intent, and content and can appear figuratively or literally (Romme et al., 2013). Additionally, it is arguably not the presence of the voices that causes the most distress, but how the voice hearer responds to the voices that decides emotional and behavioural reactions (Chadwick & Birchwood, 1994). It has been shown that the content and beliefs about voices has been related to an individual's life history (Romme & Escher, 1989, 1993; Bentall, 1990; Chadwick & Birchwood, 1994). Around 4 to 8% of the population hear voices (Romme & Morris, 2013) and that in the general population this is between 4-5% (Tien, 1991). A study by Van Os, Hanssen, Bijl, and Ravelli (2000) revealed that positive psychotic symptoms were also reported by around 18% of the general population, indicating that there may be voice hearers who may never have been psychiatrically diagnosed.

1.4 Overview of diagnosis of psychosis, challenges, and issues

Biological explanations of a person's mental health have tended to take a reductionist view, with diagnostic labelling and medication taking centre stage in the treatment of mental health disorders (Johnstone et al., 2018 & Cooke, 2017). Such a perspective of schizophrenia states that there is too much hyperactivity of the D2 neurotransmitter dopamine in the brain, which allows for an overload of stimuli, hence the positive symptoms (such as voice hearing) that are seen. This explanation has received widespread acceptance from both the public and mental health professionals but may perhaps fail to consider the very often traumatic life events that someone with such a condition has experienced (Campodonico, Varese & Berry, 2022; Devries, Busschbach, Stouwe, Laroi et al., 2019; Jansen, Pedersen, Trauelsen et al., 2016; Sampson & Reed, 2017). The dopamine hyperactivity process which is thought to be responsible for the result of hallucinations, delusions, and confused thinking, is biologically deterministic. Not everyone with an excessive amount of dopamine in the brain will go on to develop schizophrenia. Furthermore, one third of patients did not respond to anti-psychotic medication that purportedly blocked the dopamine receptor sites (Noll, 2009;

Lau & Wang et al., 2013; Kendler & Schaffner, 2011). This suggests that either other neurochemicals maybe at play, or that the development of schizophrenia is perhaps not a simple biological explanation, but a complex interplay of biological-psychological and sociological factors (Collins, 2010). Evidence for the efficacy of medication is low, with most voice hearers reporting sedation, weight gain and other adverse side-effects (Ascher-Svanum et al., 2010). Medications have also been shown to reduce emotionality to both the voices and in the general sense (Cortens et al., 2014).

It is argued that it is perhaps time for a more nuanced understanding of mental health other than what psychiatry currently offers (Rapley, Moncrieff & Dillion, 2011). Many have argued that human suffering has been de-contextualised and pathologised into mental health disorders, with the people behind the disorders often overlooked (Boyle, 2014; Szasz, 1960). The British Psychological Society and the Division of Clinical Psychology (2013) have argued that the “DSM and ICD 10…. have significant conceptual and empirical limitations… there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a disease model” (DCP, 2013, p.1). This profound statement may go some way to questioning the diagnostic tools used to medicalise mental health. It makes room for the consideration that mental ill health may not be pathological in nature and that something other than medical diagnosis may be needed. However, it is argued that this statement does not go far enough. It stops short of making the case that the abnormality of symptoms does not belong in the intrapsychic world of the patient but with society's fundamental inequalities faced by so many (Cooke, 2017; Johnstone 2018; Romme, 2013; May and Longdean; 2011 & Longdean, et al., 2012).

This literature review puts forth the argument that the DSM-V's criteria for schizophrenia is highly problematic. According to the manual, schizophrenia such as hallucinations and delusions only need be present for a period of one month or less before diagnosis is given. This definition overlooks the situational and relational factors that contribute to the development of the disorder and uses arbitrary assumptions of time, symptoms, and further criteria to denote what is an arbitrary label (Patel & Rapely, 2011). It fails to honour the uniqueness, subjectivity, and reflexivity of those in the struggle and does not function to offer a dialectical explanation of this highly complex and distressing experience (Watson, 2019; Boyle & Johnstone, 2014; Dillion & Hortsein, 2013; Craddock & Mynors-Wallis, 2014; Sweeny, Filson, Kennedy et al., 2018).

Additionally, and interestingly, Johnstone (2018) states that much of the hallmark criteria for the diagnosis of schizophrenia is not a biological one but is based on cultural context. For example, the DSM-V requires the diagnostician to reflect on the presence of unusual or odd beliefs. Johnstone (2018) asserts that psychiatric diagnosis is based on cultural standards, about what is considered mental health problems, as opposed to any biological test. The argument that psychiatry bases its defining criteria on cultural standards and not biological ones becomes problematic, considering the prominent biological explanation psychiatry makes in relation to schizophrenia.

Other studies have found that cultural context can influence voice hearing (Luhrman, Padmavati, Tharoor et al., 2015). Via implicit and explicit biases, culture can give significant meaning to voice hearing. In other words, Lurham et al., (2015) demonstrated in their study that those in the USA, (where mental illness is largely feared and often misunderstood), participants in the study described hating their voices and described themselves as crazy, compared to West African participants who saw aspects of their voice hearing as moral, good, playful, and spiritual. Similar research has been highlighted by others (Sinha & Ranganathan, 2020; Davar, 2008; Kalathil, 2008; Larøi, Luhrmann, Bell et al., 2014) which suggest that not only do different individuals, based on different cultural contexts, react differently to their voice hearing, but hallucinations can be culturally meaningful (Laroi, et al., 2014). It is therefore argued that voice hearing is culturally dependent and significantly undermines the medical establishment's view that voice hearing is solely an organic disease.

This review recognises the inherent power imbalance within the system alongside the need to provide a wider reflective and open space for those who do not adhere to the medical model's assumptive world view. The idea that hearing voices has a special medical basis, which sets it apart from other mental disorders, functions to other and stigmatise those labelled as mentally unwell (Manzo, 2004; Carel & Kidd, 2014; Moodley & Ocampo, 2014). Uncommon behaviour or behaviour that deviates from sociocultural norms and expectations of a specific society have been used to silence or control certain individuals or groups throughout history (Fernando, 2010; Walker 2005; & Markowitz, 2011). The medical model and its associated vocabulary can be thought of as the foot soldier in which social control is enacted (Arrigo

& Williams, 1999). Via its positivistic and ‘scientific’ adherence, it forms a type of binary sense-making that functions to mark those who have good mental health and those who do not (Adams, Dobles, & De Gracia et al., 2015; Johnson & Boyle et al., 2018; Parker and Shotter, 1990). This arguably strong standpoint is echoed throughout the upper echelons of psychological thought and practice:

> clients and the general public are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences . . . but which do not reflect illnesses so much as normal individual variation . . . This misses the relational context of problems and the undeniable social causation of many such problems. (Cooke and Kinderman, BPS, 2018, p.50)

1.5 Trauma and Psychosis

Trauma and psychosis are closely tied phenomena and there is extensive evidence in the research to suggest that the development of psychosis is a reaction to negative life events (Whitfield et al., 2005; Hardy et al., 2005; Jessop et al., 2008; Anketell et al., 2010; Shevlin et al., 2010; Longden et al., 2012; Corstens & Longden., 2014; Schnackenberg et al., 2018). This has been particularly noted during childhood (Janssen et al., 2004; Shevlin et al., 2010; Bentall et al., 2012; Sheffield et al., 2013; Solesvik et al., 2016; Rosen et al., 2018). Similarly, physical and emotional abuse was found to be a precipitating factor to psychosis. Holowka et al., (2003) found that 35% of adult schizophrenics had suffered abuse as children; 42% physical neglect, and 73% emotional neglect. Poor parenting skills at age 4, and harshness towards the child at this age, saw the child at age 26 more likely than others to have been diagnosed with schizophrenia (Jones et al, 1994). Birchwood et al (2000) describe how difficult life events can negatively affect the way voice hearing is experienced. Those who have suffered with early challenges are more likely to feel less in control of their voices and feel subordinate to them. Trauma has long been associated with the experience of voice hearing (Mueser et al. 1998; Frame & Morrison, 2001; Neria et al. 2002; Bebbington et al., 2004). However, there are those who hear voices with no history of trauma. In their study, Farrugia and Greech (2023) found that in both psychiatric and non-psychiatric voice hearers there was a high prevalence of trauma. Persistent Post Traumatic Stress Disorder (PTSD) symptoms was seen in the psychiatric group; this group reported higher incidence of childhood sexual abuse and were more likely to receive command hallucinations suggesting they should harm or kill themselves. Furthermore, those without mental health challenges were more likely to view their voices as harmless, pleasant, and manageable, while those with a mental health background, saw their voices as malevolent. However, they argue a cause-and-effect relationship between voice hearing and mental illness is not yet evidenced, and that researchers need to be cautious in making assumptions that those who experience voice hearing are mentally ill, as a proportion are not. The researchers suggest that beliefs about voices are partially understood in the context of traumatic life events. That is, those with trauma histories are more likely to have negative beliefs about their voices compared to those with no such history.

Recent findings of the trauma of being psychotic have revealed the by-product of trauma that comes about from having psychosis. Growing evidence supports the development of PTSD related psychosis following involuntary hospitalisation (Berry, Ford, Jellicoe-Jones and Haddock, 2013). Those who had been detained in hospital because of their illness showed higher prevalence of PTSD (Berry et al., 2013). Those who had experienced admission for either the first or subsequent time, and had been subjected to coercive measures in hospital, were more likely to experience hospital related PTSD symptoms (Meyer et al., 1999, as cited in Berry et al., 2013). The effect of experiencing a psychotic illness is compounded by the victimisation, detainment, and sometimes legal enforcement of having to take medication as belonging to the experience of the person with psychosis when detained (Mueser, Rosenberg and Wolfe, 2010). These findings also corroborate the argument that PTSD symptoms are a common consequence of psychotic symptoms, and that negative treatment experiences and PTSD are even more pronounced in those with multiple episodes of psychosis and multiple treatment admissions (Lu, Musser, Shami et al., 2010). Studies found distress associated with, threats of physical harm (including sexual assault) and experience of actual harm committed by both service users and staff alike (Centofanti et al., 2005; Cusack et al., 2003; Frueh et al., 2005;

Lu et al., 2011; Mueser et al., 2010) lead to the traumatic experiences of those with psychosis while detained.

The trauma of psychosis, it is argued, can be so harrowing that it can lead to the annihilation of the very individual, in terms of life and wellbeing (Larkin & Morrison, 2007). Evidence suggests that suicidal behaviour is highly prevalent in those with psychosis. Those that thought about, and attempted, suicide were forty-eight times more likely to experience psychosis compared to the general population (Murphy et al., 2018). The authors go on to state that while they do not recognise suicidal behaviour as a symptom of psychosis, they nevertheless see psychosis “as a response to one of the most intolerable threats that an individual can experience” (Murphy et al., 2018, p.295).

An overhaul of the system is needed in which clients can be permitted to make sense and heal from their experiences, within a relationally bound context, without having to face the harrowing journey, that many face, when entering the mental health system (Marsh, et al., 2022).

1.6 Post-Traumatic Growth, Psychosis and Recovery

While it is argued that psychosis is a highly traumatic experience, with some qualitative studies finding that psychosis is often associated with terror, helplessness, abuse, and suicidality (Shevlin, Martin, Dorahy & Adamson, 2007), it also has the potential for rich growth. Post-traumatic growth (PTG) according to Tedeschi and Callhoun (2004) suggests that out of a crisis, transformative development can be obtained in various areas of life. These areas include an increased appreciation of life, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities and a richer existential and spiritual life. Much of the research on psychosis and growth, focus on first episode psychosis in adolescents. This important literature base suggests that after a first episode of psychosis, some individuals had an improved sense of confidence (Nilesen, Frich & Friis, et al., 2016; Dunkley & Bates, 2015), were happier (Subandi et al., 2015), and were better able to handle stress and negative emotions (Ashcroft, et al., 2012; O'Toole, O'hlsen, & Taylor, et al., 2004). Furthermore, stronger connections within the community were seen (Subandi et al., 2015) and having one's negative beliefs challenged about mental illness by others was seen as influencing the production of post-traumatic growth. Self-disclosure of psychosis was also seen as facilitating post-traumatic growth (Pietruch & Jobson, 2012). Ng et al., (2021) study goes some way to support the point that psychosis can be a developmentally rich experience. The study conducted a systematic and narrative review of post-traumatic growth with people with ongoing psychosis that looked beyond a first episode. They found seven facilitators of PTG in psychosis which included personal strength and identity, receiving support, opportunities and possibilities, strategies for coping, perspective shift, emotional experience, and relationship improvement. They conclude that individuals with psychosis can, and do, grow from traumatic experiences and that trauma-informed care could go some way to supporting valued identities. They conclude "research shows that people with psychosis also report positive changes. Such changes include self-discovery, developing a sese of self, a greater appreciation of life, improved wellbeing and relationships, and spiritual engagement" (Ng et al., 2021, p.2).

However, when it comes to those who have had multi-episodes of psychosis and PTG, it is not yet clear why it has remained under-researched. Ng et al., (2021) outlines the following:

> The state of knowledge on PTG among persons reporting multiple episodes of psychosis… remains unclear… this substantial knowledge gap precludes an understanding of how to develop interventions to support PTG in these contexts. There is thus a need to synthesise knowledge on what facilitates/predicts PTG following psychosis across a broad range of contexts beyond the first episode. (Ng et al., 2021, p.4)

One theory could be that the perception of services, and hence research organisations, see those who have experienced multi-episodes as difficult to treat, access, and study. They do not fit into an orderly way of being. Their experiences are not linear or discreet and remain outside of our dualistic medical system (Mazor, 2019). However, a study by Mazor et al., (2020) appears to add to this limited arena. The researchers recruited 121 participants who had experience of hospitalisation due to psychosis and were seen at the time within community mental health services, suggesting a prolonged association with the disorder that went beyond a first experience. Results are in line with Tedeschi and Calhoun's (2018) findings that cognitive re-examination of one's core beliefs and the formulation of adaptive ones are fundamental to the development of PTG. However, they argue that this is contingent upon lower levels of distress being experienced. Higher levels of distress may hinder the person’s ability to cognitively reappraise their experience if the stress is disproportionate. Even though psychosis is considered highly traumatic with negative consequences in terms of functioning and daily life, “research shows that people with psychosis also report positive changes. Such changes include self-discovery, developing a sese of self, a greater appreciation of life, improved wellbeing and relationships, and spiritual engagement” (Ng et al., 2021, p.2). Hence, it is argued that tangible benefits for those who have experienced both a first episode and those with ongoing psychosis, have been shown to not only recover, but grow from such experiences which has important implications for the voice hearing community’s treatment trajectory.

1.7 The Delphi Method

Within some of the recovery literature, the Delphi technique has been used to obtain conceptualisations of what researchers, experts, and patients alike mean when they refer to recovery from psychosis. The Delphi method, developed in the 1960s, is based on giving a panel of experts questionnaires to ascertain their opinions on a particular issue. In each round, the panel of experts see the responses of theirs and others earlier answers, allowing them an opportunity to revise their answers should they seek to. In this way, a broad consensus can be reached in which experts are largely in agreement. It can be considered a useful research tool in which guidelines can be developed and policy implemented (Barrett and Heale, 2020). The current literature review has found that the Delphi model has been a popular mode of methodology when discussing and conceptualising recovery from hearing voices. The Delphi model has demonstrated in several areas of the literature that rebuilding life, rebuilding the self, and having hope, along with having an acceptable quality of life and the enhancement of self-esteem, were all considered factors crucial to recovery (Law and Morrison, 2014). The study outlined that less focus should be placed on reduction of symptoms, relapse, and hospital admissions, and greater emphasis on hope, improving quality of life, and help in the facilitation of personal goals. Furthermore, being non-judgemental, having the skill, motivation, and ability to recognise early warning signs as a mental health professional, encouraging the person to seek professional and timely help, and being clear that the professional was there for support, were all considered and agreed upon as being important in delivering first aid recovery from psychosis. In addition, being given effective treatment and help for stress, paranoia, and anxiety, being informed of the differing help available that would aid recovery, and the desire to see an improvement in emotional wellbeing were considered desirable in recovery from psychosis (Langlands et al., 2008). This study has important clinical implications as it suggests that reaching a consensus on what helps recovery can be used to help guide those working with patients who hear voices and perhaps play a pivotal role in policy service, delivery, and development.

1.8 Alternatives to the medical model of voice hearing

The power threat meaning framework was developed by Johnstone (Johnstone and Boyle, 2018), along with individuals with lived experience. It offers an alternative to the medical model of voice hearing, by considering the role of power, in all its forms, (interpersonal, economic, social etc) and how power and its misuse contributes to the experience of social adversities. Hence, voice hearing, within this model is not solely considered an organic disease, but a reaction to environmental, social and psychological challenges. The goal of this is approach is to help the voice hearer create more meaningful narratives of their experiences, a type of sense of making that moves away from seeing the person has mentally ill to someone who has survived. For instance, therapeutic questions may focus on asking individuals: "what has happened to you?" "What is your story?" "How did you manage to survive?" "What strengthens did you draw upon during your experience?" The framework is not designed to replace all other forms of therapeutic approaches to voice hearing, but instead, builds on existing good practice by promoting this as a complimentary meta-framework that can be used flexibly.

In addition, Romme and Escher's (2000) seminal work on voice hearing offers a theoretical and practical understanding of the phases of recovery. This model moves away from a medicalised explanation, and suggests phases of recovery as often being subjective, emotional, unique and personal. These phases of recovery are psychological in nature and can reveal and provide insight for the clinician about what someone goes through as they try and regain control of their lives:

The Crisis or startling Phase: This is the phase in which the individual is first experiencing symptoms of psychosis. It's marked by confusion, fear, and a sense of losing control. The individual may be overwhelmed by hallucinations, delusions, or disorganized thinking. The person may struggle to make sense of what is happening to them, often leading to a sense of isolation and intense emotional distress.

The organisation Phase: After the initial crisis, the individual begins to try to understand their experiences. They may reflect on why the experience happened and show motivation in wanting to be free of the anxiety that voice hearing brings. Additionally, some form of acceptance maybe taking place and the individual maybe trying to find new ways to cope with their experiences. During the organisation phase the individual may try and dialogue with their voices and set boundaries on what they will and will not tolerate from their voices.

Stabilisation Phase: During this phase the individual has learnt to accept the voices as part of them. The result being a more balanced and peaceful relationship with their voices. During the stabilisation phase, the individual learns to cope with their voices and demonstrates autonomy in choosing either to listen to their voices, or not. A move away from seeing oneself as defective or mentally ill is witnessed in this phase.

Romme and Escher's work remains a seminal part of recovery from voice hearing. They offer a real alternative to medical diagnosis by highlighting the psychological factors that contribute to recovery from voice hearing. These included concrete psychological factors that add to the understanding of voice hearing.

Recent work on alternative understandings of voice hearing comes from third wave psychological movements such as Compassion Focused therapy, Dialectical Behaviour Therapy and mindfulnes. During such work, individuals are encouraged to shift away from a threat-based lens that sees the voice as dominant and overwhelming, to cultivating compassion for the voice using a non-judgmental lens which encourages a sense of safety via a bio-psycho-social framework. In other words, individuals are invited to consider how they wish to relate to themselves, others and their voices, from a more compassionate stance, which draws on eastern philosophies of inner wisdom, and kindness to self and others (Heriot-Maitland, McCarthy-Jones, Longdean and Gilbert, 2019). Such an approach is likely to stimulate a sense of safety and peace, both biologically and psychologically. Hence, a compassion focused lens may use dialoguing with voices as a method to better understand the voices, and seek to relate to them in normalised and helpful ways, which can reduce the chances of a threat-based perspective taking hold. Psychological models offer a real alternative to understanding voice hearing, its impact and how it can assist recovery focused endeavours. Such models move away from labels such as “mental illness” and “symptoms”, to thinking about voice hearing in a holistic way. Which tends to be person centred and focuses on empowerment, meaning making, and a survivor identity.

Hence, the remainder of this literature review will be focused on the factors that facilitate recovery and how recovery from voice hearing is possible through psychological connectedness and growth.

1.9 Factors that facilitate recovery from psychosis

The definition of recovery has long been debated with many differing conceptualisations and ideas about what it means to recover from psychosis. Within the medical domain of psychosis, recovery has traditionally been seen as a reduction and alleviation in symptoms and usually comprising of medication adherence with little to no side effects or relapses (Piling and Bebbington et al., 2002). This definition has been widely accepted among mental health professionals with many randomised control trials looking to this definition when deciding upon therapeutic efficacy (Silverstein and Bellack, 2008). This is perhaps problematic as others in the field not tied to a biomedical conceptualisation see recovery as a psychological process that rebuilds hope, optimism and a self-identity rooted in resilience and individualised coping strategies (Emrich et al., 2021). It is argued that such a conceptualisation of recovery is harder to encapsulate. It is more nuanced and complex, and does not align with a binary presence, or absence way of thinking about recovery and is possibly the reason there is no agreement on its terms of reference.

The landmark text in the field of recovery and hearing voices by Romme, Escher, Dillon, Corstens, and Morris, (2009) known as *Living with voices: Fifty stories of recovery*, is the largest collection of qualitative recovery narratives of people who hear voices to date. It focuses on what recovery means and addresses in the introduction how services can play a role in helping the recovery trajectory. The narratives in the text outline the clear relationship between trauma, emotional neglect, and hearing voices. However, it goes beyond this, and cites those who have managed to take ownership and responsibility for their life and voices, which has not only led to heightened self-esteem but also a changed relationship with the voices themselves. The stories suggest that recovery includes providing the experience of hope, which meant for many, having a way out of their experiences. The sense of hope does not have to come from a trained mental health professional, but someone who takes an interest in the voice hearer more generally, such as someone from their personal support network. This is alongside taking an active role in the voice hearing experience itself. The authors agree that the voices generally have something to tell the hearer. What the voices tell the voice hearer should be where the interest lies, as it can often signify where psychological work should be carried out. For instance, one of the narrators stated: “the voices call me all sorts of names. Later I realised that the voices were related to the physical abuse… they have the characteristics of those who abused me" (Romme et al., 2009, p. 15). Furthermore, according to Romme et al., (2009) traumatic events that the voice hearer experiences can mean that emotion becomes disconnected from the self. It is only through recovery that emotions become integrated and accepted and not something that voices have control over.

Recovery from psychosis remains a complex and ever evolving facet of human experience. Studies have found that an attempt to avoid discussion about hearing voices has led to avoidant coping styles which also resulted in lower levels of personal resilience (Tait & Birchwood, 2004). Recovery from psychosis can be categorised into two typologies: turning away, and turning towards mental health experiences. Those who turn away from their experiences were those who found medication and a medical explanation of their experiences more helpful. However, during interview, such participants gave sparser detail on their experiences and had a strong sense of wanting to put the experience behind them. This contrasts with those in the turning towards group, who were more likely to have actively engaged with their voices, test beliefs about their voices, and had developed alternative explanations of their voice hearing experience that moved away from a medicalised understanding (Dejager, Rhodes and Beevan, 2016). In contrast to a turning towards approach of recovery, a sealing over recovery style can largely lead to an un-examination of events, effectively the participant puts the experience behind them, with a return to previous functioning. The individual's choice in doing so results from many internal and external factors, but can include the consideration of the person's social environment and how it is either conducive or not to recovery in the more general sense (McGlashan, 2019).

Greater religiosity has also been seen as an important outcome of recovery. Participants who heard voices ended up praying more, became more involved in religious institutions, and became more open minded when it came to religious affairs (Tanskanen et al., 2011; Subandi, 2015; Brand et al., 2010). Some participants felt guided and helped by God and attributed good things happening to them as God's will (Perry et al., 2009). Others made attempts to repent (Subandi et al., 2015), others experienced an 'opening up' of the heart to more religious experiences. Many clients are now finding a move toward Buddhism, and its associated philosophies of living without craving, and accepting struggle and pain, as an inevitable part of life, as helpful to recovery from mental illness and psychosis (Boyle 2006; Keller 2008; Kiser 2004; Ventegodt et al., 2005). Other findings corroborate the above and go further, suggesting that mindfulness, a form of

Buddhist meditation, was instrumental in the healing and transformational growth seen in recovery from psychosis. It acted as a framework to spiritual and reflective awakening (Nixon, Hagen & Peters, 2009). Voice hearing can also be part of a spiritual narrative where voice hearers find meaning in their experiences, as opposed to seeing themselves as mentally ill (Kalhovde, Elstad & Talseth, 2013). Some voice hearers believed the voices to be originating from God or the spirit world, and for some participants, voice hearing provided a profound sense of connection to spirituality and religiosity, answered existential and religious questions and has been linked to religious beliefs and self-identity (Valavanis, Thompson and Murrary, 2019). Valavanis et al., (2019) go onto to suggest that researchers and clinicians alike should be cautious about only considering voice hearing as negative and that reconceptualising voice-hearing as meaningful will help to form a more person-centred way of working. They acknowledge this can be a challenge for practitioners who traditionally saw voice-hearing from a medical and hallucinatory standpoint.

It has now been recognised that developing a relationship with one’s voices is key to recovery. For instance, those who see their voices as a normal and an understandable part of their journey are less likely to be distressed by them and are more likely to engage positively with the voices themselves (Cooke & Brett, 2020). The talking with voices approach developed by Cooke and colleagues suggest that the development of voice hearing is not only a reaction to traumatic life events, but that for recovery to take place, dialogical engagement is often needed to facilitate healing and process past trauma. Ten qualitative interviews using Interpretative Phenomenological Analysis (IPA) were used to learn more about voice hearers and their experiences of talking with their voices. The research suggests that hearers felt that talking with their voices was a powerful catalyst to change. Equally, talking with voices led to an understanding of the voice and a more peaceful relationship with it. The facilitator of such an approach needed to demonstrate openness, courage, and a non-judgmental attitude. Participants took time to build trust in the process of talking with their voices, but ultimately valued the experience and developed increased acceptance of the voices themselves. They discuss clinical implications for the use of compassionate responding to voice hearing and for workers to develop epistemological humility by holding all explanations of voice hearing in mind.

It has now been recognised that voice hearing is a not a homogenous experience and to aid recovery, formulation-based approaches are needed to better understand and assess voices to create effective and generalised coping strategies (Lakeman, 2001; Romme & Escher, 1989). Likewise, it is the individual's unique appraisal of the voices themselves and what they mean to the hearer that decides the level of distress experienced (Holt and Tickle, 2014). They go on to argue that voice hearers should be encouraged to question the content and nature of their voices and state that cognitive behavioural approaches, such as CBT, for psychosis can lead to a greater sense of control, understanding, and empowerment. Furthermore, interventions aimed at increasing self-worth and a move away from symptom driven reduction approaches can all help to facilitate recovery.

When it came to the impact of hearing voices on relationships with themselves and others, voice hearers tended to engage in downward social comparisons and viewed themselves less favourably, at times blaming the voices for failing to achieve life goals (Mawson, Berry, Murrary et al., 2011). The researchers also found that perceived companionship of the voice might increase social isolation and further inhibit the development of new relationships. However, research by Benjamin (1989) highlighted that those who heard voices had developed coherent and complimentary relationships with their voices, which may have served as an adaptive function.

Research has also shown that there is a lack of curiosity when it comes to asking participants about their voice hearing experiences - it does not appear to form part of routine clinical practice (Haddock & Slade, 1996; Stephane et al., 2003). Not talking about voices appears to be a systemic phenomenon, ranging from lack of discussion with clinicians and family members. Not talking about voices can lead to less functional ways of coping, social isolation, withdrawal, and a chronicity of the experience (Romme & Escher, 1993, 2000). When given the opportunity to talk, participants can discuss the origin of their voices, which appears to provide context and understanding to their experience. It is also an opportunity to understand many of the established frameworks participants have built in order to distinguish reality from other experiences. It is argued that when discussing their framework of strategies, far from lacking insight, participants show personally meaningful and creative ways of dealing with their experiences (Fenekou & Georgaca, 2010). Hence, from a recovery perspective, a qualitative style interview, that is both systematic and open-ended, focusing on what participants think is important to discuss, should be prioritised during clinical administration and treatment

(Banister, Burman, Parker, Taylor & Tindall, 1994). Furthermore, if patients are provided with opportunities to discuss their lived experience, they can then be helped to develop more functional coping strategies that do not impede on their psychosocial development (James, 2001; Romme & Escher, 1993; 2000).

Personal growth is also considered relevant when understanding recovery. It takes time, includes many, and varied, psychological and emotional changes, and can often feel like an internal battle, but from which emerges a person who has experienced self-development. Acceptance of the self and a more resilient and understanding person is seen and experienced (Dixon, Sanderson, Alexander et al., 2018). The authors go on to argue for the importance of holding hope for the patient, and that clinicians unable to provide this (and indeed hold pessimistic views on client's recovery trajectory) will struggle to support clients in their recovery process.

Creativity has also been emphasised as important for recovery. For some, connecting with their creativity was a route out of psychosis. Journalling, singing, dancing, writing books and articles, acting and painting, are all considered ways to self-expression, connection with emotion, and freedom of expression. Furthermore, others spent time consciously cultivating their creativity, while some approached this on a more intuitive basis (Nixon, Hagen and Peters, 2009). The movement of transpersonal psychology, mindfulness and spirituality have been known to not only help with recovery, via its ability to transcend the self into higher states of consciousness, but to facilitate creativity of the mind and body via holistic healing and therapeutic practices (Kasprow and Scotton 1999; Wilber 1986; 2000), some of which has included non-traditional practices such as acupuncture and reiki (Nixon et al., 2009).

Within the literature, Leamy and Bird et al., (2011) conducted a systematic review and found thirteen key characteristics as being key to the recovery journey. The top three included recovery as an active process, the recovery journey being unique and individualised, and being non-linear. In addition to connecting to peers and support groups, having hope and optimism, and feeling empowered to take control of one's life, have all being facilitators of personal growth and recovery from psychosis. They go onto assert that focus should be had on the exact definition of recovery, as no formal definition to date currently exists. They argue without this, it can lead to chaos in both clinical and academic settings and make for a poorer understanding of what recovery looks like.

Recognition that recovery is non-linear and takes time was also found by Dixon, Sanderson, Alexander et al., (2018). They go onto to assert that recovery also includes having the right support, opening up to others, and taking the mental health journey day by day as important. Participants spoke about how their hallucinations shaped who they were in the present, providing them with a deep understanding of humanity, via a holistic lens, that looked beyond mental health difficulties. Others agree that recovery from psychosis is non-linear but go further and suggest that recovery is also an attitude, a stance, and a way of approaching the day's challenges which may not include a neatly packaged cure at the end of the process (Deegan, 1996).

Recovery from psychosis is more than just the determination of a reduction in symptoms but can create new and varied opportunities to connect with family and friends. Recovery from psychosis needs to be a holistic endeavour in which communication, listening, and being compassionate are necessary when providing assistance to those struggling (Forchuck and Jewell et al., 2003).

The concept of empowerment in psychology is an important one and takes its ideas from sociological perspectives which suggest there is an unequal distribution of power and inequality in certain societies which leads to feelings of powerlessness and apathy (Cattaneo & Chapman, 2010; Feste & Anderson, 1995; Zimmerman, 1995). In the field of recovery, empowerment can lead to a sense of achievement of having overcome psychosis and can help solidify self-esteem and self-efficacy. In addition, empowerment is moderately and positively correlated with social support, resilience, hope, quality of life and negatively correlated with feelings of loneliness, depression, and stigma in relation to recovery from psychosis (Wciórka et al, 2015). The authors go on to find that symptom alleviation, while considered important in relation to the frequency, content and amount of distress caused by the voices, was not the only factor that was recognised as recovery. Changes to the self and individualised coping mechanisms such as peer support, therapy, and support from loved ones were also considered important. The authors conclude that recovery should be thought of as multi-dimensional, individualised, and unique with service provision needing to take account of such person-centred principles.

Lastly, the concept of recovery is considered important when thinking about behavioural and social change. Those who experienced recovery from psychosis speak of improvements in sleep, reduction in self-harm and suicidal ideation and a regaining of independence. This went alongside having stable living conditions, seeking, and maintaining, employment and financial stability (Wood, Price and Morrison, 2010).

1.10 Hearing voices Network

It is also argued that the power of the recovery movement has spearheaded the Hearing Voices Network. The first Hearing Voices Network was founded in 1987 by psychiatrist Marius Romme. The network is based on the philosophy that hearing voices should be free from taboo and stigma. Individuals come together to share their experiences in a peer supported, collaborative manner, free from the power imbalance so embedded in psychiatric settings (Dos Santos & Beevan, 2015). The Hearing Voices Network aims to empower, actively listen, and challenge the inequalities and oppressive practices that those who hear voices experience (Hearing Voices Network UK, 2023). Moreover, labels such as ‘schizophrenia’ and ‘psychosis’ are actively rejected, with person first terminology being embraced and encouraged. The network aims to bring to the fore the issue of mental health and functions to educate those with limited understanding. The hearing voices network finds that 3-10% of the population hear voices, see visions, or have other similar sensory experiences. Thus, far from wanting to study the voice hearing experience from a purely academic viewpoint, the network aims to bring a normative perspective to the debate (Dillion & Horstein, 2013). Since its inception, the Hearing Voices Network has spread worldwide and there are now over 180 groups across the UK, including groups for young people, people in prison, women, and people from BAME communities (Hearing Voices Network UK, 2023). One main proponent of the hearing voices network is Jacqui Dillion, chair of the Hearing Voices Network in the UK. In her work, Dillion aims to destigmatise the idea of hearing voices and contextualise it within the power imbalance and structures that vanquish the vulnerable and keep them oppressed.

Hearing voices networks have demonstrated the powerful and healing effects of group attendance (Chadwick, Sambrooke et al., 2000). Participants have been known to find hearing voices groups to be empowering and compassionate spaces that facilitated personal growth and allowed for validation of all experiences (Romme and Escher, 1993). Studies have highlighted the importance of participants connecting in the group; the usefulness of group containment and continuity; and the value of exploring voice hearing and gaining insight (Payne, Allen and Lavender, 2017). Hearing voices groups are not only facilitators of validation and personal growth but can also act as friendly and tolerant spaces which can create a turning point in the life story of many voice hearers and help them to cope better (Rácz, Kaló and Kassai et al., 2017). HVN Groups can also act as emotional containers that create psychological safety and lead to psychological actualisation and growth (Bion, 1962, as cited in Payne & Lavender, 2017).

The importance of sharing and connecting with others has also been proven to be valuable to the recovery process for those attending HVN groups. The idea of sharing one's journey with others, a little bit at a time, at weekly intervals, is very helpful to the recovery process. The consistency of the group, and feedback, was seen as helping in being able to provide solutions or suggestions to real life problems. (Dos Santos and Beevan, 2015).

Initially, group attendance is a factor that many group members struggle with. Many have been known to struggle with anxiety about not knowing what to initially say or do when in a group or have concerns about not knowing anyone there. Prior to group attendance, some participants experienced shame, isolation and disempowerment. However, significant benefits are had during actual group attendance. A sense of normalisation; knowing that they are not the only ones to hear voices can bring a great sense of relief alongside acceptance, a sense of belonging, and the experience of validation without fear of judgement were all factors associated with recovery from group attendance (Corentin, Fitzgerald et al., 2023; Oakland and Berry., 2015).

In addition, participants with regular attendance at HVN groups found that they experienced fewer voices, became less afraid of their voices, felt the voices had less power over them and heard more positive voices, which they attributed to group attendance. Furthermore, a chance to talk to others about their experiences and having a general sense of relatedness to others were all considered benefits. Group attendance has also been found to have benefits in several affective, social, and clinical outcomes. For example, being able to meet others who also heard voices, finding support in the group that was not always available elsewhere, and the groups being a confidential and safe space are all considered as being drivers and factors that facilitated recovery (Beavan and De Jager et al., 2017). Likewise, many group members denied feeling pathologised when being allowed to talk openly about their experiences, free from judgment and stigma and that the benefits of the group were experienced promptly with no difference seen in duration of membership (Longdean, Read and Dillion, 2018).

Successful HVN groups work to reduce stress for participants and allow for the sharing of experiences which can provide dissemination of strategies for coping with voices, as well as helping others to consider alternative beliefs, which is another form of generalised coping (Ruddle, Mason and Wykes, 2011). Via the sharing of their experiences, members can develop novel and creative ways to cope and may regain a sense of power and control through solidarity, and the establishment of new coping mechanisms that have been shared via the group process. (Meddings, 1998). As well as learning new coping strategies from peers, HVN group members can help individuals feel less alone, as described above, and the experience can become normalised and fears surrounding hearing voices reduced (Romme et al., 1992).

Voice hearing can feel omnipotent, with a sense that one lacks control over the experience. Attending HVN groups can minimise the fear and distress associated with voice hearing and improve self-esteem, reduce stigma, and help people to regain a sense of control and feel understood, validated and less isolated (Downs, 2001). The perceived omnipotence of voice hearing was considered particularly important in affecting how people coped with the voices. Those who attended group-based HVN groups tended to decrease in the perceived level of power that the voice had over the individual, increased their coping strategies and a sense of control was restored after group attendance (Birchwood and Chadwick, 1997).

In conclusion, “HVN explicitly accepts all explanations for hearing voices, and encourages people to explore their own beliefs, be they spiritual, religious, paranormal, technological, cultural, counter-cultural, philosophical, medical, and so on. HVN welcomes people with a range of experiences, including people who see visions or have other unusual perceptions or sensations. Hearing voices groups create sanctuary, safe spaces to share taboo experiences, where there are real possibilities for healing and growth. People are free to share and explore their experiences in detail, including the content of what their voices say, without the threat of censorship, loss of liberty or forced medication, an unfortunately all-too-common feature of disclosure in traditional psychiatric settings” (Dillion & Horstein, 2013, P. 289).

10. Research Rationale

Hence, the rationale for this study is to explore the factors that influence recovery for those who have attended HVN groups. The Delphi method, which has arguably been influential in facilitating our understanding of recovery, by drawing upon expert opinion and understanding, is something this study acknowledges as useful when thinking about recovery. However, the experts in the present study, will be those with lived experience of voice hearing, as opposed to researchers or academics. Hence, the study aims to add to the discussion on how people who hear voices experience everyday life, what they find helpful and unhelpful, how they experience their recovery and what contributes to their wellbeing. This will provide meaningful insights to our understanding and practice with people who hear voices. The study will also seek to provide voice to those who are experts by experience, and aim to strengthen their voice, and raise awareness of the different types of recovery pathways and factors that contribute to healing from voice hearing.

2. Methodology

2.1 The Rationale of Interpretative Phenomenology Analysis (IPA)

Voice hearing is a unique, subjective, and altogether human experience. It is a deeply personal phenomena that can only be understood via a sense-making framework. The research topic on voice hearing is particularly suited to IPA because it is interested in understanding and contextualising the lived experience of those who hear voices. Via deep reflective enquiry, IPA aims to gain a representative understanding of the experience under investigation, which is well suited to the individualistic nature and journey of voice hearing.

Phenomenology developed by Edmund Husserl (1913, as cited in Behnke, 1996) is the study of consciousness and lived experience and is an important precursor to modern day IPA. Phenomenologists attempt to understand lived encounters via epoché, the bracketing of their own preconceived notions to focus on how people perceive, talk about, and experience their worlds and the phenomena within it. Husserl (1913, as cited in Behnke, 1996) believed that consciousness was based on intentionality e.g., the mind in its noesis state (e.g., the act of thinking) is always directed, and in its noema state (e.g., the content of thought) is always thinking *of* something. In other words, intentionality is the act of consciousness (what is thought about and experienced) and the object of that attention.

The phenomenological attitude, as described by Husserl (Smith, Flowers and Larkin, 2022) describes the process of the phenomenological method which involves transcending the experience of the everyday to that of deep and consistent reflection. The true nature of the experience then reveals itself via a process of eidetic reduction. Meaning, reducing the phenomena to its invariant properties so that it surpasses the subjective perception of individual manifestations, to a place of being seen for its essence.

Heidegger (1927), once a student of Husserl, proposed the notion of Dasein, which translates to 'being in the world'. Thus, the human being is uniquely and inextricably linked to the world in which we reside. This argument moves away from a cartesian dualism that suggests a delineation of mind-body, subject-object, to one in which we are intersubjectively bound by a relational context. An understanding of this relatedness according to Heidegger was fundamental to the study of phenomenology (Smith, Flowers and Larkin, 2022). Hermeneutics is a primary concern of IPA (Smith, Flowers and Larkin, 2022) and is derived from the Greek verb hermeneuein, which means to interpret, and the noun hermeneia, which means to make meaning intelligible and is fundamental to the principles of IPA (Wigi, 2010). Hermeneutics began with the interpretation of biblical texts and has developed into a more general concern of striving to interpret and understand. Underpinning hermeneutics is the double hermeneutics and the hermeneutic circle. Smith (2004), qualifies a double hermeneutic as the following: "the participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their" personal and social world." (Smith, 2004, p. 40). In this sense a dual interpretative engagement is seen in which the researcher is sense-making on several ontological and epistemological levels, with a bifocal lens needing to be held in the mind of the researcher.

Differentially, the hermeneutic circle looks to the sum, and its parts, in a cyclical, dynamic and circular way. One must look to the whole and the sum of parts to gain meaningful interpretation of the phenomena under investigation. The analysis in this sense becomes non-linear and iterative in nature, with repeated sustainment and engagement with the material to produce rich and descriptive narrative grounded in the data and psychological concepts.

The third major influence of IPA is idiography. The idiography method is the study of particular people, in particular contexts, of a particular subject matter. Hence, detail becomes paramount, which includes detailed analysis of the phenomena under investigation. The idiography method analyses the data on a case-by-case basis and contextualises narrative, subjectivity and reflexivity over generalisation. However, it should be noted that idiography is not simply a qualitative approach and Heavy, as cited by Willig et al., (2017,) argues that all positivistic endeavour starts from an idiographic approach. “The logical route to universal laws and structures starts from an idiographic base” (Willig and Rogers, 2017, p.197). In response, this research aims to focus on the unique subjectivity of each participant via an idiographic approach. Their narrative of voice hearing will be subjected to careful analysis and will reveal the diversity of experience, along with a distinct and unique chronicle of each person’s events. It would be erroneous to think that idiography is just concerned with the individual. Smith, Larkin and Flowers (2022) understand idiography to be in relation to phenomena, as in Dasein, and not the sole focus of the individual per se. However, an individual can offer us insights into the phenomenon and their relationship to it. Idiography is different to the nomothetic method, which is concerned with the general laws of human behaviour. Furthermore, a detailed IPA analysis can involve asking critical questions of participants' accounts, making for an empathic and descriptive narrative. Aiming to produce "rich experiential descriptions", and to provide a critical and questioning approach "in ways which participants might be unwilling or unable to do themselves" (Eatough & Smith, 2008, p. 189).

The strengths of IPA are numerous, and it is worth highlighting that IPA remains a fore-runner in qualitative research as it allows for an in-depth investigation on a sample of individuals whose voices may go unheard (Dennison, 2019). IPA challenges accepted rhetoric and probes one's realities, beliefs, and assumptions, and houses such lived experience in a psychologically informed format. Enquiry during an IPA study is broad and open-ended, with many of the findings moving away from a binary conceptualisation to one in which findings are complex and embedded in the lived experience of the participant. The participant within an IPA study is considered an active agent within the research process, from helping to design the research question to member checking; all of this allows for a credibility which empowers the individual taking part and moves away from ‘doing to’ to ‘working with’ approach (Steffen, 2013). In addition, subjectivity in an IPA study is considered an asset and not to be shied away from, therefore, making the research process a deeply personal and meaningful experience for the participant concerned. IPA’s method of data collection remains flexible - interviews, diaries, and various others, allow for a broader scope of results to be had (Smith et al., 2002). IPA offers a complete theoretical basis, which is simultaneously accessible and thorough, in how one approaches an IPA methodology. Likewise, many IPA studies have a social justice slant, akin to the ethos of counselling psychology’s doctrine.

Hence, the epistemological leanings of IPA are closely tied to this research project thus the rationale of choice. IPA’s theoretical background is particular to phenomenology, idiography, and hermeneutics. This strong undertone allows me, the researcher, to intentionally explore, make sense of and provide a detailed account of an individual’s experience of voice hearing. IPA as the method of choice for this study allows for the lived experience of the participant to be brought to the fore while simultaneously making room for the subjectivity of the researcher, while bringing to bear epoché, the suspension of judgment, in order to account for the content that brings to light a coherent narrative and, likewise, understanding of an individual's experience of recovery and voice hearing at case level.

Hence, like the rationale presented by the Farrugia and Grech (2023) research study, IPA is characterised by a participant-focused research project that aims to better understand the hearing voices phenomena via the fostering of interpersonal interactions aimed at facilitating the process of information-giving from participants. Bringing to bear epoché will bring to light a coherent and hermeneutic narrative that will aid in understanding of an individual's experience of the unique experience of voice hearing (Middleton, Cooke and May,2024). Furthermore, IPA seeks an understanding of the ontology of the participant to bring forth an advanced epistemology to further understand shared and differing human experiences. Hence, this study will bring to light the idiographic nature of mental health challenges. Given IPA's idiographic nature, the study will rely on individual detailed accounts of the phenomena and will negate the striving for a positivist generalisation. This therefore implies a detailed understanding of mental health and its characteristics, leading to the desired outcome of adding something meaningful to the existing debate on voice hearing.

After outlining the rationale for IPA above, it is equally important to discuss other qualitative approaches that were considered for the project but not used, one of these being thematic analysis. According to Clark and Braun (2006) TA was a “poorly demarcated and rarely acknowledged, yet widely used qualitative analytical method.” (Braun and Clarke, 2006, p.77). However, since their 2006 seminal paper, Clark and Braun have revolutionised TA and it is now considered a “systematic approach for identifying, analysing and reporting patterns-themes-across a data set” (Braun and Clarke, 2013, p.178). TA is a relatively flexible way of analysing data and is not tied to any theory, framework, or data collection method; It is relatively straightforward to carry out, and the results are accessible to both educated and larger population audiences. TA can either be ‘bottom-up’, where data and conclusions are immersed within the data, or ‘top-down’, where the researcher uses the data to explore from a particular theoretical perspective.

It was thought that TA, for the present study, would be able to highlight salient themes and with its flexible methodology, it was believed that several data collection methods, such as focus groups and semi-structured interviews, would allow for a holistic and saturated way of obtaining data. However, upon further consideration, the researcher wanted to go beyond this; just identifying themes did not allow for the sense-making and interpretative framework that comes with IPA. Furthermore, IPA remains faithful to the qualitative approach and looks to the idiographic nature of the individual to answer pertinent research questions. This is different to TA where some argue it can have a quantitative flavour via coding and inter-rater reliability.

While TA remains flexible, its approach can be said to lack consistency. Not as established as IPA, researchers new to TA, may struggle to develop a coherent narrative when developing themes in the data. While reflexive thematic analysis has been developed in recent years, the positionality of the research, and suspension of judgement, to help with meaning making, does not appear as striking within its literature base (Nowell, Norris, White et al., 2017).

2.2 Procedure

The first point of contact with participants was with a project leader of the Hearing Voices Network (HVN). HVN was chosen due to their philosophy and approach to mental health. They actively seek a move away from medicalised ways of viewing mental health and work to normalise, educate and peer-support the person who hears voices. They are a recovery-focused organisation and allow support, freedom, and dignity to all who attend their meetings (HVN, 2023). Hence, my reason for deciding to work with the organisation. I approached two local project leads of different HVN branches via email, with the study aims and rationale being outlined to each project lead. A series of telephone calls and emails followed to discuss the project. Once the project leads were happy with the legitimacy of the project and had a chance to ask questions, meetings were then held face-to-face with interested potential research participants to formally introduce the project and its aims. At this meeting, potential participants were provided with information about the project, hard copies of the informed consent forms, and participant information sheets were all given. They were asked to think about whether or not they would like to participate in the study and to inform me of their decision via email.

Inclusion criteria included those who hear voices from any gender, religious background, age and ethnicity. Participants should be relatively stable with their condition, meaning it no longer severely compromises their day-to-day functioning, symptoms are all handled appropriately with minimal impact on themselves or others. Examples of someone whose disorder has minimal impact might include those who are able to engage in hobbies and work once again; they may be able to live independently or with minimal assistance, and those whose communication style has not been overly compromised (showing a reflective capacity), and those with a support network they value. An absence of symptoms was not thought necessary for the study. However, experiences needed to be well managed by the participant and existing support network. Exclusion criteria included anyone that has unmanaged voice hearing experiences which impacts their day-to-day functioning. In addition, those that were recently suicidal, had a recent history of substance abuse and were deemed a risk to themselves or others either currently or in the recent past were excluded. Such individuals may also need large amounts of assistance to live in the community, and/or be hospitalised recently. They may be treatment resistant both psychologically and medically and show minimal interest in any existing support network. Furthermore, communication skills might be compromised, and the person may show little capacity for reflection. Each participant was carefully screened via a two-stage process. Firstly, over several weeks, conversations were had with each of the project leads to determine who would potentially be suitable for the project. Project leads were made aware of the inclusion and exclusion criteria and suggested those that maybe suitable for the project based on said criteria. Group meetings then took place with all participants. All those who attended said meetings were provided with a demographics questionnaire, which asked the below screening questions to determine who was suitable for the study and who was not. Each person was asked the screening questions (see below) and then signed the consent forms face to face individually.

- In your own words how would you describe your mental health?
- Have you currently, or in the past, ever been diagnosed with a mental health problem? (e.g., by a psychologist, GP, CPN, Psychiatrist or other mental health professional).
- How does the nature of your mental health affect you?

- Have you been hospitalised in the last six months in relation to your mental health?
- Have you had any suicidal thoughts in the last six months?

2.3 Participants

Seven participants were recruited. Four females and three males. All were White British from the South West of England and most described themselves as working class. Participant ages ranged from 30-50 years of age. All participants described themselves as hearing voices and all had attended at least one HVN group session. Ten potential participants contacted me via email after the initial introduction and seven were recruited. IPA studies typically recruit small sample sizes. “Recently there has been a trend for some IPA studies to be conducted with very small numbers of participants” (Smith and Osborn 2008, p.56). Hefferon and Rodriguez (2011) also outline students of professional doctorates should use between four and ten participants in an IPA study, this may be due to the consideration that a large number of research participants (within a qualitative study) may compromise the detail needed for a good quality, in-depth piece of IPA research. Furthermore, Smith, Flowers and Larkin (2022) primarily argue: “there is no right answer to the question of the sample size…however, professional doctorates …typically…have between six and ten interviews” (Smith, Flowers and Larkin, 2022, p. 46). The number of participants has therefore been kept purposely small and homogeneous in line with the idiographic method of IPA in order to reveal meaningful structures in the data (Smith, 2004).

Pseudonym	**Gender**	**Age**	**Approx length of time heard voices**
Paul	*Male*	55	10 + yrs
Richard	*Male*	Unknown	18 months
Jasmine	*Female*	42	10+ yrs
Lisa	*Female*	51	3+ yrs
Sarah	*Female*	47	15+ yrs
Kerry	*Female*	40	23 + yrs
Michael	*Male*	Unknown	20 + yrs

Table 1.1 Participant Demographics

2.4 Data collection

The traditional method of data collection for IPA is semi-structured interviews. Semi-structured interviews are useful when the researcher is interested in the subjective experience of the respondent. Here, the researcher follows most closely the narrative of the participant; his or her thoughts, feelings, and experiences are considered crucial to the understanding of the research question. Therefore, while the researcher may have a series of questions for discussion she may wish to address during the interview, she is not dictated by this - the interview schedule does not dominate the interview itself. Semi-structured interviews lend themselves to a phenomenological method of enquiry because they prize nuance and grey areas over a binary form of data gathering which is inherent in structured interviews and questionnaires (Smith, Larkin & Flowers, 2022). During a semi-structured interview the researcher is free to probe areas of interest and be guided by the respondent’s dialogue. A sense of rigidity in terms of a question-and-answer format is absent in a semi-structured interview. Such methods produce rich and descriptive data and can illuminate the topic under investigation (Smith et al., 2022).

In addition, a deep sense of curiosity, probing, listening and follow up questions all allow for an in-depth research response. When conducting an IPA semi-structured interview there is no right or wrong answers, and the participant should be encouraged to provide as much information as they can. Silences should not be filled by the researcher, unless to ask another question and the researcher should pay close attention to the non-verbal and verbal signals of the research participants (Smith et al., 2022).

With the advent of technology there are many forms in which a semi-structured interview can take place. For example, via telephone and video conferencing, such methods can provide accessibility and convenience for both researcher and participant. However, the researcher in this study decided upon a face-to-face approach based on feedback from the participants she approached (Braun and Clarke, 2013; Hennink, Hutter and Bailey, 2020). Many of the participants felt that a face-to-face interview would put them at ease and allow for a smoother interview. In addition, it is believed that with a live face-to-face interview, the researcher can more readily pick up on nuance and non-verbal communication (Hennink, Hutter and Bailey, 2020). However, the researcher wanted flexibility and so decided to request MS teams interviews from the UWE ethics committee, dependent on participant preference. All participants requested face-to-face interviews, and each interview lasted approximately fifty minutes. All interviews took place on HVN premises. In each setting the researcher was given a private room to ensure confidentiality. Each project lead was on site for the duration of the interviews and made themselves available if needed, to maintain safety. In addition, the researcher's supervisor offered debriefs after the interviews took place.

The interview scheduled was developed by a detailed research process of how to create an interview schedule (Braun and Clarke, 2021). It started with questions that aimed to build rapport, with the aim of putting participants at ease in order to help facilitate communication. Questions included asking about their journey, how their weekend was and if they wanted a glass of water. In response to developing an understanding of the participants' own views of their mental health, participants were asked to describe their mental health - what language they used when talking about their mental health and how they thought about their mental health more generally. After which, participants were asked about ongoing hearing voice hearing experiences - some had heard voices for years, while others for only a matter of months; this helped to understand and contextualise their recovery journey. Lastly, the main questions focused on recovery. The questions around recovery were based on the principles from Tedeschi and Callhoun’s work, (2018) which suggest that recovery and growth from difficult experiences is based on the following domains: improvement in relationships, new possibilities, inner strengths, spiritual/existential beliefs, and the appreciation of life. Interviews were tape recorded, lasted approximately an hour and were carried out in HVN group work settings.

2.5 Question development

The semi-structured interviews were developed via a trial pilot study. Fellow students were interviewed and asked for feedback on what they thought about the structure, style and number of questions. The feedback received was generally positive and suggested that it appeared to ask questions that were relevant to lived experience of psychosis. I did, however, find consensus differed on what terms to use for language like schizophrenia and psychosis, and so settled on asking participants what terms they preferred to use to describe their mental health, which felt person-centred, while still acknowledging that much work is needed around language and terminology, and how, perhaps agreement is needed in order to make the field of mental health and its existing lexicon more coherent.

2.6 Data analysis

IPA analysis is not rigidly prescriptive; typically, it is iterative and inductive (Smith, et al., 2022). Fundamental to the process is producing rich descriptive detail, analysis case-by-case, and comparing the convergence and divergence of each participant response. Recent changes within IPA have meant that some of the terminology of key aspects of the process of analysis have changed, so that new parlance have replaced the old terms; what used to be called emergent themes are now called experiential statements and a collection of experiential statements make a personal experiential statement or PET (Smith, Flowers and Larkin, 2022).

The first stage of analysis included the researcher listening and re-listening to the recorded interview as well reading and re-reading the transcripts to become familiar with its contents. The researcher spent time listening to the content of the interview, rewinding parts of it and making initial notes and comments, case-by-case. Once each interview was transcribed, noting was the next phase of the IPA process. Each transcript was read several times. However, this time, the researcher used highlighter pens to mark what was significant about linguistic and descriptive meanings. There are no rules as to what is considered significant/or interesting, and each reading threw up new insights (Smith, Flowers, and Larkin, 2022). Furthermore, the descriptive, linguistic and conceptual notes made in this phase were documented in the left-hand margin of the transcript in pencil. It is important, when noting, to stay focused on the words of the participant. Their words and their phenomenological experience acted as a “way in” to their perspectival world view (Smith, Flowers and Larkin, 2022). Hence, the participants’ use of metaphors, language, and conveyed emotion allowed access to detailed description and subsequent in-depth interpretive analysis.

Once noting had been completed, the primary task was to manage the volume of data and detail produced by the noting, while maintaining its complexity and nuance. Smith and Nizza (2022) go onto state: “Each experiential statement should be a concise summary of what emerges as important in the notes associated with the corresponding portion of the transcript.” (p.39). While Smith, Flowers and Larkin (2022) state: “The main task in turning notes into experiential statements involves an attempt to produce a concise and pithy summary of what was important in the various notes attached to a piece of transcript” (p. 87). The experiential statements for this study were written in pencil in the right-hand margin of each transcript and were then transferred to a tabulated Word document for ease of reference. They corresponded to the notes in the text that had been noted in the transcript. Each experiential statement title was relatively discrete, had a clear definition, scope, and purpose. It represented the clustering of important notes in succinct and terse ways. Verbs, adjectives, and nouns are all used for the experiential statements. It provides rich, yet concise and meaningful, data and clearly identifies the topic of the theme. Smith, Flowers and Larkin (2022) state they have chosen to use the term “experiential statements” because they want to directly refer to the participant’s experiences. The word ‘statement’ is used because as analysts we are making statements of the data.

After the development of experiential statements, connections began to be made between them. During this stage Smith et al., (2022) are at pains to state that: “This level of analysis is not prescriptive, and the analyst is encouraged to explore and innovate in terms of organising the analysis… there is no single correct way for doing it or what determines what goes with what” (Smith, Flowers and Larkin, 2022, p.90-91). During this stage of the research, each experiential statement was typed into a Word document in list form, providing a bird’s eye view of the statements. Clusters of experiential statements were then grouped into categories based on specific topics. This then allowed the researcher to examine possible connections between all the statements and to see what aligned or diverged with what.

Furthermore, the process of developing Personal Experiential Statements or (PETS) started with the building blocks of experiential statements. Experiential statements are clustered into PETS. Those PETS can have several sub-themes and under each sub-theme you are able to see a set of experiential statements that make up that PET (Smith, 2024). To create the PETS for this study, the researcher took each case and their corresponding experiential statements and created PETS underneath each pseudonym. Placing the corresponding PETS underneath each pseudonym helped to provide an overview of patterns in the data set. The sub-themes of PETS came later and included the grouping of similar PETS into sub-themes.

Once the PETS had been organised visually, it was then easier to work with the group experiential themes, or ‘GETs’. Smith, Flowers and Larkin (2022) stated that the aim of GETs “is to look for patterns of similarities and differences across the Personal Experiential Themes (PETS)…We want to understand

and explore points of convergence and divergence" (Smith et al., 2022, p. 100).

Table 1.2: Summary of analytical process of the voice hearing project

Stage 1: Immersing oneself in the data by listening to the recorded interviews case-by-case. This included, while listening to the recording, my most striking observations of the audio.
Stage 2: Exploratory note-taking was conducted and a record of anything of interest was recorded within the transcript. Linguistic, conceptual, descriptive, similes and metaphors were all noted. Staying close to the participant's truth while maintaining a phenomenological focus was seen.
Step 3: During this stage, I attempted to reduce and manage the volume of detail and data in step 2. Attempts were made to turn exploratory notes into concise, pithy summaries which then became experiential statements.

Step 4: Once a cluster of experiential statements was established, it was given a title that described its overall characteristics. These experiential clusters became known as the participant’s personal experiential themes or PETs. When there was a large number of PETs, some were grouped together to form sub-themes.
Step 5: Once PETS were named, patterns of similarities and differences across the PETS were noted. PETS were ordered on a Word document so that a bird’s eye view could be seen. PETS were then reordered and moved according to connections seen within the data set to produce GETs. *
**Please see appendix for examples of analysis*

2.7 Ethics

The planning and ethical approval of this study was conducted in line with the British Psychological Society Code of Ethics and Conduct (2006) and the British Psychological Society Code of Human Research Ethics (2010). Furthermore, ethical approval was granted by the University West of England's Research and Ethics committee (4th November 2022 UWE REC REF No: HAS.22.09.0245). The researcher attended all three HVN group meetings to introduce the project and hand out appropriate consent and information forms. Participants were then informed that once they had read the forms, they could email me to indicate further interest, set up another face-to-face meeting to discuss the project further, or to ask any questions. Each participant who emailed the researcher was provided with a face-to-face meeting to discuss any concerns, ask questions and/or to indicate interest in taking part. Once participants had discussed the project and the researcher satisfied they had been provided with information, they had the opportunity to sign the forms in that meeting or have further time to think about their participation. Participants were reminded of confidentiality arrangements verbally and within the participant information sheet.

The minimum necessary person identifiable information was collected for the purpose of the study. The study complied with the General Data Protection Regulation (GDPR) and Data Protection Act 2018, which require data to be de-identified as soon as it is practical to do so. The processing of the personal data of participants was minimised by making use of a unique participant study pseudonym on all study documents and on all electronic databases. All documents were stored securely on the University of the West of England One Drive in password protected folders and were only accessible by study staff. The researcher safeguarded the privacy of participants' personal data and only the minimum amount of personal data was collected. The personal details collected included the participants' names, email addresses and phone numbers. No other members of the research team had access to participants' personal details.

A key concern was that the research involved vulnerable participants. Vulnerable individuals include those with diminished capacity to make an informed decision and relates to, but is not limited to, those with a mental health problem and learning disabilities (Quest & Marco, 2003).

Conducting research on vulnerable populations can lead to the risk of exploitation, coercion, deception, and negligence of this cohort. However, it is argued that research can also provide valuable insights into a community that may have been marginalised. If we value the dignity, views, and rights of vulnerable people, then more research, not less is needed (Grant & Ramcharan, 2007). Research for this population can lead to benefits such as improved healthcare systems, mental health provision and challenge normalised pathologizing attitudes.

Hence, in this study, all participants were provided with an in-depth participant information sheet, detailing the aims, purpose, and nature of the study. All participants were fully informed of confidentiality and the potential risks and benefits to taking part. Each participant understood their participation was voluntary and that their affiliation to the Hearing Voices Network would not be affected if they withdrew from the study.

2.8 Reflexivity account of data collection and analysis process

The process of data collection was a rewarding, yet simultaneously challenging process. The process of applying for ethics had taken place during the COVID-19 pandemic and as a result I had originally decided to conduct all interviews online. This, at the time, I believed felt convenient, and would negate transportation considerations. However, as time went on, I started to receive feedback from project leads that indicated participants felt uncomfortable with online interviews. Many felt that an online interview would heighten their paranoia and symptoms of voice hearing and would lead to a relapse in their mental health status. Furthermore, practical considerations needed to be considered - many participants did not own a laptop, know how to use one or did not have an upgraded smart phone to enable digital connection. This for me led to the learning point that in some instances, technology might not aid the wellbeing of those with mental health difficulties and that face-to-face was still a powerful tool to aid and build trust. This point was proven during the initial meetings I held with participants to discuss the project; most asked questions they may not have felt able to if online. I noted a positive interpersonal connection between myself and group members when I attended face-to-face, at once discussing the project and the potential wider implications it could have for the voice hearing community in general. For the majority, conducting the interviews was a highly rewarding experience; I was able to witness each journey, and how most participants had recovered from their voice hearing experience to find meaning and purpose in their lives. This did not negate actively witnessing some who had heard voices during the interview, which was a challenge because I had to decide between my professional role as psychologist in training, who understood voice hearing and how to manage it, and naïve researcher who was just trying to make sense of their world. I tended to settle on what I believe was a compassionate and gentle approach to those who heard voices during interview, remaining calm, offering space, water and frequent breaks. When such incidences happened, it felt as though I was witnessing the recovery, and trauma, in action. No one left without a full debrief and emergency numbers. However, this felt as an addition to what was being offered, which was interpersonal attunement. It also helped, I believe, that I had had similar experiences which meant I did not feel at a loss about what to say or do.

Analysis was another aspect of the experience that engaged me; I was able to see, via close connection with the transcripts, how the experience of voice hearing often came about due to social and psychological challenges that had remained unresolved and resulted in psychosis. The narratives were at times hard to listen to, particularly when discussing the abuse some had been through. It felt harrowing to witness the pain some had clearly gone through and how some of the systems had failed participants who were in clear need of help. However, engaging with the transcripts demonstrated the clear recovery process the majority had gone through from furthering their education, finding religion, gaining employment, and having healthy relationships with family and friends; all were evidence of individuals who had managed to transform their lives beyond that of just being considered an unwell voice hearer. The concept of religion was a surprise for me, this felt like a prominent factor in some of the narratives and was somewhat different to the journey I had been on to recover. However, upon reflection, while this was identified as a recovery factor in the literature, discussing religion can often be personal, with careful consideration needing to be given as to how this is addressed. Hence, I believe that my non-judgemental stance and curiosity helped to facilitate said discussion. However, this was not the case with all participants, and some wanted to 'test' my religiosity before disclosing their own experiences. In addition, I noted the gender slant when analysing the data. It was the women who spoke about their children and the challenges having a mental health problem had on parenting. This, for me, only highlighted their resilience; having to parent with what is considered to be one of the most serious mental health conditions was something that left me full of admiration for them. While I too had similar mental health challenges, trustworthiness of the data is improved when the researcher considers how their influence over the data, interview and reporting of results was managed. It is argued that limiting this influence allows for a clearer representation of the phenomena under investigation. Hence, I was at great pains to suspend judgement, limiting my epistemological assumptions and judgements to making efforts to provide a space that was unclouded with a prior theoretical knowledge. This was achieved using an open listening stance, asking open-ended questions that elicited information in non-assuming ways and reading and re-reading the transcripts in a naïve and fresh way. Furthermore, groundness of the data was had, by sticking close to participants' meaning, using their quotes and their words has helped to support claims that analysis was free from outside judgment and closely represented how participants actually saw their world. Hence, in the present study a continual back and forth iterative approach was used when working with the data to ground findings within the data.

Furthermore, the sub-gets used in the study were considered a way to capture the lived experience of each participant and helped to explain the content of the different themes. Each GET tended to have two sub-gets, which tended to be descriptively opposite to each other. For example, the challenges of parenthood vs the connection of parenthood, or the usefulness of religion compared to its harmful effects. It is argued that without these sub-gets, and their oppositely named counterparts, there would have been a reduction in the rich, descriptive nature of each GET, which would not have captured the full picture of each participant.

Lastly, it is argued that the ‘insider’ status of the researcher presents a double bind, at once propelling her to have access to insights that may not be available to those who have not undergone similar experiences to a position of being unable to suspend judgement due to the enmeshment of her experiences with those of the participants. There is a danger that the voices of those interviewed may become lost in the researcher's personal lens and a type of countertransference of the data is purported. Hence, the principles of validity become important as outlined by Levitt (2020), when helping the researcher to stay within the boundaries of research that is valid and tells the story of those under investigation. On balance, however, it is believed that the researcher's experiences of both the similarities and differences added to the rich, descriptive idiographic narrative of the topic, which in turn achieved a better understanding of how serious mental health challenges affect the human psyche.

3. Analysis

I present the narratives of seven participants who have all experienced hearing voices. I report on how participants make sense of these experiences and analyse their unique and individualised journey of recovery. All were engaged with the organisation Hearing Voices Network (HVN) and regularly attended peer support sessions within HVN.

Table 1.3 Group Experiential Statements and their Sub-Themes

1.Voice hearing described as distressing and related to negative life events

1.1 Voice hearing linked to distressing life events

1.2 Voice hearing related to intimate relationship abuse and disruption

2. Religion and spirituality as both healer and iniquitous force

2.1 Religion has an iniquitous force

2.2 Religion and its healing force considered a facilitator to recovery

3. The experience of being a parent while coping with a mental health challenge vs. being parented and connection

3.1 Parenting with a mental health problem

3.2 The connection of parenthood and bonding

4. Networks of mental health support that assist the recovery process vs non-listening mental health networks that slow down recovery

1 Helpful Mental health support systems

4.2 Unhelpful mental health support systems

5. Recovery linked to self-actualisation and wellbeing

5.1 Recovery being linked to a general sense of wellbeing

5.2 Recovery being linked to helping others and overcoming challenges

GET 1. Voice hearing described as distressing and related to negative life events

Adverse life events for all seven participants impacted the distress they experienced.   This distress appeared to manifest itself in the voice hearing experience, which caused suffering. All seven participants had experienced some form of suffering: from childhood sexual abuse, domestic violence, bereavement, and substance abuse. The voice hearing experience for some appeared to be related to these distressing life events.

1.1 Voice hearing linked to distressing life events

Both Kerry and Paul have experiences of loss and abuse, and this appears to manifest in the experience of their voice hearing. The tone and content of both of their voices appear to add to their suffering. The fact both participants use the word "loud" to describe the volume of their voices may signify a sense of feeling overwhelmed and not being able to function due to the dominant tone of the voices. Their experiences of loss, abuse, and stress is perhaps the reason the voices are loud and distressing in nature.

"But when things are bad and I am stressed, or I'm not coping very well, they are very loud and overtake any kind of concentration." Kerry.

"Because the voices are very loud, they are very aggressive. So, I have to have the music up really loud." Paul.

Some of the participants also describe a sense of feeling overwhelmed and no longer feel able to cope with the effects of voice hearing and see no other way out of their predicament other than via suicide. Suicide for Paul may perhaps be the only way to cope with the distress he feels.

"It was at that stage where I just tried to commit suicide because I was just overwhelmed with it (the voices)." Paul.

In addition, suffering comes in the form of sexual abuse for some of the participants and appears to have impacted on their voice hearing experience. It appears that the trauma of being abused for Kerry has resulted in her voices blaming her for the abuse. This is likely to have caused not only psychological distress, but as demonstrated below, resulted in a low sense of self-worth. For Paul, he appears to believe that his present lack of energy and limited will to live (which he mentions throughout the interview), is worse than the sexual abuse he suffered at the hands of his father. In other words, the effects of the abuse have led both participants to experience voices that were either abusive or lead to consequences that include low vitality after the abuse occurred.

“I was abused but then they’ll go “But that’s your fault”. “It’s your fault you were abused”. Kerry.

“Like when I have spoken to someone in the past, my therapist or something…I said I would rather have the time I was being abused by my dad because at that stage I had the will to live” Paul.

Not having the will to live appears to be considered the ultimate in suffering, over and above the bodily boundary violation of sexual abuse for Paul. Looked at in the wider context of his experiences around the time of his abuse, he was caring for his parents:

“And then once I got to 16 or 17 I was too big to be physically abused…but my mum was disabled so I stayed home and looked after Mum…then my dad started to become quite frail, so then I looked after him. So, I just looked after both of them really.” Paul.

It was during this time Paul describes the voices as “*very descriptive, a little bit aggressive, but not terrible.”* It could be that Paul’s role as carer to his parents had purpose and meaning, even in the harrowing context of the abuse he suffered, and may be the reason why the voices were not *“terrible”* at the time.

The suffering of abuse for these participants appears to be demonstrated in loss of self-esteem. They describe a loss of confidence in their sense of self, or a self that has become even more unlikeable to the participant personally.

“But as soon as I interacted with anyone, they'd (the voices) become really critical. And then just like losing my confidence.” Paul.

“With myself I’ve never really liked myself or loved myself, but they (the voices) just make me feel even worse now.” Kerry.

Here, both participants lack a foundational sense of self-compassion which appears to have significant links to limited self-worth. For instance, in the first quote the voices are critical instead of positive and in the second quote the voices reinforce rather than challenge Kerry’s reduced sense of self-love. A lack and limited level of self-compassion can cause many psychological difficulties, such as making social interactions challenging and engaging in acts that neglect the self.

For Lisa, her experience of homelessness appears to have been one of the reasons she was hospitalised twice for mental health difficulties. Not only did Lisa identify not having a home of her own as being challenging but that it was "incredibly" difficult to get over, suggesting that her voice hearing experience was hard to overcome and possibly hindered her ability to move on, initially.

"So, they know I have been really, really unwell in the past and they [her children] know I have been hospitalised but it wasn't my choice. But I think that was because I was in a state of homelessness… Because otherwise all the pain I went through losing my home… having a nervous breakdown in my own home, it's incredibly difficult to get over." Lisa.

Lisa's recovery would likely have been made more difficult and challenging due to her homelessness status. Her experience of homelessness would have slowed her recovery process and made it uncertain. This point is supported by Lisa's current appreciation for the fact she now has a place to call home, meaning, having experienced homelessness, she may now understand the role that having a secure base has on one's general wellbeing alongside living in an area that is removed from family turmoil.

"And I was really lucky… I've got my own flat, I'm back at work and I'm managing now… because having my own flat [in area] takes me away from the emotional stress because in [area] my mum and my brother live there and there would be a lot of emotional stress there." Lisa.

In addition, the voice hearing experience for Paul, Michael and Kerry has also revealed the relentless nature of the experience. The voices for some participants do not allow for psychological cessation but instead drive the participants further into despair and distress with their unremitting talk. The voice hearing experience for these participants is driven by a never-ending cyclical process of re-experiencing. Time is measured in years, hours and days with the accompanying voices being a near constant to this frequency. Participants appear to be undergoing pain, fear and suffering of the mind in a powerless state of hopelessness. Consequently, suffering for these participants is experienced by a relentless and frequent phenomenological loop of negative constant voice hearing.

"I was getting them pretty much 24/'… for the last 15 years I've had them 24/7. Paul.

"They drive me mad from when I wake up." Michael.

"I probably have two or three days where it's quite bad and then it may, you know, subside a little bit for a day or two and then they all come back. It's like a vicious cycle." Kerry.

The suffering Michael experienced, in the form of drug taking, and family loss, appears to have impacted his voice hearing experience into a distressing one. In the form of attacks, despite the distressing nature of his voices, Michael may still find some comfort from them, and to eradicate them is also not the solution for him, as demonstrated below:

"God got rid of them for me ages ago and I wasn't used to it as I had always had them… I was in hospital at the time, so I discharged myself and smoked a blimming joint to get them back again as I have always had them." Michael.

Therefore, for some participants, there is a complex relationship between their suffering and voice hearing experience. Despite the distress the voices represent, they also live alongside them, with the voices, for some, perhaps providing a sense of companionship and something that will be missed if eradicated for good.

In summary, voice hearing for these participants appears to be linked to distressing life events, life events that have perhaps altered the way they experience voice hearing. Factors identified has unhelpful in participants' recovery journey include childhood abuse, family loss, substance misuse and homelessness. This has resulted in voice hearing that is experienced as loud and aggressive, relentless, and impacting self-esteem levels. Others, on the other hand, have a more nuanced relationship to their voice hearing, and while distressed by them, may consider them am of companionship.

1.2 Voice hearing related to intimate relationship abuse and disruption

The experience of challenging relationships appears to be a significant factor in participants' experience of voice hearing. The challenge of the relationship appears to either have precipitated voice hearing or worsened its affects.

For Sarah, it was the experience of domestic violence that activated her mental illness. She describes this experience as "very hard" and shares this is the reason she "got schizophrenia".

"And then I met [name] who was violent and then I was very mentally unwell, then I got schizophrenia…I look back and think it was very hard going through domestic violence. It was very painful and very hard. … The voices are very troubling when I am alone." Sarah.

Domestic violence for Sarah, and the bodily violation this brings, is likely to have fed into her experience of mental illness. In addition, the very real consequences of being a victim of domestic violence and the traumatisation and brain damage (see below) she suffered, because of domestic abuse, appear to have left Sarah feeling intensely angry, perhaps due to the injustice and persecution she experienced at the hands of her partner.

"Because I went through very bad domestic violence and then that came to an end, and it left me with a rage of anger. You know I felt very, very angry and out of control and then I developed schizophrenia… I was very, very traumatised and very, very, very brain damaged". Sarah.

It is perhaps possible to state that the development of Sarah's schizophrenia is due to relational abuse and the negative effect it would have had on her psyche has led to a trauma response that manifests itself in her current diagnosis of schizophrenia.

Richard, on the other hand, states that a stressful relationship break up and life-threatening injuries appears to have resulted in him experiencing not one, bu106romsibly various voices, from God and angels to demons. He also appears to have experienced delusional beliefs around this time. Hence, it could be reasonably surmised that a bad break-up, coupled with facing death, is likely to have been a destabilising factor for Richard. In general, there appeared to be a pattern of disruptive relationships for Richard, as he speaks of his parents’ divorce and how this too affected him and his mental wellbeing.

“So, my parents were unfortunately divorcing and that triggered something called recurring depression and anxiety which I suffer from. I then had a tree climbing accident on Easter Sunday in [year] which resulted in me having life threatening injuries… and also in [year] I had a bad…bad break up with the then girlfriend and I had a mental health event around that… My psychosis made me believe I was a prophet and that I had been chosen by God to lead God’s people across the English Channel… I also experienced things like the voice of God, the voice of angels and the voice of demons.” Richard.

Jasmine’s experience of voice hearing represents the negative experience of past relationships. The use of the word “shadow” to describe her voice, suggests she experiences the voices as dark, without light, and possibly malevolent. The fact that “shadow” represents an abusive ex would perhaps suggest a link between Jasmine’s experience of relationship abuse which is culminating in negative voice hearing.

“So, did your voices represent the people you were in relationships with?” [Question from interviewer] “…Yeah, yes, they did. Especially the shadow as well [the name for her

current voice]…he's the one that represents a bad, bad ex of mine." Jasmine.

Despite the abuse Jasmine has suffered, it appears to have made her stronger and less tolerant of future abuse. She discusses how she will no longer endure abuse from partners and will quickly *"show the door"* to her new partner if he abuses her.

"I'm proud that it has happened as it's made me a stronger person…because you're never going to hit me down again. I'm up for good… if you try to knock me down, there's the door… I say to my boyfriend who I hI been with for six months... I tell him if you're going to piss me off then there's the door you went through". Jasmine.

Jasmine has clearly decided to assertively communicate her needs and boundaries to her new partner, perhaps as way to take preventive action from possible future abuse. Even with this newfound confidence, Jasmine (as demonstrated above), still lives with the scars of past relational abuse in the form of her "shadow" voice and appears wary of being abused again. This, however, appears to feed into her recovery narrative, as she states she is *"proud"* of what she went through as it has a resulted in someone more resilient and less likely to be knocked by life's future challenges.

In summary, this sub-theme has demonstrated how interpersonal abuse and relationship disruptions can lead to voice hearing (Kerry and Richard). However, out of such a challenge some participants (Jasmine), have been made stronger and more aware of their own personal boundaries, and demonstrate their willingness to communicate their newfound strengthen and assertion to current and future partners, which perhaps speaks to her resilience and investment in her recovery journey.

GET 2 Religion and spirituality as both healer and iniquitous force

This powerful GET sees Michael living in fear that he is going to hell. He appears to believe that he has sinned against God. There is a sense that Michael has become fixated on his going to hell and appears not to be able to manage to think of other faith-based explanations that would perhaps provide him with some inner peace. On the other hand, we see Jasmine and Richard taking great strength from religion and it appears to have influenced their recovery for the better.

2.1 Religion has an iniquitous force

Michael uses the word “blasphemed,” a religious term, which many come to think of as indicating the use of either taking God’s name in vain, or using language that offends God, which results in an unforgivable sin. Over several pages of transcript, the participant appears to imply that his physical ailments are due to his blaspheming God and that his voices are also a product of his wrongdoing. The participant’s fear is real to him and comes from his strongly held religious convictions. This impacts his levels of anxiety, and we see a man that has spent the last twenty years fearing he will go to hell due to his blaspheming actions.

"But then I blasphemed God, and I didn't do it purposefully and… I've had all these weird things happen to me. It just got worse and worse I had a burst appenI and I had a collapsed lung... I've blasphemed God and I started to get really bad voices." Michael

"If you lose your salvation which is what I believe I have… There's an unforgivable sin which is the blasphemy against his spirit which is what I believe I did and then there's kind of no way back for me… There's no out for me. There's no hope for me." Michael.

This is leading Michael to believe that his improper actions mean there is no hope or salvation for him, and he is certainly going to hell. In accordance with his religious beliefs, Michael tries to redeem himself from the blasphemy by engaging in deliverance. Deliverance, in religious terms, is a type of exorcism that rids the body of evil spirits and brings the person back into the love of God. What is interesting to note is that Michael's attempts at redemption did not go according to plan because, according to him, he did not confess properly. The context in which the deliverance and confession was due to take place is described by Michael as a business.

It is not explicit as to what he means by this, but it could be speculated that perhaps he felt this business would not be handled by legitimate priests and hence he felt he could not confess, due to the inappropriate context of how he believed the deliverance may have been handled. Either way, Michael mistrusted the process, made half a confession, and then engaged in further religious flagellation and personal regret.

"I went to the church for help, and they said I needed deliverance, which is an exorcism. But I only made half a confession... There was two people I was meant to… I didn't confess to the other person it was a business. I didn't do what God initially asked me because I could have been out of this. Instead, I hesitated. It says in the Bible, "He who hesitates is lost."" Michael.

His mistrust is possibly due to a latent sense of paranoia and suspicion, particularly of God, the one entity his Christian teachings would direct him to trust. Mistrust and suspicion are the hallmarks of negative voice hearing. . Michael cannot find "salvation" because he cannot depend on his mind to find the answers he seeks and instead he attributes poor mental wellbeing and unprocessed bereavement to his soul being lost and a lack of faith in God, for which he blames himself.

“God was saying, “Trust me,” you know, and I was umming and ahhing about it, thinking, “Is this right?” you know? It’s my own fault. It’s my own fault. No one else to blame.” Michael.

The guilt and fear that Michael blasphemed against God and only made half a confession, appears to be an obsessive preoccupation for him. This mental filtering leaves no room for alternative perspectives, and he is stuck in a perpetual cycle of lost hope. Michael’s experience appears to typify a pseudo living hell, he is alive, but in a permanent state of terror of going to hell, he is hearing voices, that do not comfort or soothe, but attack. There is also a sense of depression and lost vitality in his thinking, speech, and behaviour, where nothing brings him joy. This has ensured he no longer spends time pursuing things that make life worth living. Michael’s loss of interest in his usual activities may be a signifier that he has lost all meaning and purpose in his life. Therefore, religion for Michael does not appear to have brought him inner peace, but turmoil to his sanity and wellbeing. His lived experience is marred with what he believes are his religious transgressions and sinful deeds. As a result, his voice hearing experience forms part of an iniquitous ontology that renders him hopeless and powerless.

"There's no hope for me… These voices are just attacking me… I live in fear, I am absolutely terrified. I've got nothing, I've lost interest in music; I've lost interest in absolutely everything. But now I am terrified of going to hell because I blasphemed God." Michael.

In summary, Michael's lack of hope and optimism appears to be influenced by his view that he offended God. His belief in God appears to be based on a fear that he is going to hell. He spends little to no time during his interview discussing concepts such as redemption and forgiveness. In addition, his voice hearing experiences are marred by punishment and vengeance, and he is left in a cycle of fear and lost hope.

2.2 Religion and its healing nature as a facilitator to recovery

We see Richard and Sarah believing that God is good and is a source of strength for them during challenging times. Religion in this sense is seen as a facilitator to recovery. It appears to provide both with a sense of general life purpose, and world views of the world being a good place.

Sarah spends time questioning the nature of her voice hearing experience and instead of the fear-based attention that Michael attaches to his experience, Sarah appears to attribute her voice hearing to a manifestation of God speaking to her. Not only does she attribute her voice hearing as God speaking to her, but she also attaches positive emotions to this experience.

"I think that it is God that is speaking to me…. What I was hearing was very good, so I felt very happy." Sarah.

The context and relationship with voice hearing as happy, can have a powerful and consequential effect when it comes to being able to positively link it to good things. Particularly in terms of personal growth and the development of strength. Hence, Sarah states:

"It [voice hearing]makes me feel very kind of empowered." Sarah.

The use of the word "empowered" is synonymous with confidence, authorisation, and enablement. This, it could be argued, may be a sign that voice hearing for Sarah is not considered distressing, but something that allows her to find some motivation to move forward with her life, with purpose and meaning. Furthermore, Sarah's voice hearing experience presents as a sense of spiritual connection to significant others. Hearing the voices of significant others appears to be close to a spiritual and comforting entity for Sarah. Religion has helped her to cope with such an experience and her belief in God as a Good entity is clear.

"I hear the voice of God sometimes. I hear the voice of my family… I hear the voice of the team sometimes. She [God] says things like "It's a good planet." Sarah.

In this respect, God is considered benign, and appears, in this quote, to want Sarah to believe that the planet, and her existence on it, is good. This positive voice hearing experience would therefore suggest that it is no coincidence that Sarah demonstrates throughout the interview a sense of purpose, meaning and fulfilment when it comes to working with, and her desire to help, others.

"I like… helping people." Sarah.

Sarah also engages in a kind of spiritual wishful fulfilment in choosing to believe that her deceased father is back with her mother. The quote below may demonstrate that Sarah's relationship to voice hearing is based on spirituality, and is a positive one, founded on an enduring connection to loved ones, even when they have passed away.

"I hear my dad connecting with me, saying he is back with my mum." Sarah.

Religion is also seen as sacrosanct and helpful to the growth of one's sense of self when we consider Richard's interview. Richard's use of the metaphor "throw the towel in", which refers to a boxer, who during a round of fighting, will literally throw the towel into the ring, to signify defeat to his opponent; we see Richard using this metaphor to suggest that religion for him is considered a source of strength, something he draws upon during harder times, which enables him to do the opposite of throwing the towel in. Being able to draw upon one's faith as the answer to challenging times is likely to increase his personal resilience and perceived ability to cope. Therefore, we see Richard continuing with the themes of an unyielding and fighter spirit, when he says:

"I think an element of my faith and beliefs has helped me persevere when I've just often wanted to chuck the towel, throw the towel in… I think having a sort of fighter attitude has helped me to overcome the worst of my issues." Richard.

Using the word fighter to symbolise one's sense of self recalls connotations of not giving up, working hard to be triumphant and standing strong in the face of adversity. Such positive associations have enabled Richard to overcome his struggles and likely strengthen and solidify his faith in Jesus.

"I believe…that my relationship and my belief in Jesus as the good shepherd…has allowed me to cope better and to feel that someone is listening." Richard.

The use of the language to describe Jesus as the "Good Sheperd" would suggest that Richard sees Jesus as someone he can turn to, someone who cares for their 'flock' and congregation, a guide, and a protector, for those in need and possibly the reason why Richard describes Jesus as someone that is listening. Here, we see a view of God that is loving and benevolent, a God considered Good, and consequently someone who has been able to move forward with his life in a purposeful and meaningful way. This has simultaneously impacted his sense of self into a fighter that perseveres through hard times.

Furthermore, religion, for Richard, has not only strengthened his personal levels of resilience, but has also helped him to become a man who demonstrates elements of compassion and forgiveness and believes these to be being consequential to his faith and his voice hearing experience.

"Through my faith, it's made me more forgiving, compassionate…and endeavour to be more understanding." Richard.

Richard demonstrates from the quote above an ability to grow from his trials, due to his investment in qualities that demonstrate emotional and psychological evolution.

During interview, Richard shares he is going on a pilgrimage to France to follow in the footsteps of Saint Therese of Lisieux.

"I'm going to France on a pilgrimage and we're following in the footsteps of Saint Therese of Lisieux…through her prayers, or something she did, her father was miraculously cured of psychosis/schizophrenia…. So when I go on this Pilgrimage… it will have some meaning for me." Richard.

According to the Society of the Little Flower (an organisation dedicated to the life and works of Saint Therese), her father died of a dementia related illness. However, what is important here, it could be argued, is not the exact nature and cause of her father's illness, but rather the meaning the pilgrimage holds for Richard. He uses the word "miracles" to describe the act of being cured - only a saint can perform miracles before they are canonised. Hence, the participant appears to believe that he will be cured of his illness if he takes this religious journey. What we are seeing from Richard is religion being considered the cure to illness, a sense that via travel to France, where Saint Therese abided and lived, his proximity to her, and her sainthood will help to remedy any illnesses he may have. The specific belief in miracles, which, simply put, means something that modern science cannot explain, appears to hold some foundational truth and purpose for Richard. The meaning of the pilgrimage for Richard and the belief in miracles does not appear to have led to mental illness, distress, or trauma. Instead, what we see are strongly held, clear beliefs in Jesus and his Saints, and how, for this participant, this can lead to emotional development and a source of strength and purpose.

This source of foundational strength via religious practice is supported when Richard says:

"Father [name] gave me a really nice blessing invoking the Holy Spirit on me and God's love, and that he will guide me through my hardships." Richard.

The sense that he is being guided would suggest that Richard is looking for support outside of himself and that his hardships can be taken on by the Holy Spirit, possibly then providing him with less of a sense of isolation.

However, Richards’s faith in God also provides him with a sense of community and love for the human race when he says:

“In my eyes you are a fellow human being, you are valued, you are important, and as a human being, generally speaking, I love you because you are my fellow neighbour.” Richard.

This powerful statement invokes images of Richard’s communal idea of love, togetherness, and a sense that increased appreciation for his fellow man is part of his journey towards recovery.

In summary, the strength both Richard and Sarah draw from religion appears to be a healer in their recovery stories. For instance, Richard had recovered enough, to be able to contemplate future career opportunities, while Sarah heard voices that were no longer distressing in nature. For Richard in particular, religion has made him more compassionate and forgiving and created resilience in that he now sees himself as a “fighter” and someone capable of overcoming their hardships via the help of Jesus Christ. Sarah too looks towards future possibilities and appears to have a world view of the planet as “good”.

GET 3 The experience of being a parent while coping with a mental health challenge vs. being parented and connection

Here we see participants discussing the encounter between mental health which has been depleted and the general lack of support and agency that was granted to them. Both mental health services and family members appear to provide limited understanding when it comes to understanding the challenges between parenthood and mental health difficulties. In addition, Richard and Sarah describe the experience of being parented by mothers who are loving and hardworking.

3.1 Parenting with a mental health problem

For Lisa, there appears to be a conflict between doing “simple things” with the children, that most parents would like to do, and her mental health being a barrier to carrying these tasks out. Lisa’s mental health appeared to be struggling against the demands of parenthood.

“So simple things, like going to the park with my children… I’d get as far as putting their bikes in the boot of my car and then just as I am about to grab my keys and say “right let’s go” I’d start crying and having panic attacks.” Lisa.

Here, Lisa describes the clash between duty, motherhood, and ability. For her, she lacks personal agency to carry out parental tasks due to her poor mental health.

"And I was fighting with my mum… and she called social services on me and said that she thought I was an unfit parent… I don't have a relationship with my mum now." Lisa.

Lisa uses the phrase "fighting with my mum" which would suggest that there was a sense of acrimony and divergence between the pair, stemming from possibly a lack of appreciation from wider family members as to the toll mental health can take on one's functioning and ability to parent. This has led Lisa to no longer have a relationship with her mother. It is also interesting that Lisa uses the phrase "unfit parent" to describe how she believed her mother saw her - such language has judgemental overtones and may be the reason Lisa has ceased contact with her mother.

Kerry's voice hearing experience is described as "debilitating" and is causing her to think of self-harm and suicide. We therefore see Kerry having to remove herself physically from her children, perhaps, she thinks, to protect them from witnessing her struggles.

"Because yesterday was a really bad day for me and they [the voices] were consuming my thoughts. I couldn't think straight.

I felt like I couldn't be around my children because I was having these horrible thoughts of suicide and self-harm and those kinds of things. That's how debilitating they are. I have to like put myself in my room or away from my children." Kerry.

Not only is Kerry putting herself in her room perhaps considered a way to protect her children but may also act as a form of self-preservation and coping mechanism. Kerry's voices also appear to consider her an unfit mother and undeserving of the role of motherhood.

"You end up isolating yourself… you end up staying in your room… in fear of trying to protect the ones you love. You don't deserve to be here anymore. You don't deserve to be a mum. Why should you have your children when you can't look after them properly?" Kerry.

Her voices appear to tell Kery she cannot look after her children and hence is undeserving. This is likely to fuel feelings of limited self-worth and question her value as a mother. In addition, there is a sense that mental health and its association with the helping professions has led to a lack of agency and choice as to how and when to tell said children about the parents' mental health difficulties. However, this experience for Jasmine is not considered detrimental, but rather it is internalised as needing to be done for the protection of the children. This is supported by Jasmine stating:

"Did you choose to tell them [about mental health issues]?" [question from interviewer]*I... "I got told not to... yeah because it's an adult conversation… They were too young to understand… I wanted to protect you girls." Jasmine.*

Although Jasmine appears to have internalised the rationale for being told not to tell her children of her mental health struggles, we see more evidence of the helping professionals not providing a sense of agency when it comes to the care of those with mental health difficulties from the helping professions when Jasmine states:

"Even when they [the children] went into care and they dropped me off straight home… they didn't take me to my mum's or anything, they just dropped me off at mine." Jasmine.

The fact Jasmine was not asked where she would like to be dropped off once her children had been taken away from her suggests a failure to provide agency and emotional sensitivity to the person with psychosis who is also a parent. She appears to not have been given due consideration as to the effects having her children taken away from her would have had on her. Thus, Jasmine comments:

"And I felt like my whole life ripped apart from me … And then I walked back in that house with no kids there and I just went, I broke down." Jasmine.

The use of the words "ripped" and "broke down" reveals the absolute emotional devastation this experience had on Jasmine. Despite this and dealing with psychosis, her bond with her children remained unbroken and she demonstrates concern for their wellbeing:

"Even though I hit mental health badly when I had my kids with me, I still had that strong bond… I want to know how my little girl is because I haven't heard from her today." Jasmine.

The meaning here would suggest that although poor mental health has prevented her from being physically there with her children, she is still a parent in all the ways that matter. For example, from the concern she demonstrated, to the maternal bond she had developed, it appears distance has been unable to break her love and care for her children.

3.2 The connection of being parented and bonding

Richard, however, appears to discuss the issue of parenting from the point of view of the child. He provides insight into the differences in parental bonds he experienced between his mother and father.

"On my dad's side, I feel like the odd one out, they don't always get me and understand me and comprehend what makes me tick… as opposed to the wonderful, awe-enveloping love of motherhood….My mother means the world to me." Richard.

The differences between his mother and father appears to have made a real difference to Richard either feeling loved or misunderstood. Richard mentions his mother more than once in the interview. He appears to see her as someone providing very useful support and, in the quote above, he states his mother means the "world" to him, meaning, she means a great deal to him personally. Hence, it could be argued that his mother's love and support may have been a very helpful way to help him cope with his voice hearing experiences and that via her love and support, his mother provided the foundation for his subsequent growth.

Similar concepts of the experience of being parented by mothers is expressed by Sarah. She describes a mother to whom she is close and worries about her mother's mortality, perhaps due to the loss this would represent to her personal support network. In addition, Sarah appears to hold her mother in a level of esteem as she describes a hard-working woman who has managed to buy a house in France. It could be suggested that this may be the reason Sarah appears focused on volunteering in the world of work, and perhaps why she regrets wasting her youth, in her opinion; all are related to her mother's influence and role modelling.

"I get very frightened of my mum dying, I get very frightened about that because we are very, very close… It's like my mum; she bought a house in France. She worked and then she bought a house in France; now she's come back; and she did all of that because she could work. But I'm 47 and just going into the workplace now because of my illness." Sarah.

The experience of being parented by her mother for Sarah appears to be a motivator in wanting to work and the influence of her mother's work ethic is possibly what helped Sarah to cope with her voice hearing experience in productive ways - via her involvement with peer support groups.

In summary, for these participants, parenting and being parented, comes with a complex set of interpersonal subtilities, which impact their mental health in various ways.

For Jasmine, Kerry, and Lisa, outside forces (be it organisations or their voice hearing experience), shape their experience of parenthood to the point that recovery from hearing voices while simultaneously parenting is experienced as a challenge. However, for Richard and Sarah, the experience of being parented by their mothers appears to have been a positive one which has led to the development of motivation and personal growth for each.

Get 4 Networks of mental health support that assist the recovery process vs non-listening mental health networks that slow down recovery

Both helpful and unhelpful systems are at play here. The factors that help the recovery process in helpful systems include: good support such as therapy and a support network that listens; attending groups; and the development of friendships. Factors that hinder the process of recovery include not being listened to, forced sedation, and a general fear of psychiatry.

4.1 Helpful Mental Health Support Systems

Richard distinguishes between Cognitive Behavioural Therapy (CBT) and Cognitive Analytical Therapy (CAT) therapy and demonstrates the positives of CAT theory and therapy. CAT for him has enabled him to talk about the relationship with his father, that to Richard offers something more than standard CBT. The qualities of being listened to and the relationship with the mental health professional (the therapist in this instance), is seen by Richard as being important in being able to not only accept professional external support, but profoundly benefit from it, in a way that builds relational bonds and encourages recovery.

"So the cognitive analytical therapy… went one step further than CBT and it… the approach worked better for me because, rather than the whole hot cross bun theory, we were using more of a psychoanalytical approach… so the visual element for me was helpful… so it makes you feel like you're being listened to, she's (the therapist) taken on board what you've said… Just being able to talk about the difficult relationship with my dad." Richard.

The listening ear of professionals has also been helpful for Richard:

"Dr. [name]… he's just been a listening ear, a good, good friend who I've a good sense of camaraderie with, and he listens to me and that makes me feel valued as a person." Richard.

The quote above appears to suggest that professionals go beyond being just a listening ear but cement personal friendships, when camaraderie is experienced by the participant. The quality of friendship and a listening ear is helping Richard to feel valued as a person. Richard may also be fulfilling and experiencing his needs for psychological growth, via authentic connections, sharing and external support.

Other external systems of support Richard appears to find helpful include group support:

"Through coming to things like the group, that I am not just an anomaly, I'm not just alone and that there is a sense of camaraderie… people in situations similar, just like mine, and it makes you feel not alone." Richard.

Not feeling alone is important to Richard, and the HVN peer support group appears to provide him with the knowledge that there are "people in similar situations". This fact may be providing Richard with some comfort, as he may be receiving a sense of collective normalisation when he is with the group, which may foster healing and recovery.

Furthermore, Richard's other system of support appears to reside with his mother. He describes her as "fantastic" and someone who has attended several important appointments with him. Having a "fantastic" mother is likely to have helped Richard feel valued and his problems considered important. He uses the word "rushing" to describe his mother's behaviour when he had a psychotic episode. When one rushes, they have a sense of urgency about their person, and this is usually because they consider the task at hand important to complete. Knowing that his mother rushed to see him may have left Richard feeling valued.

“So, I’ve got a fantastic mum who’s come with me to a number of appointments at [name] with my consultant psychiatrist… and she [Mum] came rushing to see me when I had my psychotic episode back in December [year] and she came to visit me when I was on [name] ward.” Richard.

For Lisa, her friendships and the qualities of honesty are likely being considered as important to sustainable wellbeing. The advantage of good friendship provides an ability in being able to competently manage her mental health. It is not only personal friendship and personal attachment that is helpful for Lisa, but good professional and structured support is also considered beneficial:

“I’ve made some really nice friends. When you’ve got friends around you that you can be open and honest with… I think that helps… I had support from my CPN and a community support worker... all they wanted to do was to see me as happy and stable in my own flat.” Lisa.

Lisa also uses the phrase “all they wanted to do was see me happy and stable in my own flat.” This would suggest she believes the motives of her mental health team were good. This belief may be the reason Lisa has been able to move back into the world of work and flourish as a result.

Lisa also goes on to describe volunteering as “really good” as she states, expectations and complications were kept to a minimum. Her positive experience of volunteering (another system) appears to have provided Lisa with a sense of clarity as to what is expected of her, and a sense that what it expected of her is manageable. Lisa goes on to suggest that if she were to work full time it may not have been possible to have met her volunteering role’s expectations.

“Volunteering was really good… there were no complications and no other expectations on me. When you’re working full time, you’re very busy and you don’t have much time for yourself. If I had a high-pressured job where I was bringing w’rk home with me as well, I probably wouldn't like that.” Lisa.

Lisa also goes on to state that work has improved her personal levels of confidence. It therefore appears that the system and world of work for Lisa, and its associated and part-time nature, has been transformative to the pathway to wellness and fulfilment.

“My confidence has massively improved since I’ve been at work.” Lisa.

For Sarah, a positive system comes in the form of her HVN group work. It speaks to the part of her that likes helping people, and the group has possibly provided an alternative explanation as to her voice hearing experience, by describing it as a spiritual one.

"I do groups and stuff and that gets me out… I like doing groups... helping people who have just started their experience and guiding them and helping them… because when I have been to groups they said it [the voice hearing experience] could be a spiritual message." Sarah.

Sarah's systems of support, which includes a mental health organisation, have not only supported her but appear to have added to her existence by helping her to find friends. A system that has enabled the development of friendships is likely to be helpful to the participant in many ways, one being increase in life satisfaction and a sense of feeling loved, as described by Sarah.

"Through [name] House, I've had a lot of help from Mind and [name] House and they've put me in the right direction and Stuff, and they have helped me find friends… friendships are important because they make you feel loved." Sarah.

Feeling loved via the utilisation and engagement with friendship is perhaps a system that has worked well in the case of Sarah. She is able to give back (by helping others and being involved with groups), but to also receive that support from others too, in the form of friendly affection.

Meaning from the group has also been found in Michael's experience- it's somewhere he can socialise and find out if others have struggled too.

"Well, I mean, I come to the group. I don't know, because like I said I do get support… it's just somewhere to go and somewhere to socialise, you know, and to hear if anybody else maybe that's had it. But I don't know." Michael.

Michael appears to be seeking some sense of normalisation in the form of the group but perhaps remains unsure about the possibility of experiencing this, as he ends the quote with: *"But I don't know."* However, his regular attendance at groups would suggest that on some occasions he may be experiencing the support he seeks.

It is also clear that a robust external support system does not only have to exist in human form:

"My pets, my animals… it's lovely to be with them… He's literally been my strength, he's been my reason for living (my pet rabbit) … he's been my reason for getting out of bed and… and he's been such a good boy… like Lily, when she knows I'm not right…she will come and cuddle me." Jasmine.

In this respect, the participant's animals are having a profound influence on her being able to cope: *"He's been my reason for living",* this reason for living demonstrates strong protective and influential factors for her continuing to carry on, and possibly avoid the ultimate in self-harm: suicide. There is also a sense that the participant and her animals have an unspoken bond that manifests itself when the participant is "not right". As she states, Lily will cuddle her when she needs it, highlighting that she believes Lily has a sense of the participant's emotional life and will act when her mental health is failing.

"So would you describe your relationship with your mental health nurse as a good one?" [question from interviewer] "Yeah, it was a very good relationship I had with my nurse. That's why I was like please don't go. I know you have to retire. But please don't go. I am going to miss you. I have missed seeing [name] but I said to myself, if I ever need to, I know to pick up the phone to the doctors". Jasmine.

For Jasmine, the relationship with her nurse is described as a "good one" and she will "miss" her. This may speak to the quality of the relationship she experienced and how this has helped her, more generally, to get back to a place of wellbeing. In addition, Jasmine reminds herself in this quote of the ongoing and existing support in the form of her doctors. This is encouraging and shows that Jasmine is aware of other systems of support that may potentially help in the future.

Furthermore, we see a sense of gratitude when good external support is offered and the idea that such support can entirely change the trajectory of one's life chances if external support is accepted, is demonstrated by Richard:

"I think if it wasn't for these helps and interventions my life would have taken an entirely different turn. I could have been in a high security mental hospital … it's enabled me to have hope, to have a sense of direction, to feel that my life has a value, has purpose and that life is not worth giving up on." Richard.

This quote is likely to be pregnant with meaning for Richard and clearly demonstrates that out of his hardship has come new possibilities and sustained hope, development, and recovery. The external support system he has experienced has allowed him to approach his life with vigour, optimism, and vitality. Hence, a robust external support system for those with psychosis may be key in being able to help the participants back to a place of wellness and possibly exceed their original emotional and psychological starting point.

4.2 Unhelpful Mental Health Support Systems

However, some experience within this GET unhelpful systems. Lisa appears to suggest that being placed in hospital means that one's choices have been taken away, which is likely to have included her freedom. She also suggests that being placed in a secure unit meant she was not allowed out of the hospital at times. The "secure unit" is likely to have felt prohibitive to Lisa with a sense that she lacks control over what she can and cannot do. Hence, the system is probably representative as not working for her.

"It's not great being in hospital… and having all of your normal choices taken away from you… I was placed in a secure unit and wasn't allowed out… I was being given medication that I didn't think I wanted or needed, and they said "well, we're just going to give you a depo then." Lisa.

Lisa's choice to have or not have medication is taken out of her hands, as she is told that if she refuses medication, another alternative medication (which usually includes being forcibly given medication), the "depo" will be given instead. The system here, it could be argued, is not providing Lisa with choice, but is using power to provide two undesirable alternatives. Therefore, this system approach could be potentially unhelpful to Lisa and her growth, as she tries to overcome her mental health struggles and become an autonomous and independent person, capable of making her own decisions without system interference.

She goes onto to identify medication as being ineffective for her and her needs:

"I've taken–meds before in the past and they didn't work - they made me worse… I don't think that that [meds] was keeping me stable." Lisa.

Consequently, Lisa's assessment is that not only did the medication not work, but it also made her psychological health worse; perhaps this is a demonstration of a system failing to listen to the person with mental health needs.

The idea of the non-listening system is also perhaps echoed by Paul. Paul appears to be paying lip service to the medical professionals in telling them what they want to hear. The fact he is not "fine" appears not to have been picked up by his medical team and we see a man who is in fact suicidal**.**

"I struggle late at night with suicidal thoughts… psychiatrists scare the crap out of me. I just always say what they wanted me to say just to get out of the room. And I was telling them how I felt and they were saying are you safe to be out? And

stuff like that. And I was saying yeah, I am fine. But I wasn't. I really was not fine." Paul.

It could be that Paul's omission of the truth is indicative of a system that struggles to build solid relationships with patients, and which do not allow for the deepening of conversations that would uncover said truth, in a more compassionate and patient-centred way. Given the realities of the system (ward rounds and multi-disciplinary team meetings), where the patient is likely to stand in front of a panel of mental health experts and be closely questioned, it is not surprising that Paul fears psychiatrists, who embody the system and its realities.

Once again, we see the idea of the non-listening mental health system, in particular, psychiatrists, as failing to hear the needs of the participant because Kerry states:

"Each time I see the psychiatrist and tell them… nothing changes… trying to see a psychiatrist and explain to them how everything is and nothing changes… what's the point?… It's like a battle I am fighting all on my own… I feel I've been massively let down." Kerry.

What is being witnessed here is perhaps, a sense of hopelessness and futility at trying to get her needs met. When Kerry states "what's the point?" it's as if she is tired of trying to get her needs met, so verbally signifies defeat by asking “what’s the point?”. There is also a sense of loneliness in her fight against her mental health struggles, her system is not there to support her, and so she feels like she is fighting a battle all on her own. This is leading to her feeling “massively let down.” The system in this instance has missed an opportunity to support Kerry in her hour of need and instead we see a participant that is frustrated and hopeless, having to face a system that appears to not be putting her needs first, or actively taking steps to pro-actively listen to her reality.

In summary, it is perhaps true that a non-binary outcome is being seen when it comes to helpful or unhelpful systems. The majority of participants have experienced a unique blend of the two: helpful and unhelpful. The reality of the unhelpful system is tied up in socio-political considerations of the strain on mental health systems and one reason why some have not found them helpful some of the time. While those who have found them helpful, appear to have greatly benefited in the form of the development of love and friendship, which appear to have facilitated recovery.

Get 5 Recovery linked to self-actualisation and wellbeing

All seven participants appear to demonstrate the psychological concept of self-actualisation. All participants have shown that their recovery has included reaching one’s potential, either via improvements in general wellbeing, for instance becoming more tolerant and compassionate towards the self or seeking recovery via helping and caring for others, or through the development of friendships and support networks.

5.1 Recovery being linked to a general sense of wellbeing

“I had a lot of friends...we played a lot of sport, I felt okay about myself … Men sort of appreciate other men who play sport well, so I felt right about myself… I was weightlifting at the gym, so I had a lot of energy… Like I didn’t feel terrible.” Paul.

Paul appears to be perceiving sport as a way to connect to other males and develop a sense of shared camaraderie through his love of weightlifting. This quote helps to highlight the idea of sport providing a positive sense of self because other males provide appreciation and recognition if one is skilled at such an activity. For a while, this may have led to Paul to developing some positive coping strategies, to enable him to manage his wellbeing in healthy and adaptive ways alongside the opportunity to develop support networks that led to friendship, via the utilisation of sport.

"On the flip side, it [hearing voices] has made me more compassionate… and have more time to understand people… and not be so judgemental." Kerry.

For Kerry, the voice hearing experience has turned her towards compassion for others, not away from it. Via her experience, she can perhaps foster a non-judgemental approach as outlined above. This in turn is likely leading to a sense of identity that is more positive in nature; she is likely to feel a sense of wellbeing if she can approach and understand others, who have also heard voices like she has, with a sense of kindness and humanity.

"Yeah, it does help me coming here, you know… I come to the group because like I said I do get support… they [the voices] weren't so bad because she [Michael's partner at the time], was quite good with them. Yeah. She'd say if I had a bad time, she'd say "Oh Michael, just take some tablets and go to bed," you know stuff like that." Michael.

Michael has allowed himself to be provided with support from the group and his partner. Allowing oneself to be helped is perhaps leading Michael to think of his sense of self that is worthy of care and support, something that Michael may not have considered on a conscious level. The fact that Michael may believe that he is cared for by both the group and his partner could be leading to a latent sense that Michael feels his self has some value.

Being more tolerant towards herself for Lisa is likely to lead to the forgiveness of mistakes, and an idea of the self that is not solely rooted in self-criticism and self-hatred. She uses the term “good enough” in reference to herself and her actions, which suggests she has set a personal benchmark for herself that does not have to reach perfect standards but can accommodate the idea of transgressions and flaws. In this respect, this may be leading to a closer and stronger relationship with the self, which is based on self-kindness, compassion, and acceptance of one’s flawed humanity. The quote below appears to demonstrate that Lisa no longer feels incomplete; she appears to suggest that she has everything she needs to feel fulfilled and that she appreciates and loves these things, mainly her home and children. She reiterates a sense of self-respect when she states that she likes herself, suggesting an authentic and congruent self that coincides with a self that has seen turbulent times but has managed to survive this experience, to find what she describes as peace. Being at peace with oneself is likely to be the essence of personal growth, recovery and development which is based on resilience, fortitude, and well-being.

"Now I'm more tolerant of myself… and I knew that whatever I was doing, whether it was well or unwell, it was good enough… I like myself, I like my home and I love my children, I'm at peace with myself, it's not like I feel there is something missing." Lisa

"I trust myself and I know myself and I like myself… in the beginning I was very troubled, and I didn't like myself and was very out of control and very angry but I am not like that now… I like myself now and I've given myself a chance." Sarah.

Sarah's quote may mean she now sees herself as more deserving of opportunity. The overcoming of her struggles may have meant she is now open and considering new possibilities that she may not have thought possible prior to her ongoing psychosis. She may believe that giving herself a chance may mean the development of new interests and adaptability to new challenges. Hence, the first line states she knows and likes herself; trusting and liking oneself is more conducive to new options and provides a solid foundation for growth, personal harmony, recovery and development. This is supported by Sarah wanting to develop as a peer support mentor and set up her own hearing voices network.

5.2 Recovery linked to helping others and overcoming challenges

Jasmine demonstrates a sense of “wanting to give back” to those who have been in similar situations to her. This act of service, along with her work within the community as a committee member, would suggest someone who has been able to grow from her experience of mental health and has made decisions that lead to personal growth and outward demonstrations of compassion. In addition, she states that she is doing things she would “never dream” of doing, possibly showing that not only has she grown from her struggles, but she has perhaps surpassed previous functioning to engage in activities she would never have thought possible.

“I get myself involved and help single mum’s out with their children as well… I love helping people out. That’s me. I can’t see anybody struggle. I don’t like it when people are struggling, because I know how hard it was for me… I love myself laughing and smiling and seeing myself doing all the things that I would never dream of doing.” Jasmine

"So, coming through the other side of mental health, it's made me realise… I do have value as a person… I can contribute to the betterment of society and the human race… I *would like to go down the mental health route… if possible, as in a job role within the NHS, so a psychiatric nurse, or even a psychologist like you… Really just make a difference to people's lives." Richard.*

Here, Richard appears to suggest that new possibilities are possible not only for him, but also for the betterment of society. It could be argued that this demonstrates the essence of recovery. His ambitions appear focused on wanting to make a difference and he sees that through this effort he does indeed have value as a human being. This narrative is consistent with Richard's perspective on growing from his psychotic experiences and demonstrates someone who has not lost a sense of compassion, despite his past hardships.

In summary, all seven participants appear to have demonstrated new possibilities for growth and recovery and an increased sense of wellbeing. The sense of self, for all participants, is rooted in trust, compassion, and deserving of care and opportunity, with some fulfilling dreams via community involvement and making plans to do generous acts of service.

In conclusion, the phenomenological experience for each participant was unique and simultaneously shared. The voice hearing experience appeared to impact participants' sense of self in profound and challenging ways and is context specific. All participants had a voice hearing experience that was complex and nuanced, with a blend of factors that either enhanced or disrupted emotional growth.

4.1 Summary of findings

In summary, this study identifies five group experiential themes and their sub-themes (voice hearing linked to negative life events, voice hearing and religion, hearing voices and parenthood, helpful vs. unhelpful systems and recovery linked to self-actualisation and wellbeing). The results demonstrated that for most participants recovery included the presence of the following: having hope, religion, the development of a supportive network, continuing education and being involved in the community. These factors appeared to help facilitate their recovery journeys and allowed some to experience psychological stability. However, this was not the case for all, and some experienced perpetual negative voice hearing and were unable to move forward in their recovery journey in meaningful ways.

4.2 Discussion

This study primarily aimed to look at how those with ongoing psychosis recover and grow from their experiences. It wanted to add to the debate that recovery can and does take place among those with serious mental health disorders. However, the findings of the research went beyond this and found that recovery was neither a linear nor a straightforward process. It was complex and included many facets which not only included recovery facilitators, but adverse life experiences that appeared to be the precipitant of psychosis, but of which, many participants were able to overcome.

The link between trauma and psychosis is well-established, and a review conducted by Cooke (2013), found that between half and three-quarters of psychiatric inpatients, had either been physically or sexually abused as children, and that experiencing multiple childhood traumas appears to give approximately the same risk of developing psychosis as smoking does for developing lung cancer." (p.42). Furthermore, an inpatient study found psychotic symptoms in 75% of those who had suffered physical abuse as children (Read and Argyle, 1999) and Lipschitz et al (1999b) found that physical abuse started around age 4 and lasted on average 6 years. Moreover, those who had suffered either childhood sexual abuse, or physical abuse, had significantly more positive symptoms of schizophrenia than the non-abused, and the symptoms related to the abuse, and included thought insertion, paranoid ideation, and visual hallucinations (Ross et al, 1994). The above research therefore reveals the impact of trauma on voice hearing.

Hence, there is extensive evidence in the research to suggest that the development of psychosis is a reaction to negative life events (Whitfield et al., 2005; Hardy et al., 2005; Jessop et al., 2008; Anketell et al., 2010; Shevlin et al., 2010; Longden et al., 2012; Corstens & Longden., 2013; Schnackenberg et al., 2018)particularly during childhood (Janssen et al., 2004; Shevlin et al., 2010; Bentall et al., 2012; Sheffield et al., 2013; Solesvik et al., 2016; Rosen et al., 2018; Hurtado et al., 2021). All seven participants in the present study had experienced one or more negative life event which included, but was not limited to, bereavement, substance abuse, parental challenges, domestic violence, sexual abuse, and bullying. Some of the participants in the study had experienced abuse and trauma as children. Bebbington (2009) finds that those with a history of trauma in childhood, particularly of sexual abuse, are more likely to go onto develop psychosis. At least two of the participants in the study self-disclosed sexual abuse as children. It is also known that negative life events like childhood trauma have not only been shown to be a precursor to psychosis, but can lead to several other psychological presentations such as depression, anxiety, PTSD, substance abuse and self-harm. (Bentall et al., 2012; Hardy, 2017; Bonoldi, Simeone, Rocchetti, 2013). This coincides with the findings of the present study, those who had experienced childhood trauma subsequently went on to experience mental health disorders such as depression and substance abuse, which also included incidences of self-harm in the form of disordered eating. The finding that adverse life events can be a predecessor to psychosis is supported by Romme and Escher (2006, as cited in, Larkin and Morrison, 2007), who find that 70% of people who have psychosis proceeded the trigger of a traumatic event, and a vulnerability was present from the experience of childhood adversity.

Perhaps another finding that is of note in the present study included the experience of women; there appeared to be issues particular to the female experience in the study. For instance, two of the three women had experienced domestic violence. However, research remains sparse as to how domestic violence can act as a precursor or maintenance factor in the development of voice hearing. McCarthy-Jones et al., (2015) remain critical of this and state that patriarchy is an often overlooked factor in women's experience of voice hearing and that sexism and sexist exploitation continues to remerge in the narrative of women voice hearers as a causative agent. Voice hearing among women who have experienced domestic violence, they argue, shapes and influences the content of the voices themselves. This was found to be true in the present study, with one participant describing hearing the voice of her male partner. These experiences (of domestic violence), may be what McCarthy-Jones et al., (2015) means when she refers to the physical violation of women's bodies as translating into the mental violation of voice hearing. The experiences of oppression via domestic violence and women having to exist within marginalised contexts that pathologises their experience and avoids situating their pain within wider socio-political contexts is what allows for their perpetual abuse, she argues.

While it appears evident that negative life events appear to be associated with the development of the voice hearing experience, caution must be taken. Some of the studies in the literature demonstrated only modest effects between the relationship between negative life events and voice hearing (Raune et al., 2006). It is also argued that casual links have not yet been demonstrated as to the relationship between negative life events and psychosis. Many factors can be, and are, at play as to why someone will go on to develop psychosis, with a complex interplay between biological, social, and psychological factors likely being present, and to dismiss one aspect over another will likely be erroneous.

Increased religiosity was seen in participants who had experienced psychosis in the present study. This appeared to a be factor identified among some as being influential in their recovery journey. Some participants in this study saw God as a source of strength, hope and something that helped to facilitate recovery, which included moving beyond the experience itself via the use of prayer and attendance at pilgrimages. Tanskanen et al., (2011) appear to support this finding and outline in their study that praying and attendance at a youth church group for some participants, led to individuals becoming more involved and devout in their relationship with God, which only intensified when formally detained in hospital. Religious experiences in both the wider literature and in the present study appeared to find that religion led to positive experiences; participants became more involved in religious institutions and appeared to repent and accept their destiny, while also growing from adversity (Pietruch et al.,2012; Tanskanen et al., 2011; Connell et al., 2015). Clarke (2010) in her work, notes the overlap and prevalence between evangelical Christians and voice hearing. In this study, it was found that two of the seven participants identified as Catholics or Christians. Furthermore, Menezes and Moreira-Almeida (2010) argue that some apparent psychotic manifestations are non-pathological in nature and reflect spiritual reflective awakenings/experiences. This point is supported by Valavanis et al., (2019) who go on to suggest that not all voice hearing is negative and that there is a notable tendency within the literature to omit such findings.

It is argued that voice hearers who are religious tend to affirm their identities via their religion; they may see themselves as fighters, able to overcome the most difficult circumstances (as in the present study) or experience positive emotions and a sense of peace when hearing voices. Mc-Carthy-Jones et al., (2013). Romme et al., (2009) find in their work that utilising religion during psychosis can lead to a sense of inner strength, comfort and hope, with a participant from his work suggesting that prayer saved her life on more than one occasion. The sense of hope of recovery from psychosis was seen in the present study, where the participant spoke of his faith providing him with the strength and determination to carry on and not give up. Hence religion, it can be argued, for some, is essential in recovering from psychosis and can be a means to development and psychological growth. Cockshutt (2004) goes on to suggest that "Voice-hearers' pre-existing spiritual worldviews… may offer a coherent framework to make sense of voice-hearing, increase ownership and feelings of control, and reduce distress." (p.248). He goes on to state that when no other convincing explanation is available as to why one hears voices, a spiritual understanding may help alleviate anxiety and allow for new and improved coping strategies such as prayer and meditation. Thus, voice hearing and the turning towards religion may provide solace and peace that can lead to the development of recovery-orientated processes.

It should be noted however, that for some, religion is not considered a source of recovery out of psychosis but may in fact hinder it. Religious content is not an uncommon feature of psychosis, with some studies suggesting the presence of religious delusions and hallucinations (Gearing et al, 2011). However, there appears to be no consensus on what a religious delusion or hallucination is, and consensus varies from study to study with often mixed and unsatisfactory results (Cooke, 2014). However, according to the DSM-V, a delusion is a firm and fixed belief, whereas a hallucination is defined as a sensory experience without external stimulation (APA, 2000). According to Gearing et al., (2011) between 20 to 60 percent of people diagnosed with voice hearing appear to have some religious content to their delusional beliefs. This is supported by the present study: the participant in this study appeared to be operating under a delusion that he was going to hell for having blasphemed against God. This appeared to be a firm and fixed believe which he had lived with for over twenty years. This delusion may have in turn led to his hallucinations, which included the voices attacking him for his perceived wrongdoing. Hence, for this participant, his belief in God and its associated religion may have acted as a perpetuating and maintenance factor to negative and traumatic voice hearing. His delusional beliefs may have affected his ability to experience recovery in any meaningful sense; therefore, what was seen was an individual unable to move past his apparent “sins”.

Culture may also play a part in religious delusions, with a study reporting that in a Saudi sample of voice hearers, 53 percent reported religious content in their voice hearing compared to just 11 percent in the UK sample (Kent and Wahass, 1996). This may suggest that religion may be both a protective and risk factor when it comes to recovery from psychosis and cultural context may play a part in the prevalence of religious hallucinations and delusions. Furthermore, some have argued that the severity and impact of voice hearing may play a role in determining whether voice hearing is considered benign or negative (Cottman, 2011). Hence, the individual in this study may simply have been too unwell and experiencing voice hearing to a greater degree to have benefitted from religions' facilitative recovery process.

In contrast to the above, parenthood appeared to play a role in the recovery journey of some participants. According to Seeman (2010) approximately half of all women with a diagnosis of schizophrenia are mothers. Most women with schizophrenia value their roles as mothers and their adult children remain attached to them. This point is supported in the present study; even though some participants had their children taken into care, close bonds with their offspring was evident and some of the parents continued to wonder after their children's wellbeing. In addition, some participants reported to feeling proud of their children, for what they had achieved as adults, despite their adverse starts in life. Seeman (2010) also goes on to state that there are associated risks with a person who is a parent who also happens to have a psychotic illness. This includes poverty, substance abuse, social isolation, homelessness/substandard living, and domestic violence. In this study, one participant reported to losing everything, including her home, when she was raising her children, which compounded her problem. In addition, Seeman (2010) states that while there are challenges for parents with schizophrenia, it does not preclude effective parenting. This point, it is argued, is supported in the present study; some of the participants' children, both now older, appeared to have grown into effective and functional adults, with stable relationships and families of their own.

Most of the parents in this study demonstrated high levels of warmth towards their children, with many stating that even though they no longer lived with their children, the bond of parent and child had not been broken. However, it was interesting to note that many experienced psychosis around the time they were parenting their children. Radley, Barlow and Johns (2022) support this claim and provide an explanation in their own study:

> Some parents spoke about how parenting stress was a trigger for psychosis, and this was particularly true for the women in the sample who were more likely to report having parenting-related stress, and were more likely to be a single parent or perform the majority of parenting tasks (p.2439).

In the present study, participants spoke about the associated stress of parenting, either being unable to fulfil parental duties and how that left them feeling, or the pressure of having to parent while also hearing voices. This tended to lead to feelings of guilt and self-blame, with one participant stating that her voices would often comment that she did not deserve to be a mother.

Radley, Barlow and Johns (2022) also point out that for most mothers in their sample with psychosis, it seemed that the parents experienced the stress of parenting, had a limited support network and undertook the raising of their children entirely alone. Such findings coincide with the present study. Participants appeared to be the main care-givers to their children, and none mentioned a co-parent. Furthermore, the support they received was either non-existent or minimal. One participant spoke about her mother failing to understand her mental health struggles and when she did reach out for help, instead of receiving help, social services were called, with her being branded an “unfit” parent.

This study also found that some participants felt a need to protect their children from knowing the full extent of their psychosis and some participants were advised not to tell their children to avoid causing further worry and harm. The Radley et al., (2022) study found similar results in that most participants wanted to keep their illness away from their children, especially from younger children. However, there is evidence to suggest that children whose parents are mentally ill do want to know and understand about their parents' mental health struggles (Gladstone et al., 2011; Wahl et al., 2017).

Additionally, there were participants in the present study who were not parents, but the children of parents. It was noted that such participants described a bond and connection with their parents. Mothers were considered as providing love and support to their children with psychosis and ended up being viewed as an important source of support. One participant described his mother has meaning the "world" to him while another was in fear of her mother's mortality due to the potential loss of the bond they shared. Studies have found that parents who were actively involved in their children's treatment and coping processes were significantly less likely to be pessimistic about their child's recovery outcomes (Kalpheck et al., 2014). Furthermore, in this study, opportunities to make sense of their psychosis with loved ones led to a relatively meaningful narrative of voice hearing, which in turn is more likely to lead to recovery from it.

A parental bond is perhaps even more imperative in recovery from psychosis as for so long studies have found that parents often blame themselves for their child's psychosis, which frequently causes considerable emotional distress, often unaided by unhelpful responses from professional staff (Ferriter and Huband, 2003). Hence, the present study may cautiously demonstrate that it is those with healthy attachment parental bonds that are most likely to recover from voice hearing.

Britz (2017) argues there is a seeming disconnect between clinical approaches that stem from an illness model which reinforces the power imbalance in the relationships between clinicians, researchers, and individuals. She goes on to argue that clinical services and systems have traditionally not listened to and have actively excluded the lived experience of those with psychosis. This point is supported by the present study where two of the seven participants felt unheard by their medical team or were told medication may have to be given forcibly. This, it is argued, is removing free-choice, agency, and liberty in ever-increasing ways. Furthermore, systems tend to focus on problem deficits when thinking about patients, with clinical training programmes and mental health systems overly focused on the question of 'what is wrong with you?' This precludes a more personalised and person-centred approach which tends to contextualise psychological pain, and instead of asking ‘what is wrong with you?’, asks ‘what’s happened to you?’ (Carter et al., 2016; Magliano et al., 2016). However, such a powerful shift will not happen readily, with many private mental organisations, including the NHS and those systems in the USA, being dependent on a payment by results system that focuses on clinicians achieving symptom reduction, in short periods of time, and then being rewarded for this as opposed to promoting recovery in the more organic sense (Faulkner and Thomas, 2002; Callard et al., 2012). In addition, it appears that many patients reject the quality of a cold unfeeling, faceless professional or mental health system, and need and want systems with a personal touch; personal disclosure (while a contested topic) is something that is of value to patients, alongside the traditional clinical expertise. Patients also want to feel a part of the decision making process in wider mental health systems, particularly so when they are not acutely unwell. Patient choice is also important, along with continuity of care and care in the community (Laugharne, Priebe, and McCabe et al., 2012). In the present study, patients discussed how developing a friendship with their mental health team was important to their recovery; this, it is argued, supports the above point that patients appreciate a level of service that has an individualised and personal touch. Likewise, placing patients at the heart of the development of service decision-making and policy is paramount. However, the current study saw recovery being facilitated by participants wanting to see change via working from the inside. Some had ambitions to qualify as mental health nurses which would suggest that not only do patients want to be part of the decision-making process, but they also want to be part of the system itself, with the power to help others and effect change.

Systems come in many forms and for some participants in the study, recovery was related to attending the hearing voices network. This could be considered an alternative mental health support network. Hence, some participants saw the hearing voices network, and other attendees as family, while others found it to lessen the effects of loneliness and alienation. Consequently, the group system in this study has enabled the recovery process. Such a claim is supported by Schaefer, Boumans et al., (2021) who found that those attending hearing voices groups found them to be non-judgmental places of support, where normalisation and validation of all experiences was seen. They found that participants who met other people who heard voices opened up new opportunities to feeling connected and bonded to others in similar situations. Furthermore, the findings from Mapplebeck and Farrell (2015) suggest that the support systems of family and friends play a major role in helping the person feel understood, valued, and supported.

According to Atapattu, Gonzales and Williams (2022), recovery is an individual and unique process, much like the experience of undergoing psychosis, and as a result it is difficult to identify causative factors of recovery. However, they interviewed five psychologists using IPA to try and determine what does in fact lead to recovery from psychosis. Findings suggest that recovery can occur in four different domains: behavioural, insight, cognitive, and social recovery. For those experiencing behavioural recovery, they found that families played a crucial role. They instilled hope, provided emotional and practical resources, and assisted when the person lacked insight. This was seen in the present study, where loving mothers were considered paramount in the development of recovery. Insight development for the psychologists was also considered a form of recovery. Psychoeducation which helps to inform and educate the patient on their experiences was considered helpful, while cognitive recovery was important in demonstrating a reduction in shame and trauma. The present study showed that those who had experienced abuse all experienced some form of internal blame: blaming themselves for hearing voices or for being abused. Hence, Atapttu et al., (2022) suggests that a reduction in shame and trauma can facilitate the recovery process. Lastly, social recovery was identified as including peer connection and the enhancement of careers/vocation along with reduction in the experience of stigma.

Self-actualisation, wellbeing and a general sense of agency, empowerment, and confidence was seen in participants who took part in the study. The voice hearing experience did not appear to negatively affect participants’ moves towards a self that was linked to positivity. Pitt et al.,(2007) notably found that patient accounts highlight the importance of developing a compassionate relationship with the self which helps to facilitate growth and recovery. Despite their enduring nature of their experiences, some participants spoke of developing hopeful plans for themselves in the future and drew upon existing coping strategies to help develop a self-identity that was linked to friendship, masculine solidarity, and sport. Others mentioned that they felt at peace with themselves and felt that what they did was good enough. Waite et al., (2015) further cements this finding by outlining that as confidence increased for participants, self-belief also improved, resulting in a cohesive and positive self-concept which helped to facilitate growth and recovery.

According to Schrank, Riches, and Bird, et al., (2014) recovery from psychosis is an ongoing, fluid, and dynamic process. Participants in the study described a sense of self that had been enhanced via the experience of good feelings, symptom relief, connection, hope, self-worth, empowerment and meaning, all of which are findings similar to the present study. Those in the current study spoke powerfully about the sense of hope they had experienced because of receiving support for their condition; many discussed the concept of self-worth and that initially having a low sense of self-worth, due to abuse, they were now able to value and prioritise themselves personally. In addition, some spoke about how love for their fellow human and traveller had led to feelings of love and connection. Furthermore, the study by Schrank et al., (2014) found that proximal factors such as systemic therapies, the development of family relationships, and supporting networks as being one key factor to recovery.

In keeping with the idea of recovery, the majority of participants had developed a sense of self-identity that was based on acts of service towards others e.g. helping their communities or becoming less judgemental of others; they had developed a self that was growth and future orientated, wanting to gain qualifications and gain employment and some were more tolerant and accepting of themselves.

Such findings are in keeping with more recent approaches to hearing voices such as Acceptance and Commitment Therapy (ACT) or Compassion Focused Therapy (CFT) which argue for a more tolerant, less judgmental approach to voices and general distress, which focus on staying present, cognitive distance and diffusion; gently observing the self, and allowing for inner wisdom and "wise mind" to come to the fore (Harris, 2019)

CFT uses psychoeducation to teach voice hearers about the deep connection of our mammalian brain and its link to threat based motivational systems. For example, for abused and traumatised individuals, this part of our brain becomes highly sensitised and "switched on" so that we are constantly in a state of hypervigilance and threat, this is because the experience of trauma has allowed for a mainly subordinate position, which renders the survivor powerless and always aware of threat-based contexts. Researchers go onto suggest that powerful motivational interviewing techniques can help people realise when they are in a threat-based state of mind, and how to revert to a more compassionate one, via the use of ancient techniques such as mindfulness, which cultivates awareness and kind compassion for ourselves and others (Heriot-Mailand, et al, 2019)

Lastly, Romme et al., (2009) provide a much-needed voice to voice hearers and provide examples from their work of what voice hearers mean by recovery. Many identify having a part-time job, continuing with education, having friends and family support, reduction in medication, alongside just being able to cope day-to-day with life, as the meaning and essence of recovery. Furthermore, their work cites acceptances of one’s voices and changing the nature of their voice hearing experience and relationship with their voices as being the route to recovery. Via the utilisation of hope, support, and acceptance the Romme et al., (2009) landmark study and the current study have demonstrated that it is entirely possible to overcome hearing voices and to take back control of one’s life and destiny.

4.3 Strengths of the study

This study attempted to capture the full lived experience of each participant. However, suspension of judgment is not only impossible but should not be strived for and therefore what is seen is an open and honest account of each participant's recovery journey.

Equally, the voice of those most marginalised within our communities, females was highlighted in the present study. Many of the women in the study appeared to feel empowered they were being given the opportunity to share and to tell their story with the researcher. Hence, providing a platform for these women’s struggles to be seen and heard.

The choice of using HVN to recruit participants allowed meaningful insights into the workings of the organisation. It revealed that independent organisations can play a major role in the recovery journey of many a voice hearer. This is important, as unlike many NHS departments, such organisations do not have to grapple with long waiting lists or stretched resources and can therefore focus solely on the recovery journey. Hence, the decision to recruit from HVN meant that the study benefited from witnessing individuals who grew from having contact with an organisation that does not solely subscribe to the medical model’s world view.

Lastly, the study provides hope, from retelling the story of participant's, it has revealed that voice hearing is not the allotted death sentence many come to see it as. In fact, what they study shows is the often complex, nuanced and unique journey each person went through to achieve recovery. While some went onto to surpass their previous functioning and excel, others, at times found this more challenging. However, what was meaningful, was that each person had a relationship to their voices (good or bad) and it was that relationship (among other important factors) that determined their recovery destiny.

4.3 a Limitations of the study

Of the seven participants interviewed, all were from White, westernised backgrounds with no participant being from a Black and Minority Ethnic Background. This, it could be argued, can lead to bias when discussing the lived experience of those with psychosis as only belonging to those with non BAME backgrounds. Fernando (2012) argues that:

> in multicultural environments like the US, Canada, and the UK, mental health care systems must serve the needs of increasingly diverse populations. Yet, our capacity to do so is affected by systemic and institutionalized racism that has affected psychiatry and mental health treatment since its inception (Fernando, 2012, p.113).

If services are finding BAME communities “hard to reach”, this has a consequential effect on access to diverse research participants that academics seek. Hence, this study may have had an unintended consequence of not providing voice to those from BAME backgrounds due to larger structural inequalities beyond its control.

Furthermore, the researcher made industrious efforts to obtain a larger sample size, however, the number of participants in the present study was small and limited, making the ability to provide wider claims as to its findings difficult to achieve. It is noted, however, that the aim of an IPA study is not necessarily to provide statements of generalisability, and Smith and Osborn (2008) state that for professional doctorates a sample size of between 6 and 10 is adequate.

In addition, participants were at different stages of wellness, and the number of years in which each participant heard voices was not controlled for. It could be argued that Richard, who had heard voices for “only” 18 months, would have had a very different experience to Paul and Michael, who had both heard voices for over 10 years. This difference may have ensured that recovery for these three participants would have meant differing levels of experience and depth to their interviews. Arguably, this may have led too much heterogeneity, and what may be evident is a lack of similarity and coherence in participants’ stories.

Furthermore, the exclusion criteria within the present study may have affected the richness of data obtained and may not have given voice to those who were more severely affected by psychosis. For instance, excluding those recently released from hospital, may have had the unintended effect of silencing those who may have experienced trauma at the hands of the mental health system, and/or other traumatic experiences, and an opportunity may have been missed in hearing their narratives on voice hearing and recovery.

4.4 Implications for Counselling Psychology

The research has shown that hearing voices is a common human phenomenon which usually occurs due to negative life events. It is the case that many overcome or learn to live peacefully with their voices. Hence, the work by Escher and Romme (2000), Corstens, Longdean and May (2012) and Cooke (2017) suggest a novel and alternative approach to managing voice hearing: dialoguing with one's voices. Being able to foster a relationship with one's voices can help to reduce the fear, anxiety, and confusion surrounding voice hearing. Counselling psychologists have a significant role to play in being able to facilitate such a process via a judgement-free, graded, and compassionate approach. Helping the person to make sense of their experience and assisting the individual to see voice hearing voices as a meaningful part of their life could be useful in aiding recovery. Furthermore, counselling psychologists can encourage the person who hears voices to reframe their experience by viewing voices as potentially having something to say/teach the person as a road towards recovery; this is very different to the simplistic symptom reduction seen in the ill-ness driven model.

In addition, the social justice and advocacy approach of counselling psychologists place us in a unique position in being able to speak on behalf of voice hearers; to destigmatise, de-pathologise, and in some instances, de-criminalise mental health difficulties, which could lead to powerful change among a wider social context. However, this cannot be carried out in isolation and must see joined up working among mental health professionals, policy makers and those with lived experience, to combat society's current mis-informed and negative view of voice hearing. This way of working has significant implications for counselling psychology as it would see the profession as leaders in change in making for a more progressive and inclusive way of working with those who hear voices.

4.4 a Future directions

Partly due to the sample obtained, we were able to answer questions about individuals who experience persistent voice hearing and what a recovery journey looks like for these individuals. Most of the participants in this study had heard voices for five or more years and all had shown some form of recovery. Future research should focus on how specific factors such as religion, parenthood and self-actualisation (all found in this study), can either be a specific hinderance or enabler of recovery, and how treatment services can play a role in the recovery process.

In addition, much has been said about trauma and voice hearing and those in this study would likely have heard more than one voice, on more than once occasion. Therefore, researchers should now focus their attention on those who have experienced multiple voice hearing experiences and if such individuals differ in their recovery journey compared to those who have experienced a first episode only. Multi-voice hearing experiences will likely provide valuable insights into the nature of resilience for these individuals, and answer the question: “Is recovery considered a more challenging prospect if one has had multi episodes of voice hearing?” In addition, for clinicians needing a practical approach; the Maastricht approach developed by Romme et al (2008) can form the basis of work with someone who hears voices. As a semi-structured interview, it asks the voice hear questions about the nature and triggers to voice hearing, leading to the development of treatment plans, coping strategies and eventual dialoguing with one’s voices, which could have profound effects on how those who hear voices are treated and seen. Likewise, clinicians should draw upon some of the compassion focused research, surrounding voice hearing, and help the hearer to develop a more stable frame of mind using principles of empathy that draw upon neuropsychology and trauma informed perspectives to help those suffering understand it is the trauma that impacts on voice hearing; and that recovery is ultimately possible if the person is allowed to heal within a compassionate space.

4.5 Conclusion

It can be identified that those who appeared to grow and recover most from their voice hearing experience were participants who had the following: were involved in community activities either via work, volunteering, or peer support group work; had faith which focused on compassion and spirituality; had reframed their voice hearing experience into a “positive” of wanting to help others and give back to others and their communities; had support in the form of friends, pets, children and mothers; had plans for their future, be it to train and educate themselves; and saw themselves as more resilient for having gone through hearing voices. In addition, those that had grown emotionally from their experience appeared to be more tolerant of themselves and used words like “complete” to describe their current psychological functioning. What remains evident from this study is the need for relational humanity, in all its forms, to be at the forefront of all psychological services and treatments. It is only then can we hope to see greater strides in being able to understand and help those who experience voice hearing.

Lastly, the significance and findings of this thesis cannot be under-estimated. It has given voice and a platform to those who may not have otherwise been able to tell their story. It provides insight for clinicians, those with lived experience and policy makers in being able to understand the often-challenging journey that voice hearing can bring about, and how, through resilience, support and self-compassion one can overcome its consequences.

References

Atapattu, M. S., Gonzales, H. M., & Williams, N. (2022). Recovery from psychosis: An integrated model of interpersonal and intrapersonal factors from the perspective of psychologists. *Journal of Psychosocial Rehabilitation and Mental Health*, *9*(4), 379-393.

Anketell, C., Dorahy, M. J., Shannon, M., Elder, R., Hamilton, G., Corry, M., ... & O'Rawe, B. (2010). An exploratory analysis of voice hearing in chronic PTSD: potential associated mechanisms. *Journal of Trauma & Dissociation*, *11*(1), 93-107.

Arrigo, B. A., & Williams, C. R. (1999). Chaos theory and the social control thesis: A post-Foucauldian analysis of mental illness and involuntary civil confinement. *Social Justice*, *26*(1 (75), 177-207.

Ashcroft, K., Barrow, F., Lee, R., & MacKinnon, K. (2012). Mindfulness groups for early psychosis: A qualitative study. *Psychology and Psychotherapy: Theory, Research and Practice*, *85*(3), 327-334.

Ascher-Svanum, H., Nyhuis, A.W., Staufer, V., Kinon, B.J., Faries, D. E., Phillips, G. A., … Naber, D. (2010). Reasons for discontinuation and continuation of antipsychotics in the treatment of schizophrenia from patient and clinician perspectives. Current Medical Research and Opinion, 26(10), 2403–2410. https://doi.org/10.1185/03007995.2010.515900.

Adams, G., Dobles, I., Gómez, L. H., Kurtiş, T., & Molina, L. E. (2015). Decolonizing psychological science: Introduction to the special thematic section. *Journal of Social and Political Psychology*, *3*(1).

Barrett, D., & Heale, R. (2020). What are Delphi studies?. *Evidence-based nursing*, *23*(3), 68-69.

Braun, V., & Clarke, V. (2013). Successful qualitative research: A practical guide for beginners.

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and psychotherapy research*, *21*(1), 37-47.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). Qualitative methods in psychology: A research guide. Buckingham: Open University Press.

Bebbington, P. (2009). Childhood sexual abuse and psychosis: aetiology and mechanism. *Epidemiology and Psychiatric Sciences*, *18*(4), 284-293.

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do specific early-life adversities lead to specific symptoms of psychosis? A study from the 2007 the adult psychiatric morbidity survey. Schizophrenia Bulletin, 38(4), 734-740

Behnke, Elizabeth A., 1996, "Edmund Husserl's Contribution to Phenomenology of the Body in Ideas II," in Nenon and Embree (eds.), 135–160.

Bentall RP (1990). The illusion of reality: a review and integration of psychological research on hallucinations. Psychological Bulletin 107, 82–95.

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do specific early-life adversities lead to specific symptoms of psychosis? A study from the 2007 the adult psychiatric morbidity survey. Schizophrenia Bulletin, 38(4), 734-740.

Benjamin, L. S. (1989) Is chronicity a function of the relationship between the person and the auditory hallucination? Schizophrenia Bulletin, 15, 291â€”310.

Beavan, V., de Jager, A., & dos Santos, B. (2017). Do peer-support groups for voice-hearers work? A small scale study of Hearing Voices Network support groups in Australia. *Psychosis*, *9*(1), 57-66.

Boyle, M. (2014). *Schizophrenia: A scientific delusion?*. Routledge.

Boyle, M., & Johnstone, L. (2014). Alternatives to psychiatric diagnosis. *The Lancet Psychiatry*, *1*(6), 409-411.

Boyle, M. (2006). Developing real alternatives to medical models. *Ethical human psychology and psychiatry*, *8*(3), 191-200.

Bonoldi, I., Simeone, E., Rocchetti, M., Codjoe, L., Rossi, G., Gambi, F., ... & Fusar-Poli, P. (2013). Prevalence of self-reported childhood abuse in psychosis: a meta-analysis of retrospective studies. *Psychiatry research*, *210*(1), 8-15.

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: subordination and entrapment by voices and significant others. *Psychological medicine*, *30*(2), 337-344.

Birchwood, M. J. & Chadwick, P.D.J. (1997). The omnipotence of voices: testing the validity of the cognitive model. Psychological Medicine, 27, 13451353

Brand, R., Harrop, C., Ellet, L., (2010). What is it like to be friends with a young person with psychosis? A qualitative study. *Psychosis, 3* 205–215

Britz, B. (2017). Listening and hearing: A voice hearer's invitation into relationship. *Frontiers in Psychology*, *8*, 387.

Bebbington P, Bhugra D, Bhugra T, Singleton N, Farrell M, Jenkins R, Lewis G, Meltzer H (2004). Psychosis, victimization and childhood disadvantage: evidence from the second British National Survey of Psychiatric

Berry, K., Ford, S., Jellicoe-Jones, L., Haddock, G. (2013). PTSD symptoms associated with the experiences of psychosis of hospitalisation: A review of the literature. *Clinical Psychology Review, 33*, 526-538

Carter, L., Read, J., Pyle, M., and Morrison, A. P. (2016). The impact of causal explanations on outcome in people experiencing psychosis: a systematic review. Clin. Psychol. Psychother. doi: 10.1002/cpp.2002. [Epub ahead of print].

Cattaneo, L. B., & Chapman, A. R. (2010). The process of empowerment: a model for use in research and practice. *American psychologist*, *65*(7), 646.

Centofanti, A. T., Smith, D. I., & Altieri, T. (2005). Posttraumatic stress disorder as a reaction to the experience of psychosis and its sequelae. *Clinical Psychologist*, *9*(1), 15-23.

Cooke, A., & Kinderman, P. (2018). "But What About Real Mental Illnesses?" Alternatives to the Disease Model Approach to "Schizophrenia". *Journal of Humanistic Psychology*, *58*(1), 47-71. https://doi.org/10.1177/0022167817745621

Cooke A. (Ed.). (2014). *Understanding psychosis and schizophrenia: Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help. A report by the Division of Clinical Psychology*. Leicester, England: British Psychological Society. Retrieved from http://www.understandingpsychosis.net.

Cooke CCH. Hearing Voices, Demonic and Divine: Scientific and Theological Perspectives. Oxon (UK): Routledge; (2019) Chapter 1, Voice hearing in contemporary spiritual and religious context. Available from: https://www.ncbi.nlm.nih.gov/books/NBK540483/

Connell M, Schweitzer R, King R (2015). Recovery from first-episode psychosis: a dialogical perspective. Bulletin of the Menninger Clinic 79:70–90,

Corstens, D., Longden, E., & May, R. (2012). Talking with voices: exploring what is expressed by the voices people hear. *Psychosis*, *4*(2), 95-104.

Callard, F., Rose, D., and Wykes, T. (2012). Close to the bench as well as at the bedside: involving service users in all phases of translational research. Health Expect. 15, 389–400. doi: 10.1111/j.1369-7625.2011.00681.x

Campodonico, C., Varese, F., & Berry, K. (2022). Trauma and psychosis: a qualitative study exploring the perspectives of people with psychosis on the influence of traumatic experiences on psychotic symptoms and quality of life. *BMC psychiatry*, *22*(1), 213.

Cockshutt, G. (2004). Choices for voices: A voice hearer's perspective on hearing voices. *Cognitive Neuropsychiatry*, *9*(1-2), 9-11.

Cottam, S., Paul, S.N., Doughty, O.J., Carpenter, L., Al-Mousawi, A., Karvounis, S., & Done, D.J. (2011). Does religious belief enable positive interpretation of auditory halluci nations? A comparison of religious voice hearers with and without psychosis. Cognitive Neuropsychiatry, 16, 403–421. doi:10.1080/13546805.2010.548543

Cooke, A., & Brett, C. (2020). Clinical psychologists' use of transformative models of psychosis. *Clinical Psychology & Psychotherapy*, *27*(1), 87-96.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: implications for research and practice. *Schizophrenia bulletin*, *40*(Suppl_4), S285-S294.

Corentin, C., Fitzgerald, C., & Goodwin, J. (2023). Benefits of hearing voices groups & other self-help groups for voice hearers: A systematic review. *Issues in Mental Health Nursing*, *44*(4), 228-244.

Carel, H., & Kidd, I. J. (2014). Epistemic injustice in healthcare: a philosophial analysis. *Medicine, Health Care and Philosophy*, *17*, 529-540.

Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *The British Journal of Psychiatry*, *164*(2), 190-201.

Chadwick, P., Sambrooke, S., Rasch, S., & Davies, E. (2000). Challenging the omnipotence of voices: group cognitive behavior therapy for voices. *Behaviour Research and Therapy*, *38*(10), 993-1003.

Clarke, V., & Braun, V. (2013). Successful qualitative research: A practical guide for beginners.

Clarke, I. (2010). Psychosis and spirituality: The discontinuity model. In I. Clarke (Ed.), Psychosis and spirituality: Consolidating the new paradigm (2nd ed., pp. 101–114). Chichester: Wiley-Blackwell

Collins, N. (2010, July 28). Eccentrics 'could be diagnosed with mental disorders'. Retrieved 14 November 2013 from www.telegraph.co.uk/health/healthnews/7913122/Eccentrics-could-bediagnosed-with-mental-disorders.html

Craddock, N., & Mynors-Wallis, L. (2014). Psychiatric diagnosis: impersonal, imperfect and important. *The British Journal of Psychiatry*, *204*(2), 93-95.

Davar, B. V. (2008). From mental illness to disability. Indian Journal of Gender Studies, 15(2), 261–290

Cusack, K. J., Frueh, B. C., Hiers, T., Suffoletta-Maierle, S., & Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in*

Mental Health and Mental Health Services Research, *30*, 453-460.

De Vries, B., van Busschbach, J. T., van der Stouwe, E. C., Aleman, A., van Dijk, J. J., Lysaker, P. H., & Pijnenborg, G. H. (2019). Prevalence rate and risk factors of victimization in adult patients with a psychotic disorder: a systematic review and meta-analysis. *Schizophrenia bulletin*, *45*(1), 114-126.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric rehabilitation journal*, *19*(3), 91.

Dixon, L., Sanderson, C., Alexander, T., & Holt, L. (2018). A weird but interesting journey: personal traumatic growth for individuals with hallucinations. *J Psychol Psychother*, *8*(343), 2161-0487.

Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *Psychosis*, *5*(3), 286-295.

Division of Clinical Psychology (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift.* Leicester: British Psychological Society.

Dennison, M. (2019). IPA: The black swan of qualitative research.

De Gracia León-Palacios, M., Úbeda-Gómez, J., Escudero-Pérez, S., Barros-Albarán, M. D., López-Jiménez, A. M., & Perona-Garcelán, S. (2015). Auditory verbal hallucinations: can beliefs about voices mediate the relationship patients establish with them and negative affect?. *The Spanish journal of psychology*, *18*, E76.

De Jager, A., Rhodes, P., Beavan, V., Holmes, D., McCabe, K., Thomas, N., ... & Hayward, M. (2016). Investigating the lived experience of recovery in people who hear voices. *Qualitative health research*, *26*(10), 1409-1423.

Dos Santos, B., & Beavan, V. (2015). Qualitatively exploring hearing voices network support groups. *The Journal of Mental Health Training, Education and Practice*, *10*(1), 26-38.

Downs, J. (ed) (2001). Starting and Supporting Hearing Voices Groups: a guide to starting and facilitating hearing-voices groups. Hearing Voices Network: Manchester.

Dunkley JE, & Bates GW. (2015) Recovery and adaptation after first-episode psychosis: the relevance of posttraumatic growth. Psychosis 7: 130–140, 2015

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. The Sage handbook of qualitative research in psychology, 193-209.

Escher, S. & Romme, M. (2000). Interview with a person who hears voices, to be used in conjunction with *Making Sense of Voices*. London: Mind.

Emrich, L., Wood, L., & Taggart, D. (2021). The subjective experience of recovery from psychosis in an acute mental health inpatient setting. *Psychosis*, *13*(2), 154-166.

Farrugia, P., & Grech, P. (2023). The experience of hearing voices: challenges and coping mechanisms. *Issues in Mental Health Nursing*, *44*(12), 1254-1264.

Fernando, S. (2010). Mental health, race and culture (3rd ed.). Basingstoke: Palgrave Macmillan

Fernando, S. (2012). Race and culture issues in mental health and some thoughts on ethnic identity. *Counselling Psychology Quarterly*, *25*(2), 113-123.

Frame L, Morrison A (2001). Causes of posttraumatic stress disorder in psychotic patients. Archives of General Psychiatry 58, 305–306.

Fenekou, V., & Georgaca, E. (2010). Exploring the experience of hearing voices: A qualitative study. *Psychosis*, *2*(2), 134-143

Faulkner, A., and Thomas, P. (2002). User-led research and evidence-based medicine. Br. J. Psychiatry 180, 1–3. doi: 10.1192/bjp.180.1.1

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., ... & Hiers, T. G. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatric services, 56(9), 1123-1133.

Feste, C., & Anderson, R. M. (1995). Empowerment: from philosophy to practice. *Patient education and counseling*, *26*(1-3), 139-144.

Forchuk, C., Jewell, J., Tweedell, D., & Steinnagel, L. (2003). Reconnecting: The client experience of recovery from psychosis. *Perspectives in Psychiatric Care*, *39*(4), 141-150.

Gearing, R. E., Alonzo, D., Smolak, A., McHugh, K., Harmon, S. & Baldwin, S. (2011) Association of Religion With Delusions and Hallucinations in the Context of Schizophrenia: Implications for Engagement and Adherence. Schizophrenia Research, 126, 150–163.

Gladstone, B. M., Boydell, K. M., Seeman, M. V., & Mckeever, P. D. (2011). Children's experiences of parental mental illness: A literature review. Early Intervention in Psychiatry, 5(4), 271–289. https://doi.org/10.1111/j.1751-7893.2011.00287.x.

Grant, G., & Ramcharan, P. (2007). Valuing people and research: the learning disability research initiative-overview report.

Harris, R. (2019). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. New Harbinger Publications.

Hardy, A., Fowler, D., Freeman, D., Smith, B., Steel, C., Evans, J., ... & Dunn, G. (2005). Trauma and hallucinatory experience in psychosis. *The Journal of nervous and mental disease*, *193*(8), 501-507.

Hardy, A. (2017). Pathways from trauma to psychotic experiences: a theoretically informed model of posttraumatic stress in psychosis. *Frontiers in psychology*, *8*, 697.

Haddock, G., & Slade, P.D. (1996).Cognitive–behavioural interventions with psychotic disorders.New York: Routledge.

Hennink, M., Hutter, I., & Bailey, A. (2020). *Qualitative research methods*. Sage.

Heidgger, M. (1962 [1927]. *Being and Time.* Oxford: Blackwell

Steffen, E. (2013). Both ‘being with’and ‘doing to’: Borderline personality disorder and the

Hurtado, M. M., Villena-Jimena, A., Quemada, C., & Morales-Asencio, J. M. (2021). ‘I do not know where it comes from, I am suspicious of some childhood trauma’association of trauma with psychosis according to the experience of those affected. *European Journal of Psychotraumatology*, *12*(1), 1940759.

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *The Psychologist, 24*(10), 756–759.

Heriot-Maitland C, McCarthy-Jones S, Longden E, Gilbert P. Compassion Focused Approaches to Working With Distressing Voices. Front Psychol. 2019 Feb 1;10:152. doi: 10.3389/fpsyg.2019.00152. PMID: 30774614; PMCID: PMC6367219.

Holt, L., & Tickle, A. (2014). Exploring the experience of hearing voices from a first person perspective: A meta-ethnographic synthesis. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*(3), 278-297.

Holowka, D., King, S., Saheb, D., Pukall, M., & Brunet, A. (2003) Childhood abuse and dissociative symptoms in adult schizophrenia. *Psychosis Research, 60,* 87-90

https://Hearing -Voices.org

.James, A. (2001).Raising our voices: An account of the hearing voices movement. Gloucester: Handsell Publications.

Jansen, J. E., Pedersen, M. B., Trauelsen, A. M., Nielsen, H. G. L., Haahr, U. H., & Simonsen, E. (2016). The experience of childhood trauma and its influence on the course of illness in first-episode psychosis: A qualitative study. *The Journal of nervous and mental disease*, *204*(3), 210-216.

Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., de Graaf, R., & van Os, J. (2004). Childhood abuse as a risk factor for psychotic experiences. Acta Psychiatrica Scandinavica, 109(1), 38-45.

Jessop, M., Scott, J. & Nurcombe, B. (2008). Hallucinations in adolescent inpatients with post-traumatic stress disorder and Schizophrenia: Similarities and differences. Australasian Psychiatry, 16(4), 268-272. https://doi.org/10.1080/10398560801982580

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30-46.

Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*, 0022167818793289.

Jones, P., Rodgers, B., Murray, R., & Marmont, M. (1994) Child development risk factors for adult psychosis in the British 1946 cohort. *Lancet, 334,* 1398-1402

Johns, L. C., & Van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical psychology review*, *21*(8), 1125-1141.

Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*, 0022167818793289

Klapheck K, Lincoln TM, Bock T (2014) Meaning of psychoses as perceived by patients, their relatives and clinicians. Psychiatry Res 215: 760-765.

Kalhovde, A. M., Elstad, I., & Talseth, A. G. (2013). Understanding the experiences of hearing voices and sounds others do not hear. *Qualitative health research*, *23*(11), 1470-1480

Kasprow, M. C., & Scotton, B. W. (1999). A review of transpersonal theory and its application to the practice of psychotherapy. Journal of Psychotherapy Practice and Research, 8, 12–23.

Kalathil, J. (2008). Dancing to our own tunes: Reassessing black and minority ethnic mental health service user involvement. Modern: National Survivor User Network.

Kendler, K. S., & Schaffner, K. F. (2011). The dopamine hypothesis of schizophrenia: an historical and philosophical analysis. *Philosophy, Psychiatry, & Psychology*, *18*(1), 41-63.

Keller, K. D. (2008). Phenomenological understanding of psychosis. Existential Analysis, 19(1), 17–32

Kent, G. & Wahass, S. (1996) The Content and Characteristics of Auditory Hallucinations in Saudi Arabia and the UK: A Cross-Cultural Comparison. Acta Psychiatrica Scandinavica, 94, 433–437.

Kiser, S. (2004). An existential case study of madness: encounters with divine affliction. Journal of Humanistic Psychology, 44(4), 431–454

Lakeman, R. (2001). Making sense of the voices. *International Journal of Nursing Studies*, *38*(5), 523-531.

Larøi, F., Thomas, N., Aleman, A., Fernyhough, C., Wilkinson, S., Deamer, F., & McCarthy-Jones, S. (2019). The ice in voices: Understanding negative content in auditory-verbal hallucinations. *Clinical psychology review*, *67*, 1-10.

Larøi, F., & Luhrmann, T. M., Bell, V., Christian Jr, W. A., Deshpande, S., Fernyhough, C., ... & Woods, A. (2014). Culture and hallucinations: Overview and future directions. Schizophrenia bulletin, 40(4), 213–220

López-Jiménez, A. M., & Perona-Garcelán, S. (2015). Auditory verbal hallucinations: can beliefs about voices mediate the relationship patients establish with them and negative affect?. *The Spanish journal of psychology*, *18*, E76.

Law, H., & Morrison, A. P. (2014). Recovery in psychosis: a Delphi study with experts by experience. *Schizophrenia bulletin*, *40*(6), 1347-1355.

Lau, C. I., Wang, H. C., Hsu, J. L., & Liu, M. E. (2013). Does the dopamine hypothesis explain schizophrenia?. *Reviews in the Neurosciences*, *24*(4), 389-400.

Langlands, R., F. Jorm, A.F., Kelly, C.M. ,Kitchener, B.A., (2008) First Aid Recommendations for Psychosis: Using the

Lipschitz, D. S., Winegar, R. K., Nicolaou, A. L., Hartnick, E., Wolfson, M., & Southwick, S. M. (1999b). Perceived abuse and neglect as risk factors for suicidal behavior in adolescent inpatients. *The Journal of nervous and mental disease*, *187*(1), 32-39.

Delphi Method to Gain Consensus Between Mental Health Consumers, Carers, and Clinicians, *Schizophrenia Bulletin*, *34* Pages 435–443,

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British journal of psychiatry*, *199*(6), 445-452.

Longden, E., Corstens, D., Escher, S., & Romme, M. (2012). Voice-hearing in a biographical context: A model for formulating the relationship between voices 128 and life history. Psychosis: Psychological, Social and Integrative Approaches, 4(3), 224–234. https://doi.org/10.1080/17522439.2011.596566

Longden, E., Read, J., & Dillon, J. (2018). Assessing the impact and effectiveness of hearing voices network self-help groups. *Community mental health journal*, *54*, 184-188.

Laugharne R, Priebe S, McCabe R, Garland N, Clifford D (2012). Trust, choice and power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry*. 58(5):496-504. doi:10.1177/0020764011408658

Larkin, W., & Morrison, A. P. (Eds.). (2007). *Trauma and psychosis: New directions for theory and therapy*. Routledge.

Lu, W., Mueser, T, K., Shami, A., Siglag, M. Petrides, G., Schoepp, E., Putts, M., Saltz, J. (2011). *Post-traumatic reactions to psychosis in people with multiple psychotic episodes Schizophrenia Research,127*,66-75,

Luhrmann, T. M., Padmavati, R., Tharoor, H., & Osei, A. (2015). Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana: interview-based study. *The British Journal of Psychiatry*, *206*(1), 41-44.

Markowitz, F. E. (2011). Mental illness, crime, and violence: Risk, context, and social control. *Aggression and violent behavior*, *16*(1), 36-44.

Magliano, L., Read, J., Rinaldi, A., Costanzo, R., De Leo, R., Schioppa, G., et al. (2016). The influence of causal explanations and diagnostic labeling on psychology students' beliefs about treatments, prognosis, dangerousness and unpredictability in schizophrenia. Community Ment. Health J. 52, 361–369. doi: 10.1007/s10597-015-9901-5

May, R., & Longden, E. (2011). Rufus May. *Mental health recovery heroes past and present. Brighton: Pavilion*.

Menezes, A., & Moreira-Almeida, A. (2010). Religion, spirituality, and psychosis. Current PsychiatryReports, 12(3), 174–179. doi:10.1007/s11920-010-0117-7

Mawson, A., Berry, K., Murray, C., & Hayward, M. (2011). Voice hearing within the context of hearers' social worlds: An interpretative phenomenological analysis. Psychology and Psychotherapy:Theory,Research and Practice,84,256–272. doi:10.1348/147608310X524883

Mapplebeck, C., Joseph, S., & Sabin-Farrell, R. (2015). An interpretative phenomenological analysis of posttraumatic growth in people with psychosis. *Journal of Loss and Trauma*, *20*(1), 34-45.

Mazor, Yael. (2019). *Posttraumatic Growth in People with Serious Mental Illness and Psychosis*. University of Haifa (Israel)

Mazor, Y., M, Gelkoff, & D, R. (2020). Posttraumatic growth in psychosis: Challenges to the assumptive world. *Psychological trauma: Theory, research, practice and policy, 12* 3-10

McCarthy-Jones, S., Waegeli, A. & Watkins, J. (2013) Spirituality and Hearing Voices: Considering the Relation. Psychosis, 5, 247–258.

McCarthy-Jones, S., Trauer, T., Mackinnon, A., Sims, E., Thomas, N., & Copolov, D. L. (2014). A new phenomenological survey of auditory hallucinations: evidence for subtypes and implications for theory and practice. *Schizophrenia bulletin*, *40*(1), 231-235.

McCarthy-Jones, S., Castro Romero, M., McCarthy-Jones, R., Dillon, J., Cooper-Rompato, C., Kieran, K., ... & Blackman, L. (2015). Hearing the unheard: an interdisciplinary, mixed methodology study of women’s experiences of hearing voices (auditory verbal hallucinations). *Frontiers in Psychiatry*, *6*, 181.

McGlashan, T. H., & Levy, S. T. (2019). Sealing-over in a Therapeutic Community. *Psychiatry*, *82*(1), 1-12.

Middleton, K., Cooke, A., & May, R. (2024). “It allowed us to let our pain out”: perspectives from voice-hearers and their voices on the ‘talking with voices’ approach. *Psychosis*, *16*(2), 131-143.

Moodley, R., & Ocampo, M. (2014). Critical psychiatry and mental health. *New York and London: Routledge*.

Manzo, J. F. (2004). On the sociology and social organization of stigma: Some ethnomethodological insights. *Human Studies*, *27*(4), 401-416.

Marsh, J. J., Narita, Z., Zhai, F., Fedina, L., Schiffman, J., & DeVylder, J. (2022). Violence exposure, psychotic experiences, and social disconnection in an urban community sample. *Psychosis*, *14*(1), 57-69.

Meddings, S. (1998). A hearing voices group for people who are cognitively disorganised: challenges to group work. Clinical Psychology Forum, 112, 14 – 17.

Mueser KT, Goodman LB, Trumbetta SL, Rosenberg SD, Osher FC, Vidaver R, Aucellio P, Foy DW (1998). Trauma and posttraumatic stress disorder in severe mental illness

Mueser, K. T., Lu, W., Rosenberg, S. D., & Wolfe, R. (2010). The trauma of psychosis: posttraumatic stress disorder and recent onset psychosis. *Schizophrenia research*, *116*(2-3), 217-227.

Murphy,J., Shevlin,M., Hyland,P., Christoffersen,M., Elklit,A ., & Bentall,R. (2018) Reconsidering the association between psychosis and suicide: a suicidal drive hypothesis, Psychosis, 10:4, 286-297, DOI: 10.1080/17522439.2018.1522541

Neria Y, Bromet E, Sievers S, Lavelle J, Fochtman L (2002). Trauma exposure and post-traumatic stress disorder in psychosis: findings from a first admission cohort. Journal of Consulting and Clinical Psychology 70, 246–251.

Nixon, G., Hagen, B., & Peters, T. (2009). Psychosis and transformation: a phenomenological inquiry. International Journal of Mental Health and Addictions. doi:10.1007/s11469-009-9231-3.

Ng, F., Ibrahim, N., Franklin, D., Jordan, G., Lewandowski, F., Fang, F., Roe, D., Rennick-Egglestone, S., Newby, C., Hare-Duke, L., Llewelyn-Beardsley, J., Yeo, C., Slade, M. (2021). Posttraumatic growth in psychosis: A systematic review and narrative synthesis. Research Square DOI: https://doi.org/10.21203/rs.3.rs-635515/v1

Noll, R. (2009). *The encyclopedia of schizophrenia and other psychotic disorders*. Infobase Publishing.

Nilsen L, Frich JC, Friis S, et al: Participants' perceived benefits of family intervention following a first episode of psychosis: a qualitative study. Early Intervention in Psychiatry 10:152–159, 2016

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, *16*(1).

Oakland, L., & Berry, K. (2015). "Lifting the veil": a qualitative analysis of experiences in Hearing Voices Network groups. *Psychosis*, *7*(2), 119-129.

O'TOOLE, M. S., Ohlsen, R. I., Taylor, T. M., Purvis, R., Walters, J., & Pilowsky, L. S. (2004). Treating first episode psychosis– the service users' perspective: a focus group evaluation. *Journal of Psychiatric and Mental Health Nursing*, *11*(3), 319-326.

Payne, T., Allen, J., & Lavender, T. (2017). Hearing Voices Network groups: experiences of eight voice hearers and the connection to group processes and recovery. *Psychosis*, *9*(3), 205-215.

Patel, N., & Rapley, M. (2011). De-Medicalising Misery: Psychiatry, Psychology and the Human Condition.

Parker, I. and Shotter, J. (eds) (1990) Deconstructing Social Psychology. Routledge

Pietruch, M., & Jobson, L. (2012). Posttraumatic growth and recovery in people with first episode psychosis: an investigation into the role of self-disclosure. *Psychosis*, *4*(3), 213-223.

Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: a user-led project. *Psychiatric Bulletin*, *31*(2), 55-60.

Perry, M.B., Taylor, D., & Shaw, K.S. (2009). You have got to have a positive state of mind. An Interpretative Phenomenological Analysis of hope and first episode psychosis. *Journal of mental health, 16,* 781-793

Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G., & Morgan, C. (2002). Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological medicine*, *32*(5), 763-782.

Pietruch, M., & Jobson, L. (2012). Posttraumatic growth and recovery in people with first episode psychosis: an investigation into the role of self-disclosure. *Psychosis*, *4*(3), 213-223.

Radley, J., Barlow, J., & Johns, L. C. (2023). A family perspective on parental psychosis: An interpretative phenomenological analysis study. *Psychology and Psychotherapy: Theory, Research and Practice*, *96*(2), 347-363.

Rácz, J., Kaló, Z., Kassai, S., Kiss, M., & Pintér, J. N. (2017). The experience of voice hearing and the role of self-help group: An interpretative phenomenological analysis. *International Journal of Social Psychiatry*, *63*(4), 307-313.

Raune, D., Bebbington, P., Dunn, G., & Kuipers, E. (2006). Event attributes and the content of psychotic experiences in first-episode psychosis. *Psychological Medicine*, *36*(2), 221-230.

Rapley, M., Moncrieff, J., Dillion, J. (2011). *De-medicalising Misery: Psychiatry, Psychology and the human condition.* Palgrave Macmillian

Ross, C. A., Anderson, G., & Clark, P. (1994). Childhood abuse and the positive symptoms of schizophrenia. *Psychiatric Services*, *45*(5), 489-491.

Romme, M.A.J., & Escher, S. (2000). Making sense of voices: A guide for professionals working with voice hearers. London: MIND Publications.

Romme, M., Escher, S., Dillon, J., Corstens, D., & Morris, M. (2009). *Living with voices: 50 stories of recovery*. PCCS books

Romme, M. A., & Escher, A. D. (1989). Hearing voices. Schizophrenia Bulletin, 15(2), 209–216.

Romme, M., Escher, A. (1993). *Accepting voices*. London: MIND Publications.

Romme, M., Escher, S., Dillon, J., Corstens, D., & Morris, M. (2009). *Living with voices: 50 stories of recovery*. PCCS books.

Romme, M., Escher, S., & Dillon, J. (2013). The voices others cannot hear. *Psychiatry*, *169*, 719-724.

Romme, M., & Morris, M. (2013) The recovery process with hearing voices: accepting as well as exploring their emotional background through a supported process, Psychosis, 5:3, 259-269, DOI: 10.1080/17522439.2013.830641

Romme, M. A. J., Honig, A., Noorthoorn, E. O., & Escher, A. D. M. A. C. (1992). Coping with hearing voices: An emancipatory approach. *The British Journal of Psychiatry*, *161*(1), 99-103.

Rosen, C., McCarthy-Jones, S., Jones, N., Chase, K. A., & Sharma, R. P. (2018). Negative voice-content as a full mediator of a relation between childhood adversity and distress ensuing from hearing voices. Schizophrenia Research, 199, 361-366

Read, J., Bentall, R., Mosher, L., & Dillon, J. (Eds.). (2013). *Models of madness: Psychological, social and biological approaches to psychosis*. Routledge.

Read, J., & Argyle, N. (1999). Hallucinations, delusions, and thought disorder among adult psychiatric inpatients with a history of child abuse. *Psychiatric Services*, *50*(11), 1467-1472.

Ruddle, A., Mason, O., & Wykes, T. (2011). A review of hearing voices groups: Evidence and mechanisms of change. *Clinical psychology review*, *31*(5), 757-766.

Sampson, M., & Read, J. (2017). Are mental health staff getting better at asking about abuse and neglect?. *International journal of mental health nursing*, *26*(1), 95-104.

Schnackenberg, J. K., Fleming, M., & Martin, C. R. (2018). Experience focused counselling with voice-hearers as a trauma-sensitive approach. Results of a qualitative thematic enquiry. Community Mental Health Journal. https://doi.org/10.1007/s10597-018-0294-0

Schaefer, B., Boumans, J., Van Os, J., & Van Weeghel, J. (2021). Emerging processes within peer-support Hearing Voices Groups: A qualitative study in the Dutch context. *Frontiers in Psychiatry*, *12*, 647969

Schrank, B., Riches, S., Bird, V., Murray, J., Tylee, A., & Slade, M. (2014). A conceptual framework for improving well-being in people with a diagnosis of psychosis. *Epidemiology and psychiatric sciences*, *23*(4), 377-387.

Seeman, M. V. (2010). Parenting issues in mothers with schizophrenia. *Current Women's Health Reviews*, *6*(1), 51-57.

Sheffield, J. M., Williams, L. E., Blackford, J. U., & Heckers, S. (2013). Childhood sexual abuse increases risk of auditory hallucinations in psychotic disorders. Comprehensive Psychiatry, 54(7), 1098–1104.

Shevlin, M., Murphy, J., Read, J., Mallett, J., Adamson, G., & Houston, J. (2010). Childhood adversity and hallucinations: A community-based study using the national comorbidity survey replication. Social Psychiatry and Psychiatric Epidemiology. https://doi.org/10.1007/s00127-010-0296-x

Shevlin, M., Dorahy, M., & Adamson, G. (2007). Childhood traumas and hallucinations: an analysis of the National Comorbidity Survey. *Journal of psychiatric research*, *41*(3-4), 222-228.

Smith, J. A., Osborn, M. (2008). Interpretative phenomenological analysis. In: Smith, J. A., (Ed.), Qualitative psychology: A practical guide to research methods (pp. 25-52). Sage Publications.

Sinha, N., & Ranganathan, S. (2020). Living with voices: A thematic analysis of individuals' experiences of voice-hearing in India. *Psychosis*, *12*(2), 115-127.

Silverstein, S. M., & Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical psychology review*, *28*(7), 1108-1124.

Solesvik, M., Joa, I., Larsen, T. K., Langeveld, J., Johannessen, J. O., Bjørnestad, J., Liss, G. A., Gisselgård, J., Velden Hegelstad, W., & Brønnick, K. (2016). Visual hallucinations in first-episode psychosis: Association with childhood trauma. PLoS ONE, 11(5).

Smith, J. A., Larkin, M., & Flowers, P. (2021). Interpretative phenomenological analysis: Theory, method and research.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative research in psychology*, *1*(1), 39-54.

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.

Steffen, E. (2013). Both 'being with'and 'doing to': Borderline personality disorder and the

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych advances*, *24*(5), 319-333.

Szasz, T. S. (1960). The myth of mental illness. *American psychologist*, *15*(2), 113.

Subandi, MA., Bangkit (2015) the processes of recovery from first episode psychosis in Java. Culture, *Medicine and Psychiatry, 39,*:597–613

Stephane, M., Thuras, P., Nasrallah, H., & Georgopoulos, A.P. (2003). The internal structure of the phenomenology of auditory hallucinations.Schizophrenia Research,61,185–193.

Tanskanen, S., Morant, N., Hinton, M., Lloyd-Evans, B., Crosby, M., Killaspy, H., & Johnson, S. (2011). Service user and carer experiences of seeking help for a first episode of psychosis: a UK qualitative study. *BMC psychiatry*, *11*, 1-11.

Tait, L., & Birchwood, M. (2004). Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies. *The British Journal of Psychiatry*, *185*(5), 410-415.

Tien, A. Y. (1991). Distributions of hallucinations in the population. Social Psychiatry and Psychiatric Epidemiology 26, 287–292

Tedeschi, R., & Calhoun, L. (2004). Posttraumatic Growth: Conceptual foundations and empirical evidence, *Psychological Inquiry, 15 1-18*

Tedeschi, R., Shakespeare-Finch, .J., Taku, K., & Calhoun, L. (2018). Posttraumatic growth. Theory, research and applications. Taylor and Francis

Quest, T., & Marco, C. A. (2003). Ethics seminars: vulnerable populations in emergency medicine research. *Academic Emergency Medicine*, *10*(11), 1294-1298.

Valavanis, S., Thompson, C., & Murray, C. D. (2019). Positive aspects of voice-hearing: A qualitative metasynthesis. *Mental health, religion & culture*, *22*(2), 208-225.

van Os, J., Hanssen, M., Bijl, R., & Ravelli, A., (2000). Strauss (1969) revisited: A psychosis continuum in the general population? Schizophrenia Research. 45(1–2), 11–20

Ventegodt, S., Andersen, N. J., Neikrug, S., Kandel, I., & Merrick, J. (2005). Clinical holistic medicine: mental disorders in a holistic perspective. The Scientific World Journal, 5, 313–323.

Waite, F., Knight, M. T., & Lee, D. (2015). Self-compassion and self-criticism in recovery in psychosis: An interpretative phenomenological analysis study. *Journal of clinical psychology*, *71*(12), 1201-1217.

Watson, J. (2019). *Drop the disorder! Challenging the culture of psychiatric diagnosis.* PCCS Books

Walker, M. T. (2005). The social construction of mental illness and its implications for the recovery model. *International Journal of Psychosocial Rehabilitation*, *10*(1).

Wahl, P., Bruland, D., Bauer, U., Okan, O., & Lenz, A. (2017). What are the family needs when a parent has mental health problems? Evidence from a systematic literature review. Journal of Child and Adolescent Psychiatric Nursing, 30(1), 54–66. https://doi. org/10.1111/jcap.12171.

Whitfield, C. L., Dube, S. R., Felitti, V. J., & Anda, R. F. (2005). Adverse childhood experiences and hallucinations. Child Abuse and Neglect, 29(7), 797-810.

Wood, L., Price, J., Morrison, A., & Haddock, G. (2010). Conceptualisation of recovery from psychosis: a service-user perspective. *The Psychiatrist*, *34*(11), 465-470. inquiry. International Journal of Mental Health and Addictions. doi:10.1007/s11469-009-9231-3.

Wilber, K. (1986). The spectrum of psychopathology. In K. Wilber, J. Engler, & D. Brown (Eds.), Tranformations of consciousness (pp. 65–106). Boston: Shambhala.

Willig, C., & Rogers, W. S. (Eds.). (2017). *The SAGE handbook of qualitative research in psychology*. Sage.

Wilber, K. (2000). Integral psychology. Boston: Shambhala.

Wciórka, J., Świtaj, P., & Anczewska, M. (2015). The stages of recovery in relation to the other subjective and objective aspects of psychosis. *Psychiatry research*, *225*(3), 613-618.

Zimmerman, M. A. (1995). Psychological empowerment: Issues and illustrations. *American journal of community psychology*, *23*, 581-599.

Appendices

Ventegodt, S., Andersen, N. J., Neikrug, S., Kandel, I., & Merrick, J. (2005). Clinical holistic medicine: mental disorders in a holistic perspective. The Scientific World Journal, 5, 313–323.

Valavanis, S., Thompson, C., & Murray, C. D. (2019). Positive aspects of voice-hearing: A qualitative metasynthesis. *Mental health, religion & culture*, *22*(2), 208-225.

Wahl, P., Bruland, D., Bauer, U., Okan, O., & Lenz, A. (2017). What are the family needs when a parent has mental health problems? Evidence from a systematic literature review.

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4th November 2022

Nzinga Akinshegun

Dear Nzinga

Application title: What doesn't kill you makes you stronger: An IPA study looking into the effects of posttraumatic growth with people with multiple episodes of psychosis

Thank you for responding to the conditions raised in my letter to you of 1st of November 2022.

I can now confirm full ethics approval for your project, but please note that with the move towards living with COVID in England and across the devolved nations, guidance as set by the UK Government and the relevant devolved administrations has been updated, with much being removed in England by 1 April 2022. If you have any questions about how this may affect starting or continuing your research project or for further information, please contact res.admin@uwe.ac.uk. For research governance guidance, please contact researchgovernance@uwe.ac.uk. Please also refer to UWE Bristol Coronavirus advice

Participant information sheet

1. **Study title**

   What doesn't kill you makes you stronger: A study looking into the effects of posttraumatic growth in people with multiple episodes of psychosis.

2. **A bit about the researcher:** The researcher has worked for the NHS for the last six years as a therapist. She has an undergraduate degree in psychology and sociology, an Msc in Forensic Psychology and a PGDIP in CBT. She also has personal experience of psychosis/schizophrenia. I am currently undertaking my doctorate research in counselling psychology with the University West of England.

3. **Invitation**

   You are invited to take part in research taking place at the University of the West of England, Bristol. The researcher would like to understand how people who have experienced multiple episodes of psychosis flourish and grow stronger from their experience of psychosis. Please read this information sheet carefully and if you have any queries or would like more information, please contact Nzinga Akinshegun, Faculty of Health and Social Science, University of the West of England, Bristol Nzinga2.Akinshegun@live.uwe.ac.uk

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

   The lead researcher is Nzinga Akinshegun, and my supervisor is Dr. Eva Fragkiadaki: Eva.Fragkiadaki@uwe.ac.uk. The sponsor of the study is The University West of England.

5. **What is the aim of the research?**

   The research is looking at the experience of how people who experience multiple episodes of psychosis grow and flourish from their encounter. To help answer these questions I will be conducting individual interviews. The aim of the interviews will be to collect information that will be made anonymous. This information will be about how you have made sense of your experiences of psychosis and how you have potentially grown from it. We will be recruiting between 4-10 participants for this study. The results of the study will be analysed looking at themes and ideas that you the participant come up with during the interview. The anonymised results will be disseminated in peer reviewed journals and conferences.

6. **Why have I been invited to take part?**

   You have been approached for this study as I am interested in gaining information about your experience of mental health/psychosis, so the interview will ask you about these things. I am looking for both male, female, and non-binary individuals and ages between 18-80. The purpose of the questions will be to gain information about your experience of mental health, and how you have managed it.

7. **Do I have to take part?**

   You do not have to take part in this research. It is up to you to decide whether you want to be involved. If you do decide to take part, you will be given a copy of this information sheet to keep and will be asked to sign a consent form. You will be given an opportunity to ask any questions you may have and to discuss your potential participation with family and friends. If you do decide to take part, you are able to withdraw from the research project at any point without having to give a reason. If you do withdraw from the study, your access to care and legal rights will not be affected in anyway. If you do decide to withdraw from the study you will have 14 days after the interview to request your information is securely destroyed by writing to Nzinga2.Akinshegun@live.uwe.ac.uk after which the data may still be used in the research project. If you decide not to take part or withdraw from the study, you do not have to give a reason, and this will not affect the standard of care you receive.

8. **What's involved?**

   The first stage of the process is for you to decide whether you want to partake in the study, and for the researcher to answer any questions you may have. If you agree to this, an appointment will be made to obtain your full and informed consent to participate in the study. Once this has been obtained I will tape record an interview with you about your experience of psychosis/schizophrenia. The interview will last approximately 30-60 minutes. After the interview has taken place, you will have an opportunity to debrief and speak with the researcher and to ask any questions you may have. You will also be given helpline numbers for any extra support you may need after the study has ended. Your audio recording will then be transcribed and analysed, and once this has happened your interview will be deleted. However, the anonymised transcripts maybe used for future analysis and/or publication.

9. **What are the benefits of taking part in the research?**

Taking part in the research may mean you provide valuable knowledge for both the public and academics on what it means to live with psychosis/schizophrenia. You may also find it beneficial to discuss how you have managed to move on from your illness and what it means to grow from this experience, you will be lending your voice to this area of study.

10. **What are the possible risks of taking part?**

We do not foresee or anticipate any significant risk to you in taking part in this study. If, however, you feel uncomfortable at any time during the interview you may request it to stop. If you need any support during or after the interview has ended, then the researchers will be able to put you in touch with suitable support agencies during the debrief aspect of the process. However, you will be encouraged to speak with your personal support network should you need any further/additional support. In addition, you will have an opportunity to speak with me to discuss how you are feeling after the interview has ended and you will be provided with helpline numbers that you can use after the interview has ended.

11. **What will happen to your information?**

All the information we receive from you will be treated in the strictest confidence. All the information that you give will be kept confidential and anonymised. The only circumstance where we may not be able to keep your information confidential is if you disclose a risk of harm to yourself or others. In this case we may have to pass relevant information to appropriate agencies in order to keep you and those around you safe. You will also be asked to provide emergency contact details so that if we had any concerns about you, we would know who to contact in the first instance. This can either be a professional you are involved with or someone you trust from your existing support network. You will also be provided with support numbers (please see below) if we are concerned about you and will encourage you to contact any existing personal and professional support should we have concerns about you. Research material will be kept on password protected UWE research laptops and stored on the one cloud UWE system. Voice recordings will be destroyed securely immediately after anonymised transcription. Your anonymised data will be analysed together with other interview and file data, and we will ensure that there is no possibility of identification or re-identification from this point.

12. **Withdrawing from the study, what happens to my data?**

You are allowed to withdraw from the study at any time without having to give a reason and your treatment and rights will not be affected in anyway. You will have 14 days from the point of the interview to withdraw from the study, by written email communication, after which your data may still be used.

13. **Who will have access to my information?**

Only those from the research team will have access to information from the study as it is being completed. However, this will be in the form of anonymised transcribed interviews. This will include the student researcher and the two supervisors overseeing the project (Dr. Eva Fragkiadaki and Dr. Zoe Thomas).

14. **How will my information be kept confidential?**

All information will be held digitally on password protected UWE computers. There will be no identifiable information linked to you during the analysis of the study or when it is published e.g., appropriate pseudonyms will be used throughout the research project. In addition, a copy of the consent form will be securely held. Furthermore, if the researcher is concerned about your safety or anyone around you, the researcher will be obliged to follow best practice and safeguarding guidelines to help protect you and those around you.

15. What will happen to the results of the study?

A Report will be written containing the research findings. This report will be available on the University of the West of England's open-access Research Repository, and in peer reviewed journals. A hard copy of the report will be made available to all research participants if you would like to see it. Key findings will also be shared both within and outside the University of the West of England. Anonymous and non-identifying direct quotes may be used for publication and presentation purposes.

17. Who has ethically approved this research?

The project has been reviewed and approved by the Faculty of Health and Social Science/University of the West of England University. Any comments, questions, or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at: Researchethics@uwe.ac.uk

18. What if something goes wrong during the study?

If something goes wrong during the study, such as your mental health is affected, you have the right to request that the study is stopped and/or you to take a break from the interview. You have the right not to answer any question and move to the next one and can have time to compose yourself during the interview. If you withdraw from the study, your right to treatment will not be affected in anyway and you will be able to see and use any existing personal or professional support network as usual/normal. If you would like to make a complaint, ask a question or feedback about the study you can contact the supervisor of the study: Eva.Fragkiadaki@uwe.ac.uk.

19. What happens next?

Once you have had time to consider the risks and benefits of taking part in the study, we will then set up your first appointment, where I will verbally explain this information to you and provide you with a chance to answer any questions you may have. If you wish to go ahead at that point, you will then be asked to sign a consent form. Or you can have more time to decide if you wish. You will have up to a maximum of five days to decide if you would like to take part in the study.

20. How long do we keep your data for?

Your personal data will only be retained for as long as is necessary to fulfil the cited purpose of the research.

21. Further contact details (supervisors etc)

Eva.Fragkiadaki@uwe.ac.uk (research supervisor)
Nzinga.Akinshegun2@live.uwe.ac.uk (student)

If, after the interview you find yourself in distress and would like to speak with someone for support, then please call the below numbers-they are there to help.

- Samaritans:116,123 (A 24 hr emotional support line for anyone to call who maybe in distress)
- E: Jo@Samaritans.org (they will respond within 24 hrs)
- Mindline in Somerset: 01823276892 or freephone 08001381692 (open 24 hrs a day, 7 days a week for emotional support)
- Text shout: 85258 (free text-based service that take people from crisis to calm)
- NHS: 111
- 999 in an emergency

UWE privacy notice:

Your personal information will be processed by the University in accordance with the provisions and principles of the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act, 2018 as enacted and amended by UK legislation. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law.

Please Note: *If you have not already been provided with one, then please request a privacy notice from the researcher who gave you this information sheet.*

Thank you.

UWE Bristol University of the West of England

Participant Consent Form

What doesn't kill you makes you stronger: An IPA study looking into the effects of posttraumatic growth in people who experience multiple episodes of psychosis

This consent form will have been given to you with the Participant Information Sheet. Please ensure that you have read and understood the information contained in the Participant Information Sheet and asked any questions before you sign this form. If you have any questions please contact a member of the research team, whose details are set out on the Participant Information Sheet

If you are happy to take part in this interview research project, please sign and date the form. You will be given a copy to keep for your records.

- I have read and understood the information in the Participant Information Sheet which I have been given to read before asked to sign this form;
- I have been given the opportunity to ask questions about the study;
- I have had my questions answered satisfactorily by the research team;
- I agree that anonymised quotes may be used in the final Report of this study;
- I understand that my participation is voluntary and that I am free to withdraw at any time until the data has been anonymised, without giving a reason;
- I understand I will be required to provide emergency contact details (either personal or professional) and that such person(s) maybe contacted if the research team has concerns about me and those around me
- I agree to take part in the research

Name (Printed)…………………………………………………………………….

Signature…………………………………………………. Date…………………….

What doesn’t kill you makes you stronger: An Interpretive Phenomenological Study looking into the effects of posttraumatic growth in people with multiple episodes of psychosis

Some questions about you

In order for me to learn about the range of people taking part in this research, and to describe the broad characteristics of my participant group in my report, I would be grateful if you could answer the following questions. Please write your answer in the space provided. All these questions are optional – if you prefer not to answer a question please leave the space blank. Please note that the information provided by all participants will be aggregated.

1	*How old are you?*		
2	*How would you describe your sex/gender?*		
3	*How would you describe your occupation?*		
4	*How would you describe your sexuality?*		
5	*How would you describe your racial/ethnic background?* *(e.g., White; Black; White Jewish; Asian Muslim)*		
6	*How would you describe your social class?* *(e.g., working class; middle class; no class category)*		
7	*Do you consider yourself to be disabled?*	*Yes*	*No*
7a	*In your own words how would you describe your current mental health status?*		

8	*What words do you use when describing, thinking and talking about your mental health?*		
9	*Have you currently, or in the past ever been officially diagnosed with a mental health problem (e.g., by a Psychologist, GP, CPN, Psychiatrist or other mental health professional?)*		
10	*If yes - please tell me about the nature of your disability. How does it affect you and your life?*	________________________	
11	*Have you been hospitalized in relation to your mental health in the last six months?*	________________________	
12	*Have you had any suicidal thoughts in the last six months? Y/N* *If yes, please may you describe the nature of these thoughts (Please note: This will be treated in the strictest of confidence and information will only be shared with relevant professionals if the researcher and her team deem you to be a risk to yourself and others)*		
13	*Please provide the name, number and email address of an emergency contact so that if we had any concerns, we would know who to alert.* *If you do not have a personal contact, then please provide the name of a health care professional you are involved with, such as a Gp or mental health nurse.*		

PLEASE NOTE: *While we do not foresee any significant emotional risk to you partaking in the study, for your safety and with your permission, I will contact your nominated emergency contact (via email) to let them know you will be partaking in the study at a specific date and time, and if they could make themselves available for that specific date and time, in case I need to phone/email them in case of an emergency.*

If agreed, please fill in and sign below:

My emergency contact name is:…………………………………………………………

My emergency contact phone number is:…………………………………………………………

My emergency contact email address is:…………………………………………………………..

I agree to the above……………………………(signature)

Print name here:………………………………………..

This information will be treated in the strictest of confidence.

Thank you!

This research has been approved by the UWE Health and Applied Sciences Faculty Research Ethics Committee (FREC)

UWE Bristol | University of the West of England

Privacy Notice for Research Participants – [What doesn't kill you makes you stronger: An IPA study looking into the effects of posttraumatic growth with people with multiple episodes of psychosis]

Purpose of the Privacy Notice

This privacy notice explains how the University of the West of England, Bristol (UWE Bristol) collects, manages and uses your personal data before, during and after you participate in **the study of IPA and those who have undergone multiple episodes of psychosis.** 'Personal data' means any information relating to an identified or identifiable natural person (the data subject).

This privacy notice adheres to the General Data Protection Regulation (GDPR) principle of transparency. This means it gives information about:

- How and why your data will be used for the research;
- What your rights are under GDPR; and
- How to contact UWE Bristol and the project lead in relation to questions, concerns or exercising your rights regarding the use of your personal data.

This Privacy Notice should be read in conjunction with the Participant Information Sheet and Ethical Consent Form provided to you before you agree to take part in the research.

Why are we processing your personal data?

UWE Bristol undertakes research under its public function to provide research for the benefit of society. As a data controller we are committed to protecting the privacy and security of your personal data in accordance with the (EU) 2016/679 the General Data Protection Regulation (GDPR), the Data Protection Act 2018 (or any successor legislation) and any other legislation directly relating to privacy laws that apply (together "the Data Protection Legislation"). General information on Data Protection law is available from the Information Commissioner's Office (https://ico.org.uk/).

How do we use your personal data?

We will only process your personal data when the law allows us to. In addition, we will always comply with UWE Bristol's policies and procedures in processing your personal data. Our lawful basis for using your personal data for research purposes is fulfilling tasks in the public interest, and for archiving purposes in the public interest, for scientific or historical research purposes.

“Our lawful basis for using your special category personal data for research purposes is Article 9 (j) Archiving, research and statistics (with a basis in law) by virtue of paragraph 4 of Schedule 1 of the DPA 2018**”**

You can find out more information about lawful bases at the following webpage:

https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/

We will always tell you about the information we wish to collect from you and how we will use it. We will not use your personal data for automated decision making about you or for profiling purposes.

Our research is governed by robust policies and procedures and, where human participants are involved, is subject to ethical approval from either UWE Bristol’s Faculty or University Research Ethics Committees. This research has been approved by UWE Research Ethics (researchethics@uwe.ac.uk)

The research team adhere to the the principles of the General Data Protection Regulation (GDPR).

For more information about UWE Bristol’s research ethics approval process please see our Research Ethics webpages at www1.uwe.ac.uk/research/researchethics

What data do we collect?

The data we collect will vary from project to project. Researchers will only collect data that is essential for their project. The specific categories of personal data processed are described in the Participant Information Sheet provided to you with this Privacy Notice.

Who do we share your data with?

We will only share your personal data in accordance with the attached Participant Information Sheet.

How do we keep your data secure?

We take a robust approach to protecting your information with secure electronic and physical storage areas for research data with controlled access. Access to your personal data is strictly controlled on a need to know basis and data is stored and transmitted securely using methods such as encryption and access controls for physical records where appropriate.

Alongside these technical measures there are comprehensive and effective policies and processes in place to ensure that those who process your personal information (such as researchers, relevant University administrators and/or third-party processors) are aware of their obligations and responsibilities for the data they have access to.

By default, people are only granted access to the information they require to perform their duties. Mandatory data protection and information security training is provided to staff and expert advice available if needed.

How long do we keep your data for?

Your personal data will only be retained for as long as is necessary to fulfil the cited purpose of the research. The length of time we keep your personal data will depend on several factors including the significance of the data, funder requirements, and the nature of the study. Specific details are provided in the attached Participant Information Sheet

Anonymised data that falls outside the scope of data protection legislation as it contains no identifying or identifiable information may be stored in UWE Bristol's research data archive or another carefully selected appropriate data archive.

Your Rights and how to exercise them

Under the Data Protection legislation, you have the following **qualified** rights:

(1) The right to access your personal data held by or on behalf of the University;
(2) The right to rectification if the information is inaccurate or incomplete;
(3) The right to restrict processing and/or erasure of your personal data;
(4) The right to data portability;
(5) The right to object to processing;
(6) The right to object to automated decision making and profiling;
(7) The right to complain to the Information Commissioner's Office (ICO).

We will always respond to concerns or queries you may have. If you wish to exercise your rights or have any other general data protection queries, please contact UWE Bristol's Data Protection Officer (dataprotection@uwe.ac.uk).

If you have any complaints or queries relating to the research in which you are taking part please contact either the research project lead, whose details are in the attached Participant Information Sheet or UWE Bristol’s research governance manager (researchgovernance@uwe.ac.uk.).

Interview Schedule

..Rapport building

How are you?

Did you find it here okay?

How did you get here?

Would you like a glass of water?

What did you do at the weekend?

How is the weather where you came from?

General questions about psychosis:

In your own words, what words do you use to describe your mental health? (e.g. do you use any official labels, medical terms or something more personal to you?)

Note: if the participant does use any special labels to speak about their mental health, ask permission from the participant to use their own language throughout the interview, otherwise keep it generic and speak about "mental health"

How would you describe your mental health at the moment?

Prompts e.g., wellness, not well, on a journey etc.

Are there any changes you have made personally to get to a better place when it comes to your mental health?

Do you tend to differentiate between your experiences of mental health experiences?

If the person can distinguish between different experiences then ask the following questions below otherwise move onto the other questions:

Multi-experiences/occurrences:

How has having more than one experience of mental health challenge affected you?

What has been the biggest change for you as a person in having more than one experience of mental health?

How do you view yourself now that you have gone through more than one experience of a mental health challenge?

Can you describe what it was like having more than one experience/occurrence of mental health challenges?

How did it feel to have more than one experience of mental health occurrence?

What sorts of thoughts did you have about yourself, other people, and the world in general when you went through more than one experience of mental health?

How did it affect your behaviour, going through more than one experience of mental health?

How do you think your personal relationships have changed since you experienced mental health challenges?

Since having mental health challenges how would you describe your inner strength? (Prompts: how has it changed you? If at all. Has your experience made you stronger or weaker in anyway?)

Has anything changed in importance for you now that you have undergone mental health challenges? Prompts: changed priorities? Work? Education? Relationships? Children?

Have you developed a belief in anything since going through mental health challenges? Prompts spiritually for example.

How do you view life now that you have experienced mental health challenges? (do you appreciate it, not, or lie somewhere in between?)

How would you describe your relationship with yourself since going through mental health challenges?

How would you describe your levels of self-esteem since going through mental health challenges?

Has having mental health challenges taught you anything about yourself, the world, other people, and the future?

Debrief sheet

Thank you for your participation.

If you feel you need to talk to someone after the interview has ended, then in the first instance you should speak to a member of your support network.

I would also encourage you to call some helpline and/or emergency numbers should you feel the need to do so.

Help is out there.

- Samaritans:116,123
- E: Jo@Samaritans.org (they will respond within 24 hrs)
- Mindline in Somerset: 01823276892 or freephone 08001381692 (open 24 hrs a day, 7 days a week for emotional support)
- Text shout: 85258 (free text-based service that take people from crisis to calm)
- NHS: 111
- 999 in an emergency

TRANSCRIPT OF RECORDED INTERVIEW

R HVN interview 30.05.23

Persons Present

Interviewer (I)

Participant (P)

I: Okay. So, welcome, X. Thank you very much for agreeing to take part and for signing the consent forms – very, very grateful for that. So, as you know, as I was saying, this is an interview all about your experiences of mental health, really. And I'm just very interested to know about your experiences of mental health and how it's affected you. Please feel free to say as little or as much as you would like – the more, the better but whatever comes to mind, whatever you want to, feel free to share as much or as little as you like. I'll be listening closely and following up with some questions, you know, as and when required, basically. There are no right or wrong answers, so it's literally just what you feel and think, so there's no right and wrong answers in any of this at all. How does that sound?

P: That sounds good.

I: Yes, okay. Lovely. So, how... how do you describe your mental health at the moment?

P: Yes, so I observe it as being relatively stable and that I'm, generally speaking, coping with my mental health problems. And that... and that... and that I... what my... for the first time in a number of many years, this is the best bit of mental health, mental wellbeing, that I've had for a long time. So...

sturdy foundation is stable.

his experience.

I: What would you put that down to, X? You mentioned, you know, your mental health has been stable for the first time in many years. What would that be down to?

P: So, it would be a combination of psychiatric medicines; so, like the [inaudible 00:02:51], the antidepressant, the betablocker, propranolol, for the anxiety aspect of things, and the antipsychotic,

4x medicines identified as helping him

aripiprazole. And also receiving cognitive analytical therapy. talking therapy.

I: Okay. Okay.

P: And general support.

I: And general support. So, cognitive analytical therapy and general support. Okay, so therapy and general support, yes. Just to focus on the general support side of things, who… who… what do you mean by that? Was it like a family member, was it a friend? Say a bit more about that, and how… why was it helpful?

Positive word to describe his mother. positive

P: So, I've got a fantastic mum who… who's come with me to a number of appointments at X with my consultant psychiatrist, Dr X and she… she's… she… she was there for… she came rushing to see me when I had my psychotic episode back in December 2021. And she came to visit me when I was on X Ward for the nine days, and also, she was with me in X before I was admitted to X in the early hours of the morning, and she's just a listening ear, a shoulder to cry on and she helps me in my… certain aspects of my day-to-day life here and there. I've also got a friend called Chris Painter, who's my close friend; he's also come with me to a number of appointments at Foundation House with Dr Campbell again, and he's just been a listening ear, a good, good friend who I've a good sense of camaraderie with, and he listens to me and that makes me feel valued as a person. And also, I live in supported living with… done through Life Ways, so I've got a support team around me to give me three and a half hours of support each day should I wish to take it up. And also, I had a fantastic care coordinator called Richard Brown who's now… who's now moved onto the Steps team at Foundation House. And I was discharged from the community mental health team before being moved.

The healing power of the supportive network of family and friends.

The listening ear of professionals as helping the client to feel valued

Mother as listening ear = support needed

Shoulder to cry on = identifying the body. Imagery of the body as supportive metaphor of support

Support for him =
- Listening
- feeling valued
- Shoulder to cry on

I: So, it sounds like you've got quite a big support network in place, you know, you mentioned a listening ear and a shoulder to cry on which has been very… sounds like it's been really important to you. Yes? Have you made any personal changes to your mental health for you to get to a place of wellbeing?

The self as a fighter in being able to overcome life's trials
P.3, 13

P: So, I think in addition, on top of the medication, the talking therapy, and the general support that I've mentioned in a nutshell, I think having a sort of fighter attitude has helped me to… to overcome the worst of my issues and just persevering and just keep going even when I don't want to anymore. And just try… try hard to… to be a better person.

Fighter =
Never quitting
= Dont give up
= tough
= unyielding
→ continuing the fact of adversity

→ better, stronger than before?

I: That's really interesting that you use that 'fighter attitude', that terminology. Is that how you see yourself, as kind of a fighter?

P: Yes. So, I've had to fight to overcome my demons, to coin a figure of speech. And like, through being a fighter, I've basically overcome the… some of the most difficult situations of my entire life, so…

triumphant

I: Right. Would you mind sharing some of those?

separation as being difficult = causing MH problems?

Key events leading to M.H problems

P: Yes, so… so, my mental health story began when I was twelve. So, my parents were unfortunately divorcing and that triggered something called recurring depression-anxiety, which I suffer from. And then I had a tree-climbing accident on Easter Sunday of 2015, which resulted in me having life-threatening injuries, such a [cystic] neck fracture, a collapsed right lung, broken right rib, broken right collarbone, bad concussion, and post-traumatic amnesia, which is still, it's still causing me problems even to this day, post-accident. And also in 2016, I had… I had a bad… I had a bad breakup with the then girlfriend, and I had a mental health event around that, which made me go to Foundation House to the… they were then called the crisis team, and… sorry.

medicalised terminology.

repetition of "I had a bad" → indicating distress perhaps

→ · Divorce ①
· Accident ②
· relationship ③ break-up.

I: No, no, please, no. So, it sounds like you've had quite a few incidents that have led to maybe mental health challenges, which… how has it… why would you say you are a fighter, you know, going through all of that, why would you describe yourself as a 'fighter', in your words?

Alive

P: Because I have managed to survive, I've managed to live to tell the tale rather than takin my own life, rather than ending up in a long-term psychiatric institution, or ending up in a more intensive care environment that what I'm receiving now, and…

his outcome due to fighter attitude
· strength.
· perseverance

I: So, it sounds like… like you say, you've lived to tell the tale, you've… you haven't… yes, you've lived to tell the tale. And I'm just wondering, you know, you've mentioned sort of the listening ear as being a really good thing that's helped, like a support network. Has there been anything else, Reese, that has helped you to overcome these challenges?

P: Sorry, could you repeat that again please?

I: So, has there been anything else that has helped you to overcome your challenges, so the break-up with your partner, the divorce, the accident – has there been anything else in your experience that has helped you to overcome these challenges?

religion as helping him to carry on & not give up

P: Well, I'm a re… I'm a returning… so, I'm going from being… I'm transitioning from being a lapsed Catholic, to a returnee Catholic, so I think an element of my faith and beliefs has helped me persevere when I've just often wanted to chuck the towel, throw the towel in, and…

lapsed to returning Catholicism provides a great perhaps. Helps him "to live to tell the tale"

I: Oh, right. So, you're returning from being a non… a lapsed Catholic to a returning Catholic?

P: Yes.

I: Yes. How has your faith helped you, then? How has your emerging faith, or your new, existing… how has that kind of helped?

faith in Jesus has helping him to cope with life

P: So, I believe, in my personal opinion, that my relationship and my belief in Jesus as the good shepherd is that he'll always come and reunites himself with the lost sheep, has basically allowed me to cope better and to feel that someone's listening to my prayers, and also having support of people like Deacon Trevor, who's funnily enough a chaplain at Rydon Ward, helping with my mental health issues and having people like a good friend there called Theresa Hewitt helped me at times when I've felt able to reach out to her.

Jesus as the good shepherd

Jesus as listening to him

him as the lost sheep

I: Wow. That's really interesting. So, religion has played a part in you… in overcoming adversity to some… to some degree?

P: Yes, I would say that's a fair statement, yes.

I: You mentioned yourself… do you see yourself as a lost sheep?

P: Not only a lost sheep, but a black sheep as well because, not so much my mum's side, but on my dad's side, I feel like the odd one out. They don't always get me and understand me and comprehend what makes me tick. And that can… that can be quite challenging to accept, that they may never quite fully understand me, basically.

relational
parenting
& their
approaches
in helping
client ever
feel loved
& misunderstood
p. 5, 12

None understanding
the lost & black
sheep.
Dad not getting
him - no
understanding

I: So, you feel like a black sheep in your dad's side of the family. How has religion… has religion at all helped you to not… to help you feel less like a black sheep in dad's family?

P: Well, just going to one of the Ten Commandments now, I can't remember which number but basically, one of the Ten Commandments is to honour your father and your mother, so as much as my mother means the world to me and I love my dad, but from more of a distance, and I've explored that difficult relationship through cognitive analytical therapy, when I was obviously having that; and… and through… through my faith, it's made me more forgiving, compassionate, endeavour… and endeavour to be more understanding how… to the best of ability that my autism allows me to comprehend, so…

Christian
ideology

love, obey

faith has
helping to instill
Positive
Qualities in
his character

religion has
making him a
"better person" to
use his phrase
earlier on.

understanding.
did he get
any understanding
from his
father

I: Wow, okay, okay. So, your religion is a base for forgiveness, compassion, understanding. Does it help you to understand your dad's side of the family a bit more, just take those qualities and understand them, that… try to understand dad's family via the lens of religion?

P: Could you just repeat that again please?

I: Yes. So, I guess what I'm trying to say is has religion helped you in some respect, how has it helped you to understand your father's side of the family?

P: Well, I think what it's taught me most is that people are not perfect, and… yes, people are not perfect and that we are all, to one or more extent, all guilty of being sinners and that through Christ dying on the cross and shedding his blood for us to redeem

people as
imperfect he
says. mankind
is imperfect, also
what Jesus says.

religious
concept

"shedding blood"
graphic
violent
dramatic

us for our sins has enabled mankind to be closer to the image of God, in some sort of sanctity.

I: Very powerful, yes. Okay. So, how has… how has your mental health… so, I mean, you mentioned in… before we started recording, your psychotic episode, how has that… has that benefited in any way from your religious beliefs?

P: Well, trying to… trying to explain it to the best of my ability is, when – both during the 2016 to 2017 period and the 2021 period up to recently – I believed that my, yes, my psychosis made me believe that I was a prophet and that I had been chosen by God to lead God's people across the English Channel, and I was going to part it, and lead them to the Promised Land, and… and we were going to walk… we were going to walk along, me leading them, we were going to make it to the south coast via the motorway, and I also experienced things like the voice of God, the voice of angels, the voice of demons, and I used to see Heavenly lights. I also used to see demons, which really terrified me and, although I don't remember it personally, the 2021 psychotic episode incident, from second-hand accounts, I was screaming and crying, I apparently, yes… yes, I was screaming and crying for about four or so hours, I was shouting things like, "President Putin's out to get me", and "The KGB is out to get me", because I used to think for a while that two of the support workers in my supported living place were KGB agents working for President Putin, and meaning my demise, and that it was also a wider conspiracy of people that mean me harm, and want to hurt me, and… and I also believed that I had power like the use of gamma waves, and yes…

→ Delusion? no more so than religious delusions perhaps??
→ Moses parted the red sea
visual hallucinations?
· God speaking to him
· Angels speaking to him.
→ fear/Heaven vs hell.
Paranoia delusions.
· Fear of harm
· Fear of evil governments
↳ (but only KGB).
→ death

I: And how… so, there was a part of you that believed that God was sort of speaking to you… how did religion help you overcome that?

P: Yes. Yes, so…

I: Take a sip of water.

P: So, once I received my other treatments and I started slowly but kind of surely going back to being a returning Catholic, I think religion has helped me to realise that, along with the other supports, that

I'm actually not a prophet and that I don't have this mission, and the delusions of grandiose and paranoia, the visual and auditory hallucinations were just a result of a psychotic illness, rather than me being chosen by God, or fighting like, some sort of good… good versus evil battle with President Putin, the KGB in league with the devil. And yes…

I: Okay. Okay. Was there a particular scripture that helped you to realise you weren't a prophet? Or was there just this sense of just being… reading the Bible, that sort of thing, what was it?

P: So, I will come back to your question, but slightly side-tracking, having… with time, having enough people saying to me, "Look, Reese, you're not a prophet. What you're seeing here is basically not real. It's the result of a mental illness". So, enough of the whole, you know… you know shaking me kind of thing helped, along with medication, talking therapy, and the general support. And… and also going through my book… I have a book called Catholicism for Dummies and… which I've read, I'm currently reading, going through, in addition to my New Testament and Psalms Bible. I think, with regards to your question about scripture, I think the… the thing that got me was Revelation, so the end of times, basically. So, basically that then would be the anti-Christ, who would be supported by his advocate the false prophet, and that people would turn… turn, you know, look up to the anti-Christ as a reverential figure, and the false prophet will feed into the cult of the anti-Christ, and… because they're both from Satan to turn people away from God, but it's a matter of persevering with your… with your faith so that you don't turn to the path of the Evil One…

time as a healer

consensus of opinion helped him? too many people who didn't share his views helped him see a way out

> Books as helpful. Bible as helpful.

> hesitation

Devil. evil. opposite of Christ.

that word again.

I: Right.

P: And at the end of this process, the cosmic battle between Good and Evil, and ultimately Good will prevail.

: Good vs Evil
· Psychotic or Real?
· Binary.

I: Right.

P: And you have a new way, whatever form that may take, will come into being.

> : rebirth?
: reborn?

I: Right. Right. So, just persevering. It sounds like there was a two… two parts of this, you know, people telling you, you know, that you're not the prophet helped, but also persevering with your faith, so really, I suppose getting to grips with scripture and that sort of thing. Do you attend church at all?

P: I attend something called the Landings Programme, which happens on Friday, and basically, it's for lapsed Catholics who are looking to return to the church. So, I do that every Friday with a different theme each week, and I'm one of five in total participants, including the parish priest, Father Tom, who's the facilitator, and I have… I have been to church, the most recently I've been to church was the Pentecost [social] on Saturday just gone. And I just remember going up for a blessing on the communion, by just crossing my arms like so, just to state that – Father Tom gave me a really nice blessing invoking the Holy Spirit on me, and God's love, and that He will guide me through my hardships, and that really resonated with me, and I'm also, next week, I'm going to France on a pilgrimage with St George's Church, so with the church. And we're following in the footsteps of a Catholic saint called Sainte Thérèse of Lisieux, also known as the 'Little Flower'.

- return home?
return to Christ?

·bread + wine
· Holy
· Blessings.

. Sacred
. Special

- Holy Journey

↳ Saint

Faith & the Holy Spirit as being a guide through hard times

Pilgrimage as being a Journey to seeking miracles

I: Okay.

P: And what's – I can tie in quite beautifully – what's remarkable from what I… the little I know about her, her father actually suffered from psychosis or schizophrenia.

I: Did she… did he?

P: Yes.

I: Yes? Wow.

P: So, one of the miracles, because he had to go into what they then called a mental asylum, or institution, during the early sort of 1900s, and I think if I remember it, the story correctly like, through her prayers, or something she did, her father was miraculously cured of his psychosis-slash-schizophrenia. So, she's regarded… one of her patronages is the patron saint of like, psychotic illnesses.

Key event.
Has meaning for him.
Opposite of exorcism / Deliverance

I: Wow. Well, that's pretty apt and appropriate, isn't it?

P: Yes.

I: Yes, wow.

P: So, I feel when I go on this pilgrimage that it will have some meaning to me and when I visit her tomb, I will ask for her prayers because she's in Heaven before God as an intercessory saint, I'll ask her, God-willing, if I can receive some sort of miracle. → · A divine intervention · not attributable to scientific laws · extra ordinary

intercede on our behalf with God

Specialist religious terminology

I: Wow. That's… that is incredible. It sounds like that… religion, your Catholicism has given you a lot. Would you agree… would you agree with that, that your Catholicism has given you strength? → Synonymous with resilience

P: Yes. Strength, courage, hope. A thirst for… a zeal for life, and fellowship with other people and a like-minded community. But also, just generally, humanity in general, because regardless or not of your beliefs or non-beliefs you, in my eyes, are… are… are a fellow human being, you are valued, you are important, and as a human being, generally speaking, I love you because you're my fellow neighbour.

→ togetherness/ kinship

the love for his fellow human being.
· kinship
· community
· belonging.

faith as providing a sense of community & love for the human race.

I: Yes. Wow. Yes, that's really deep. So, has… has religion, because you've mentioned 2016 to…

P: 2017.

I: To 2017, has there been other episodes, in your own words, 'psychosis', and how have you managed, or not, to get out of those?

P: So, the 2016, 2017 period was quite interesting because… the 2021 stuff to the fairly recent period of the prophet delusion and the like, in the 2016 to 2017 period, I believed that I was a wolf. Wolf? vs sheep
wolf vs good shepherd

I: Right.

P: I believed that I was a wolf. Like… like the Big Bad Wolf kind of analogy. And I had this, yes, dissociative states, as it were, where I would, you know, either be the wolf, or I would be someone

→ Break from self

who is that?
fictional?
real?

called Geoff Briggs, or I'd believe I was, not a prophet, but some sort of chosen person. — belief in his specialness perhaps

I: And this was before, or after, or the same as the 2016 to 2017 period?

psychological concept.

P: Yes, so the… so like, the dissociative states, as it were, was during the 2016 to 2017 period. Like, dissociative in the sense of I thought I had more than one personality as… with the more recent stuff that was more, as I would describe it, yes, not… dissociative in a psychotic sense, but not dissociative in a dissociative disorder-like symptoms sense. But what I then… like, severe identity crisis, and yes, like, during the 2016 to 2017 period, I also thought that Reese was in there somewhere, but he was being kept under lock and key by the other alter egos, the other personalities. So, Reese wasn't able to break and to be Reese, he was controlled by the other alters.

personality

I: So, there was one period where you thought you were the KGB, you thought you were God's prophet, and there was another period where you thought you was a wolf, so to speak. Can you say a bit more about that period? What was going on for you then?

P: Yes. So… yes, so, yes, 2016, that was a case of the bad break-up with my then partner, and the tree… the tree… the aftereffects of the tree-climbing accident, and having links in with that, in one way or another, and trying to understand…

I: Yes. What helped you… yes, what helped you to get out of that period, so the break-up, the tree incident, how did you overcome that particular time in your life?

P: I would say my mum, my then care coordinator, Ben Reid, who was my CBT therapist, so I had cognitive behavioural therapy during the 2016, 2017 period as opposed to the more recent cognitive analytical therapy I've received, and… and, again, attempting, not as successfully, but attempting to go back to church and to faith. And just trying to do… oh, volunteering.

- mum
- CBT
- friend
- CAT therapy
- volunteering.

I: Right.

P: So, like, voluntary work with the National Trust, [inaudible 00:35:03], the [ONAB] county ranger team, the Somerset Wildlife Trust.

I: Okay.

P: That sort of stuff.

I: So, quite a lot of good things then, yes. Talk to me about the CAT, the cognitive analytical therapy, what was that like, going through that, and how did that help you?

Healing via the process of psycho-therapy

P: So, the cognitive analytical therapy, I received sixteen sessions of that and my therapist was this lovely lady called Jane Churchill, and it was really, really useful to have – don't get me wrong, CBT was helpful but only to an extent, but cognitive analytical therapy went one step further than CBT and it… the approach worked better for me because, rather than the whole hot-cross bun theory, we're using a more psychoanalytical approach through the observer eye, and the observer eye was the one that just did it for me, and basically having the CAT maps, you could see things down on paper, so the visual element for me was helpful, and also doing various… various letters from the CAT therapist, sort of, you know, saying what she's heard from you, so it makes you feel like you're being listened to, she's taken on board what you've said, and…

CBT vs CAT.

Psychoanalytical therapy has helped.

listening caring.

I: Okay.

Abuse has hampering his view of the male figure

P: And also, just being able to talk about my relationship with dad, the difficult relationship with my dad, but how amazing my relationship with my mum is, and my… my friendship with my close friend, Chris Painter, and other friends, and relationship with myself, and… I was also able to talk about the tree-climbing accident, I was able to talk about my relationship… relationships experience and… and also an incident of… unfortunately, sexual abuse, sexual assault that I had from my… who I thought was my best friend in my secondary school, called Aaron Bye, and he got away with it, basically and that hampered my view of male figures for a while, and trusting men more than women and also because of my poor relationship with my father, how that's affected my view of, you know, fatherhood and the male figure.

difficult vs amazing

- relationship with friends
- relationship with self

Sexual abuse vs injustice

obsecured of good male friend vs BAD male friend

Good mother vs BAD father

/.love
.happiness
.commitment

as opposed to the wonderful, awe-enveloping love of motherhood.

I: Okay. So quite a different contrast between the male and the female figures, you've quite different experiences in that respect. Just staying on that point a little bit, Reese, around the male… have you managed… how did that… did it have any bearing on your, in your own words, your psychosis, having been abused by this male friend, and then also not having the greatest relationship with your father – did it have any bearing on your mental health?

P: Oh, oh, yes, absolutely, one-hundred and ten percent for that matter. Because another aspect of my life, is having the autism spectrum disorder diagnosis, this developmental disability, made my peers not – at school – not understand me, not value me and bully me. I was bullied in primary school and secondary school, and the bullying I had in secondary school, along with an incident of misunderstanding with an individual, as it were, through my ASD and depression and anxiety, basically I had to go to temporary teaching provision at Autism Solutions and then after that, I went to a special needs school for people with ASD and I managed to do, through Huish Episcopi, managed to do my exams through them, through the links with that, and… just trying not to waffle on now.

disability as Being a barrier to being understood.
Lack of connection

I: No, what… just… what's Huish Epis… what's that?

P: Sorry, that's a secondary school.

I: That's a secondary school, okay.

P: So, [Longstanton] had links with a mainstream secondary school.

I: Okay.

P: So, some people did like, the [ASDAN] programme, going from Longstanton, you know, into Huish Episcopi, or I would go to Huish Episcopi to use the swimming pool, the gym, and have some maths exams.

I: Yes. Okay, okay. Since having psychosis, to use your words, and you have used those words, what would you say has changed in priority for you? So, things like, work, education, relationships – what has changed from going through that to coming through to the other side? Has anything changed in your priorities?

P: Could you slightly reword that [definitely] for me, please?

I: So, has anything changed in importance for you in terms of having gone through mental health difficulties, has anything changed in importance? So, anything's gone up – so, family may have gone up, work may have gone down in importance.

P: So, through my various mental health challenges and difficulties, it has at various points in time shifted the importance from friendships to family, and from family to general acquaintances, like people you meet out in society. And so, with regards to… with regards to study, yes, study, and my interaction with society – that kind of stuff.

I: Yes. In what way has your interaction with society changed since you've had, and then come through mental health difficulties, how has your interaction with society changed would you say?

P: So… so, coming through the other side of mental health, it's made me realise that… that I… I… I do have a value as a person, as an individual and that I can contribute to the betterment of society and the human race, and things like the environment and the planet, because I spent four years at Cannington doing various lab-based courses, so… and growing up on a working dairy farm, I've always had some sort of connection or love, and affiliation with the countryside, even to this day I still do.

.hesitation
.pauses.
-1x about to say something difficult
.self-esteem
.value.
↳ wanting to contribute to "do his bit" "Advancement of the human race."
emotion word affiliation = countryside.

I: Right. How has that… has that helped your mental health, having an affiliation with the countryside? How has that helped?

P: Yes, so doing things like outdoor volunteering as I mentioned earlier, with the various organisations. Having… having, even to this day, the still family farm to go to, you know, to be out there is a blessing, you know, for respite from the noise of that sort of, Taunton and what have you. And also… and also having some beautiful places, even in Taunton ironically, like, French Weir Park, Longrun

Meadow, Netherclay Community Woodlands. Yes, that sort of stuff.

I: Okay. So, being outdoors for you is important?

P: Oh, very important, yes, like, I think it… nature is a medicine in its own right, and doing things like eco therapy for the mind [break in audio - 00:45:44]… working well group is very therapeutic and it's… it enables you to see yourself as a part of nature and not just above nature.

Nature as healing. Like medicine

I: Has having psychosis taught you anything about yourself?

P: It's taught me… it's taught me to, in an interesting way that certain things of reality, without going too much into philosophy – general philosophy – of is reality an illusion? Is it perceptive?

^ not real.

Is reality subjective. Is my reality different to his etc.

I: So, that's a very interesting question, isn't it? Yes. So, what conclusions… have you come to any conclusions about is it… is reality an illusion or not? Did having psychosis teach you anything about reality per se?

P: You've… with the things I've seen and heard and believed, and coming through the other side of psychosis, it's… it's given me a perspective in the sense of, it makes me question… it's made me question my experiences, my values, my beliefs, my interactions, and that sort of stuff.

Shaken his core perhaps? Made him question the fundamentals.

I: Okay. So, it's made you question lots of different things, yes?

P: And who am I?

I: And who you are. Has that affected your self-esteem, from good, bad, indifferent, has having psychosis done that? How has it affected your self-esteem at all?

P: I mean, that's one of the issues I'm still working on, because I have a low self-esteem from the depression side of things, but slightly side-tracking, I will be going on a… like, a compassion, mindfulness group therapy course with the open mental health alliance at Foundation House to help with that. But with regards to your question… sorry, what was that again?

I: Well, I kind of side-tracked really, I started… because we were talking… we were first of all talking about reality, and has your psychosis made you question reality. Maybe let's stick with that, because I found that quite interesting. You said it's made you question your beliefs, your relationships. In what way has it done that, Reese? So, in what way has your having psychosis made you question your… your friendships, your beliefs? How has it done that? In what way has it done that?

P: Well, I think what it's done is, it's made me, rather than like, when you look at a picture, every person will see the picture in a different perspective or light, and sometimes – and even I'm guilty of this – we get tunnel vision, so that obscures from what the actual intended… intended… it's taking…

every person sees the picture a different a light, but is he underneath saying that, there is one reality. Reality not constructed

I: The intended view a picture should be? Yes.

P: Yes, yes. That's… that's more like it. And it… it makes you see the whole picture, rather than just one part or aspect of the picture, and you take more notice of things, rather than sort of just let it, you know, go over your head.

observant

I: Is that what psychosis… how has… how has psychosis helped you to take more… has psychosis helped you to take more notice of things or has it… say a bit more about what… explain a bit more so I… help me to understand.

P: So, it's… sorry.

I: It's all right. No. Take your time, please.

P: So, how has it affected my… what, again?

I: Yes, so it's your reality… so, we were talking about how… how has psychosis helped… questioned… you said it made you question reality.

P: Yes.

I: That was the original point, and I'm wondering how it's done that?

P: Well, because I was basically for a long time, you know, at various points, living in this alternative reality, this alternative world, and that I somehow thought that others could be experiencing or be a part of with me, it's made me realise that I… I… sorry…

I: It's all right. It's made you realise you… what would you say? What has it made you realise, having psychosis?

The group
as enablig
a sense
of normalisation

P: Yes. That's it. It's made me realise, through coming to things like the mind hearing voices group, that I'm not just an anomaly, I'm not just alone, and that there's a sense of camaraderie and the sense of that I'm not unique in this regard, and that there are people in situations similar, just like mine, and it makes you not feel alone.

togetherness
. sameness
. camaraderie
. paired .

I: Yes. Yes. That's incredible. Wow. And did it make… was there a time when you did feel alone, with the psychosis?

P: Yes. Yes. I… it… not only has the ASD made me feel like, on the outside looking in at another culture or society different from mine but it, with regards to the psychosis aspect of things, it's… it's made me…

I: It's made you?

P: What was the last bit of your question again?

I: So, does it… did… you said, you've said something so powerful, you said having the psychosis and coming to things like the Taunton hearing voices group has allowed you not to feel so alone.

P: Yes.

I: So, has… and how has psychosis done that? You said… does it… you don't feel as unique or as apart, so how has it managed to do that for you?

P: It's… so, it's made me appreciate that some… that… I'm ever so sorry.

I: That's okay, not at all. So, psychosis has made you appreciate… what has it made you appreciate?

P: It's made me appreciate that there are both similarities and differences in people's general experience of psychosis and that people… people that don't have psychosis seem to look in at the notion or the concept of psychosis as… as something to be stigmatised, something to be afraid of, something to put bad press about in the media or, you know, stereotyping in television or film; and that there needs to be more awareness put out there, there needs to be more education, I think particularly in schools. I think there needs to be conversations within, you know, certain curriculum, certain topics, you know, about mental health problems, including psychosis and… amongst other issues, like my ASD.

Jesus was stigmatised. mental healt is stigmatised

. Activism.

. An operess

I: Do you think that would have helped you, going forward? Do you think having those conversations in school about psychosis, ASD, OCD, do you think that would have helped you in any way?

P: I think it would have… had I had, you know, as good as access as that on the school curriculum, that it would have enabled me to have the tools to identify the early signs of mental ill health, and how to seek help at the earliest opportunity, because I think one of the things that's not helped me is that there was times I didn't know who to turn to or where to turn to for help and support, other… other than, you know, through family and friends but, you know, professional support. But luckily, I'm one of the few lucky people to have a really good GP…

times he didnt know were to turn.

I: Right.

P: Who's called Dr John Martin, who's really… who's been really good ever since, you know, since I was yea-high, up to where I am now with regards to getting g me the support, the help, the signposting that I needed ti eventually see through the other side of mental health.

I: That's pretty incredible. That's absolutely… yes. Okay. So, it sounds like your support network has been a big thing for you to… for you then to come out of the other side because you mentioned it at the start of this conversation that, you know, Chris, your mum, your CBT counsellor, they've really kind of supported you in that, so would you say that's been like one of the main things that has helped you move out of your psychotic episodes?

Support as being able to change one's life trajectory

P: Yes, yes, absolutely. I think if it wasn't for these helps and interventions, my life would have taken an entirely different turn, and dare I say it, I could have been dead, I could have been in a high-security mental health hospital, or I could have been like, in an intensive care environment for volatile people, and it's enable me to have a life, it's enabled me to have hope, to have a sense of direction, to feel that my life has a value, has a purpose, and that life is not worth giving up on.

the outcome if he had no support at all

I: That's amazing. And I will leave that last word to you – "life is not worth giving up on". That absolutely [incredible]. Any final thoughts, anything else you want to say, or is there… or is that…?

P: My last words are, people like yourself are doing a wonderful thing by taking the time to speak to people like me who have had, you know, various experiences of mental health, amongst other issues and that… what you're doing is going to change society and change the world, and change the understanding of mental health, and it's going to promote de-stigmatisation, and it's going to promote conversations in daily life, and that universities have a lot to play in various research, and through that research, I hope – and fingers crossed – that they're able to find more effective treatments and early interventions, and maybe even, you know… you know, if it's meant to be, a cure.

I: Yes. That's amazing. Lovely. Again, powerful words, really powerful words there. And yes, I just… in… I think, yes, I mean… and you would describe yourself, and I won't… you would describe yourself as having ongoing mental health, and you've come through the other side, you've managed to do that, that's all testimony to you, Reese, absolutely, all testimony to you. But it sounds like you've had support, you've had faith, you've had volunteering. So, that's absolutely, yes.

P: And the next part in my story is that I'm going to be enrolled on, you may or may not have heard of it, a programme called the NHS Swaps Scheme, and basically that will entail a three-week training course through Weston College and the NHS, completing a gateway qualification into Health and Social Care, level one, and various NHS modules, with a guaranteed interview at the end of it for a healthcare assistant, a porter, amongst many other roles. I've got ambitions.

I: Yes.

The future as related to goal focused growth.

P: And my [ambitions] is, I would like to go down the mental health route, if possible, as in a job role within the NHS, so a psychiatric nurse, or even a psychologist like you, or a psychiatrist, and really just make a difference to people's lives.

↳ wanting to make a difference / give back

I: Yes. I think you're more than be… I think you'd be more than up for that, I think you'd make a really great counsellor, psychologist, whatever you decide to you, there's definite potential there, for sure. Yes. Thank you very much for your time. Please take a debrief sheet. I just want to again thank you very much. Thank you.

P: Thank you.

END OF INTERVIEW

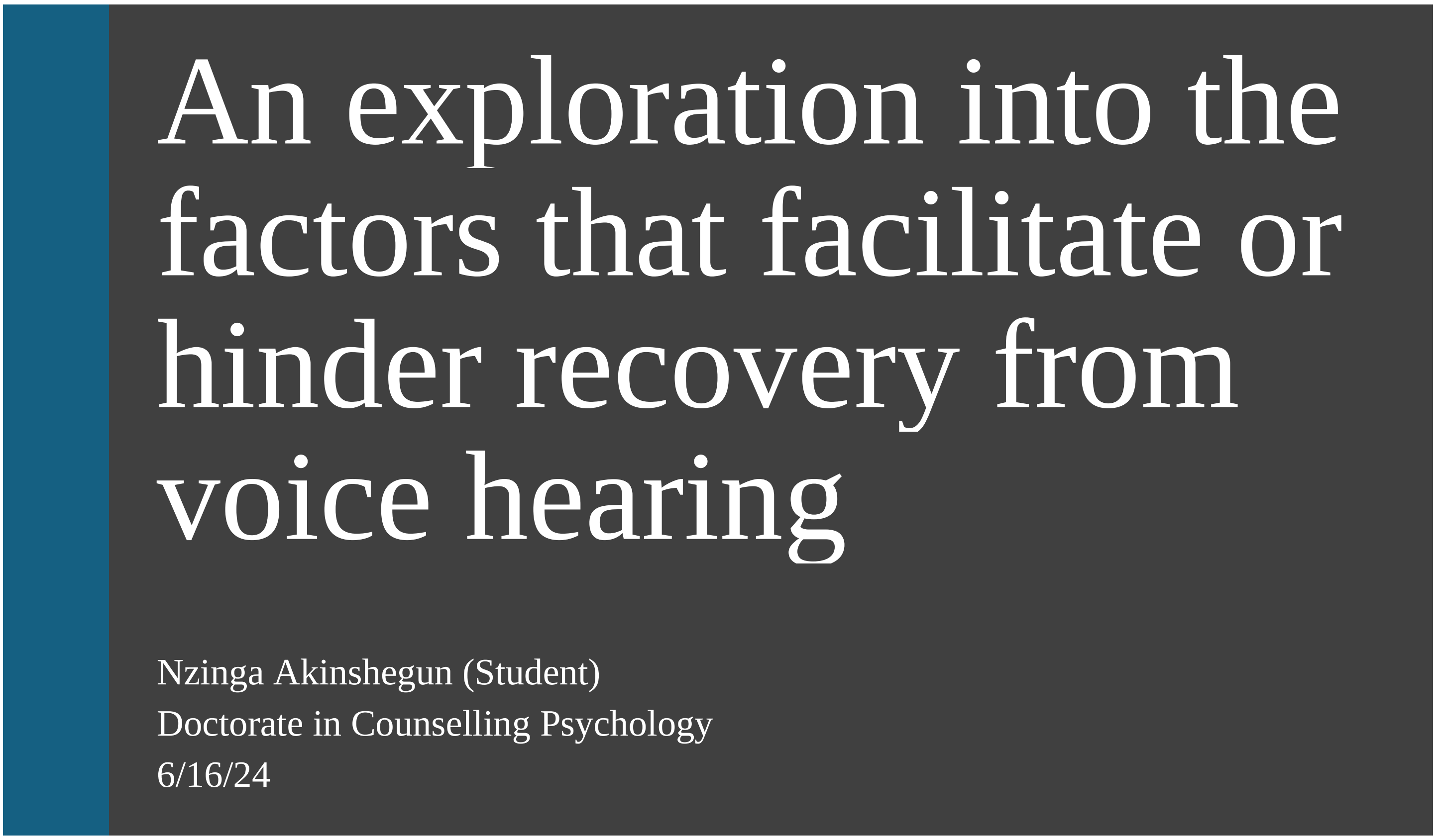
Over the last several years of working on the thesis the workings of PETS into GETS have changed considerably as the project has evolved. The actual "workings" are almost innumerable in the number of pages and tables gathered and would not be feasible to place here. Hence, here is a small snapshot of some of the PETS, ES, and how they became GETS.

Experiential Statements	***PETS***	***GROUP GET 1: Voice hearing described as distressing and related to negative life***
I didn't have a very good childhood….I was abused but then they'll go "But that's your fault". "Its your fault you were abused". P. 26 (participant A)	*The lived experience of suffering and trauma in relation to her voice hearing experience*	Sub-theme 1: Voice hearing linked to distressing life events
I just tried to commit suicide because I felt overwhelmed with it p. 5 I think I tried to commit suicide the first time, I drank bleach p. 2 (Participant p)	The voices as offering a traumatic and nefarious slant to his daily lived experience	
3) so they know that I've been really, really unwell in the past…and they know I was hospitalised but it wasn't my choice. But I think that was because I was homeless	*Voice hearing related to homelessness and lack of choice*	

Experiential Statements	***PETS***	***GROUP GET 1: Voice hearing described as distressing and related to negative life events***
And then I met [name] who was violent and then I was very mentally unwell, then I got schizophrenia…I look back and think it was very hard going through domestic violence. It was very painful and very hard. … The voices are very troubling when I am alone.” Sarah.	The voice hearing experience being considered a sign of mental illness and distress	Sub-theme 2: Voice hearing related to intimate relationship abuse and disruption
“So, my parents were unfortunately divorcing and that triggered something called recurring depression and anxiety which I suffer from. I then had a tree climbing accident on Easter Sunday in [year] which resulted in me having life threatening injuries… and also in [year] I had a bad…bad break up with the then girlfriend and I had a mental health event around that…	Voice hearing related to distressing relationship endings	

Experiential Statements	***PETS***	***GROUP GET 3:*** ***The experience of being a parent while coping with a mental health challenge vs. being parented and connection***
? …she knows that I hear voices….just too much for any child to cope with p.5 but they kind of know when mum's not right….I cant control my crying…it doesn't matter who I am in front of…. They tend to behave better when things aren't quite right p. 20, 21, 22 (voices and parenthood: You shouldn't be a mum, this is your fault why are you a mum) Amanda	parenthood versus the experience of poor mental health	Sub-theme 3.1: Parenting with a mental health problem
….So doing simple things with the children…I would normally put their….put their bikes in the boot of my car and then I'd take them to the park..I'd get as far..putting their coats on…Id start crying and having panic attacks (p.11) Lisa	The duties of parenthood needing to be fulfilled but conflicting with poor mental health	

Experiential Statements	*PETS*	*Group GET 4*
Dr. [name]… he’s just been a listening ear, a good, good friend who I’ve a good sense of camaraderie with, and he listens to me and that makes me feel valued as a person.” Richard (p.2).	Familia ties, friendship, group support, professional support as being the curative antidote to mental ill health	**Networks of mental health support that assist the recovery process vs non-listening mental health networks that slow down recovery**
I do groups and stuff and that gets me out… I like doing groups... helping people who have just started their experience and guiding them and helping them… because when I have been to groups they said it [the voice hearing experience] could be a spiritual message.” Sarah (p.3)	The transformative and healing process of group interaction and connection	Sub-themes: Helpful Mental health support systems
I’ve taken–meds before in the past and they didn’t work - they made me worse… I don’t think that that [meds] was keeping me stable.” Lisa.	Enforced medical intervention as being an obstacle to client’s self-determination	Unhelpful mental support systems



An exploration into the factors that facilitate or hinder recovery from voice hearing

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6/16/24

Journal Article

Psychosis

June 2024

Abstract

Background Hearing voices is usually defined as an auditory hallucination with no originating external stimuli. Recovery from psychosis has traditionally been conceptualised as a biomedical disorder which is managed via symptom reduction. It is usually believed to be an organic disease which causes significant disruption and has a severe impact on the individual's life. In this study, we explore the idea that recovery from hearing voices is both possible and achievable and examine the idea that recovery from hearing voices is associated with psychosocial factors that mean that recovery and/or living alongside voice hearing is conceivable.

Journal Article

Psychosis

June 2024

Introduction

Auditory hallucinations are defined as a person hearing a voice in the absence of external stimuli. (Farrugia & Greech, 2023). Around 4-8% of the population hear voices and it is a relatively common phenomenon (Romme & Morris, 2013). It has been shown that it is not the presence of the voices themselves that causes most distress but how the individual interprets them that causes the fear and distress of voice hearing. The biomedical states that there is too much dopamine in the brain and hence the positive symptoms of psychosis. However, others argue that the content and beliefs about voices are related to the individual's life history and that far from being a meaningless experience voice has much to teach us about trauma and the experience of it (Romme & Escher, 1989, 1993; Bentall, 1990; Chadwick & Birchwood, 1994).

Recovery from psychosis remains a complex, fluid and ever evolving facet of human experience. Studies have shown that recovery from hearing voices and how one engages with their voices can have an impact on recovery. Those who decide to put the experience behind them and ultimately return to baseline functioning with little to no reflective capacity about how and why their voices started demonstrate lower levels of personal resilience and avoidant coping styles (Tait & Birchwood, 2004). This contrasts with those who actively seek to engage with their voices, test beliefs about their voices and then subsequently develop alternative explanations of their voice hearing experience that moves away from a medicalised understanding fare better in the recovery trajectory (Dejager, Rhodes and Beevan, 2016; McGlashan, 2019).

Greater religiosity is also known to be a factor in recovery from voice hearing. Those who heard voices ended up praying more, became more involved in religious institutions and became more open minded to religious affairs (Tanskanen et al., 2011; Subandi, 2015; Brand et al., 2010). Some voice hearers find meaning in their experience and believe that their voices originate from God, which has been known to lead to spiritual and reflective awakening (Nixon, Hagen & Peters, 2009). Valavanis et al., (2019) go onto to suggest that practitioners should be cautious in only reconceptualising voice hearing as a mental illness and that reframing voice hearing from a religious standpoint can mean working in a person-centred and collaborative way with voice hearers. With the advancement of third-wave therapies we are now seeing individuals move towards Eastern based philosophies that teach acceptance, forgiveness and having an ability to connect and overcome life's challenges via mindfulness and present awareness (Boyle 2006; Keller 2008; Kiser 2004; Ventegodt et al., 2005). This is different to an illness-based model that sees voice hearing as an intrapsychic mental health problem with no foundation in psychological processes.

It has now been recognised that dialoguing with one's voice and subsequently developing a relationship with them can be key to recovery. The study by Cooke & Brett, (2019) support the view that hearing voices is a reaction to negative life events and that by talking with one's voice,; the person will be less distressed by them. The study, which used IPA to interview ten voice hearers, demonstrated that those who dialogued with their voices had a more peaceful and stable relationship with the voices themselves, which was a powerful catalyst to change and ultimately recover. They discuss clinical implications for the use of compassionate responding to voice hearing and for workers to develop epistemological humility by holding all explanations of voice hearing in mind.

Alternative approaches to the management of voice hearing have been trailblazed by the Hearing Voices Network (HVN). Since its inception, the hearing voices network has spread worldwide and there are now over 180 groups across the UK, including groups for young people, people in prison, women, and people from BAME communities (Hearing Voices Network UK, 2023).

The first Hearing Voices Network was founded in 1987 by psychiatrist Marius Romme. The network is based on the philosophy that hearing voices should be free from taboo and stigma. Individuals come together to share their experiences in a peer-supported, collaborative manner, free from the power imbalance so embedded in psychiatric settings (Dos Santos & Beevan, 2015). The Hearing Voices Network aims to empower, actively listen, and challenge the inequalities and oppressive practices that those who hear voices experience (Hearing Voices Network UK, 2023). Moreover, labels such as 'schizophrenia' and 'psychosis' are actively rejected, with person-first terminology being embraced and encouraged. The network aims to bring to the fore the issue of mental health and functions to educate those with limited understanding. The Hearing Voices Network finds that between 3-10% of the population hear voices, see visions, or have other similar sensory experiences. Thus, far from wanting to study the voice hearing experience from a purely academic viewpoint, the network aims to bring a normative perspective to the debate (Dillion & Horstein, 2013).

The importance of attending HVN groups has been well documented, and studies have found that group attendance can reduced shame, isolation and increase empowerment and normalisation (Corentin, Fitzgerald et al., 2023; Oakland and Berry., 2015). The importance of sharing and connecting with others has also been proven to be valuable to the recovery process for those attending HVN groups. The idea of sharing one's journey with others, a little bit at a time, at weekly intervals, is very helpful to the recovery process. The consistency of the group, and feedback, was also seen as helping in being able to provide solutions or suggestions to real life problems. (Dos Santos and Beevan, 2015).

This study seeks to examine what hinders and helps the recovery process for those who attend HVN groups. We aim to explore how recovery in this alternative format can shape the journey of the voice hearer and perhaps add to the existing debate that recovery can reach beyond a medical model approach to something akin to a person-centred slant.

Materials and methods

Analysis

The chosen methodology for this research project is interpretive phenomenological analysis. IPA's epistemological leanings seek to gain an idiographic approach to data collection and analysis. It is concerned with the unique tapestry of the individual, their story and processes. Via its established theoretical framework, it seeks to explore the lived experience of the unique individual by hermeneutic endeavour. The researcher in this process is neither a distant or objective artefact, but someone that brings to bear their own reflexive processes while simultaneously suspending judgement and allowing for the experience of the participant to come to the fore without judgment or influence.

Procedure

The study was granted ethical approval on the 04.11.22 by the University West of England's research ethics committee. Three HVN groups in the South West of England were contacted to gage interest in taking part in the study. Group leaders were contacted via phone and email, and meetings were subsequently arranged to discuss the project in more detail. Each participant was provided with an informed consent sheet, information sheet and separate time to consider whether they wanted to take part in the study. Interviews were conducted face-to-face in private HVN group therapy rooms and were recorded on a tape-recording device.

Data collection

The study used semi-structured interviews, which were conducted with participants. Semi-structured interviews are best used when the interviewer would like to gain insight into the world of the participants. During such interviews the interviewer has a series of questions/topic areas they wish to explore and ask questions about. However, the researcher is not dominated by this, and a question-and-answer format as seen in structured interviews is absent. Instead, the researcher is led by the participant and their processes during the interview. They remain open and curious and prize nuance over a binary way of responding to the interview. It is common to use open questions, follow up questions, probes and to ask questions that clarify or ask for more information. This way the interviewer ensures that information is from the participant's world view and not influenced by the researcher and their pre-existing assumptions and biases.

Participants

Seven participants were recruited. Four females and three males. All were White British from the SoutWest of England and most described themselves as working class. Participant ages ranged from 30-50 years of age. All participants described themselves has hearing voices and all had attended at least one HVN group session. Ten potential participants contacted me via email after the initial introduction and seven were recruited. IPA studies typically recruit small sample sizes. "Recently there has been a trend for some IPA studies to be conducted with very small numbers of participants" (Smith and Osborn 2008, p.56). Hefferon and Rodriguez (2011) also outline students of professional doctorates should use between four and ten participants in an IPA study, this may be due to the consideration that a large number of research participants (within a qualitative study) may compromise the detail needed for a good quality, in-depth piece of IPA research.

Journal Article

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Results

GETS	**GET 1** Voice hearing linked to negative life events	**GET 2** Religion and spirituality as both healer and iniquitous force	**GET 3** Parenthood and mental health vs being parented and connection	**GET 4** Helpful vs unhelpful systems	**GET 5** Recovery linked to self-actualisation and wellbeing
Sub themes	1.1 voice hearing linked to distressing events 1.2 voice hearing linked to relationship abuse	2.1 Religion has an iniquitous force 2.2 Religion and its healing force considered a facilitator to recovery	3.1 Parenting with a mental health problem 3.2 The connection of parenthood and bonding	4.1 Networks of mental health support 4.2 Non-Listening mental health systems	5.1 Recovery being linked to a general sense of wellbeing 5.2 Recovery being linked to helping others and overcoming challenges

Table 1.1 GETS and subthemes: Five GETS were identified in this study along with ten subthemes.

Group Experiential theme 1: Voice hearing linked to negative life events

This theme was related negative life events that affected the voice hearing experience.

Subtheme 1.1 Voice hearing linked to distressing life events

But when things are bad and I am stressed, or I'm not coping very well, they are very loud and overtake any kind of concentration. Kerry.

Because the voices are very loud, they are very aggressive. So, I have to have the music up really loud. Paul.

Subtheme 1.2 Voice hearing related to intimate relationship abuse and disruption

I met [name] who was violent and then I was very mentally unwell, then I got schizophrenia… I look back and think it was very hard going through domestic violence. It was very painful and very hard… The voices are very troubling when I am alone. Sarah.

Because I went through very bad domestic violence and then that came to an end and it left me with a rage of anger. You know I felt very, very angry and out of control and then I developed schizophrenia… I was very, very traumatised and very, very, very brain damaged. Sarah.

Group Experiential theme 2: Religion and spiritualityy as both healer and iniquitous force

This sub-theme included religion as both a protective factor and a factor that had the potential to hinder recovery.

Subtheme 2.1 Religion has an iniquitous force

But then I blasphemed God and I didn't do it purposefully and… I've had all these weird things happen to me. It just got worse and worse I had a burst appendix, and I had a collapsed lung... I've blasphemed God and I started to get really bad voices. Michael

Subtheme 2.2 Religion and its healing nature as a facilitator to recovery

I think that it is God that is speaking to me… What I was hearing was very good, so I felt very happy. Sarah.

I hear the voice of God sometimes. I hear the voice of my family… I hear the voice of the team sometimes. She [God] says things like "It's a good planet". Sarah.

I think an element of my faith and beliefs has helped me persevere when I've just often wanted to chuck the towel, throw the towel in… I think having a sort of fighter attitude has helped me to overcome the worst of my issues. Richard.

Group Experiential Theme 3: The experience of being a parent while coping with a mental health challenge vs the connection of being parented and bonding

This theme included parenthood as a stressor to voice hearing while being parented was considered as a motivational and potentially protective factor.

Subtheme 3.1 Parenting with a mental health problem

So simple things, like going to the park with my children… I'd get as far as putting their bikes in the boot of my car and then just as I am about to grab my keys and say "right let's go" I'd start crying and having panic attacks. Lisa

Even when they [the children] went into care and they dropped me off straight home… they didn't take me to my mum's or anything, they just dropped me off at mine. Jasmine.

Subtheme 3.2 The connection of parenthood and bonding

On my dad's side, I feel like the odd one out, they don't always get me and understand me and comprehend what makes me tick… as opposed to the wonderful, awe-enveloping love of motherhood… My mother means the world to me. Richard.

Group Experiential Statements 4: Helpful vs unhelpful systems

Various systems were identified as either being helpful or unhelpful during the process of recovery.

Subthemes 4.1 Networks of mental health support that assist the recovery process

So the cognitive analytical therapy… went one step further than CBT and it… the approach worked better for me because, rather than the whole hot cross bun theory, we were using more of a psychoanalytical approach… so the visual element for me was helpful… so it makes you feel like you're being listened to, she's [the therapist] taken on board what you've said… Just being able to talk about the difficult relationship with my dad. Richard.

Subthemes 4.2 Non-listening mental health systems that slow down the recovery process

It's not great being in hospital…and having all of your normal choices taken away from you… I was placed in a secure unit and wasn't allowed out… I was being given medication that I didn't think I wanted or needed, and they said "well, were just going to give you a depo then" Lisa.

Group Experiential Statements 5: Recovery linked to self-actualisation and wellbeing

The essence of recovery for this GET included a general sense of wellbeing and the fulfilment of self-actualisation.

Subthemes 5.1 Recovery being linked to a general sense of wellbeing

I had a lot of friends... we played a lot of sport, I felt okay about myself … Men sort of appreciate other men who play sport well, so I felt right about myself… I was weightlifting at the gym, so I had a lot of energy… Like I didn't feel terrible. Paul

Subthemes 5.2 Recovery linked to helping others and overcoming challenges

I get myself involved and help single mums out with their children as well… I love helping people out. That's me. I can't see anybody struggle. I don't like it when people are struggling,

So coming through the other side of mental health, it's made me realise… I do have value as a person… I can contribute to the betterment of society and the human race… I *would like to go down the mental health route… if possible, as in a job role within the NHS, so a psychiatric nurse, or even a psychologist like you… Really just make a difference to people's lives, Richard.*

Discussion

This study provides insight into the processes of recovery and the factors that either hinder or facilitate its development. Recovery was not seen as a linear process but included may facets and factors. For example, at times voice hearing came from the experience of negative life events and for those who underwent negative life events, recovery appeared harder to obtain. Recovery for these individuals included an ongoing struggle to survive with tentative demonstrations of recovery being in process. 70% of people who go onto to develop psychosis have experienced a traumatic life event (Romme and Escher, 2009). This was particularly seen in the women in the study. These women had experienced domestic violence that had proceeded voice hearing. According to McCarthy (2015) the experience of domestic violence among women voice hearers has been oppressed by wider patriarchal structures that function to keep those who have experienced violence from men as voiceless and marginalised. Voice hearers in this study, however, appear to have recovered from both the physical violation of their bodies and that of the voice hearing. One participant appeared to have asserted personal boundaries in her new relationship and had grown from her previous experience by letting her new partner know the limits of her tolerance.

Religion was an unforeseen factor in the study. At least of the two participants had identified their belief in God as being a key factor to their recovery. It appeared to provide them with strength and fortitude. Tanskanen et al., (2011) appear to support this finding and outline in their study that praying and attendance at a youth church group for some participants, led to individuals becoming more involved and devout in their relationship with God, which only intensified, when formally detained in hospital. However, religion also remained an iniquitous for some. Religious delusions appeared present for some which then fed into the experience of voce hearing. According to Gearing et al., (2015) between 20 to 60 percent of people diagnosed with voice hearing appear to have some religious content to their delusional beliefs. This was supported by the present study.

In addition, parenting stress was another unexpected finding. Some of the participants spoke about how the stress of parenting had led to mental illness, mainly due to a lack of support and the general associated day to stresses of life and parenthood in general. Radley, Barlow and Johns (2022) support this point and further suggest that it is female parents that tend to struggle, as they usually carry out the task alone with a limited support network. This study found that not only was the support network limited, but that it at times actively worked against the parents with psychosis. Equally, Gladstone et al., (2011); Wahl et al., (2017) found that some parents inadvertently added to the children's distress and worry; by keeping their illness away from their children, they tended to add to secrecy and stigma surrounding mental health illness. This was seen in the present study, with one participant being advised by social services not to tell the children for fear it would upset them.

Lastly, a general sense of actualisation was seen in some participants when it came to their recovery journey. Some had plans to further their education, become peer mentors or enter the mental health profession. Furthermore, some had developed a healthier relationship to the self and had created a good enough mindset to their ongoing growth and recovery. This was supported by Pitt et al., (2007) who notably found that patient accounts highlight the importance of developing a compassionate relationship with the self which helps to facilitate growth and recovery.

It is also known that negative life events like childhood trauma have not only been shown to be a precursor to psychosis but can lead to several other psychological presentations such as depression, anxiety, PTSD, substance abuse, and self-harm (Bentall et al, 2012; Hardy, Fowler, Freeman et al., 2017; Bonoldi, Simeone, Rocchetti, 2013). This coincides with the findings of the present study - those who had experienced childhood trauma subsequently went on to experience mental health disorders such as depression and substance abuse, which also included incidences of self-harm in the form of disordered eating. The finding that adverse life events can be a predecessor to psychosis is supported by Romme and Escher (2009), who find that 70% of people who have psychosis proceeded the trigger of a traumatic event, and a vulnerability was present from the experience of childhood adversity.

Declaration of interest:

None identified.

References

Bonoldi, I., Simeone, E., Rocchetti, M., Codjoe, L., Rossi, G., Gambi, F., ... & Fusar-Poli, P. (2013). Prevalence of self-reported childhood abuse in psychosis: a meta-analysis of retrospective studies. *Psychiatry research*, *210*(1), 8-15

Boyle, M. (2006). Developing real alternatives to medical models. *Ethical human psychology and psychiatry*, *8*(3), 191-200.

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do specific early-life adversities lead to specific symptoms of psychosis? A study from the 2007 the adult psychiatric morbidity survey. Schizophrenia Bulletin, 38(4), 734-740.

Bentall RP (1990). The illusion of reality: a review and integration of psychological research on hallucinations. Psychological Bulletin 107, 82–95.

Brand, R., Harrop, C., Ellet, L., (2010). What is it like to be friends with a young person with psychosis? A qualitative study. *Psychosis, 3* 205–215

Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *The British Journal of Psychiatry*, *164*(2), 190-201.

Cooke, A., & Brett, C. (2020). Clinical psychologists' use of transformative models of psychosis. *Clinical Psychology & Psychotherapy*, *27*(1), 87-96.

Corentin, C., Fitzgerald, C., & Goodwin, J. (2023). Benefits of hearing voices groups & other self-help groups for voice hearers: A systematic review. *Issues in Mental Health Nursing*, *44*(4), 228-244.

De Jager, A., Rhodes, P., Beavan, V., Holmes, D., McCabe, K., Thomas, N., ... & Hayward, M. (2016). Investigating the lived experience of recovery in people who hear voices. *Qualitative health research*, *26*(10), 1409-1423.

Dos Santos, B., & Beavan, V. (2015). Qualitatively exploring hearing voices network support groups. *The Journal of Mental Health Training, Education and Practice*, *10*(1), 26-38.

Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *Psychosis*, *5*(3), 286-295.

Farrugia, P., & Grech, P. (2023). The experience of hearing voices: challenges and coping mechanisms. *Issues in Mental Health Nursing*, *44*(12), 1254-1264.

Fernando, S. (2010). Mental health, race and culture (3rd ed.). Basingstoke: Palgrave Macmillan

Gladstone, B. M., Boydell, K. M., Seeman, M. V., & Mckeever, P. D. (2011). Children's experiences of parental mental illness: A literature review. Early Intervention in Psychiatry, 5(4), 271–289. https://doi.org/10.1111/j.1751-7893.2011.00287.x.

Gearing, R. E., Alonzo, D., Smolak, A., McHugh, K., Harmon, S. & Baldwin, S. (2011) Association of Religion With Delusions and Hallucinations in the Context of Schizophrenia: Implications for Engagement and Adherence. Schizophrenia Research, 126, 150–163.

Hardy, A., Fowler, D., Freeman, D., Smith, B., Steel, C., Evans, J., ... & Dunn, G. (2005). Trauma and hallucinatory experience in psychosis. *The Journal of nervous and mental disease*, *193*(8), 501-507.

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *The Psychologist, 24*(10), 756–759.

Keller, K. D. (2008). Phenomenological understanding of psychosis. Existential Analysis, 19(1), 17–32

Kiser, S. (2004). An existential case study of madness: encounters with divine affliction. Journal of Humanistic Psychology, 44(4), 431–454

Romme, M., Escher, S., Dillon, J., Corstens, D., & Morris, M. (2009). *Living with voices: 50 stories of recovery*. PCCS books

McCarthy-Jones, S., Castro Romero, M., McCarthy-Jones, R., Dillon, J., Cooper-Rompato, C., Kieran, K., ... & Blackman, L. (2015). Hearing the unheard: an interdisciplinary, mixed methodology study of women’s experiences of hearing voices (auditory verbal hallucinations). *Frontiers in Psychiatry*, *6*, 181.

McGlashan, T. H., & Levy, S. T. (2019). Sealing-over in a Therapeutic Community. *Psychiatry*, *82*(1), 1-12.

Nixon, G., Hagen, B., & Peters, T. (2010). Psychosis and transformation: A phenomenological inquiry. *International Journal of Mental Health and Addiction*, *8*, 527-544.

Oakland, L., & Berry, K. (2015). “Lifting the veil”: a qualitative analysis of experiences in Hearing Voices Network groups. *Psychosis*, *7*(2), 119-129.

Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: a user-led project. *Psychiatric Bulletin*, *31*(2), 55-60.

Radley, J., Barlow, J., & Johns, L. C. (2023). A family perspective on parental psychosis: An interpretative phenomenological analysis study. *Psychology and Psychotherapy: Theory, Research and Practice*, *96*(2), 347-363.

Romme, M., Escher, S., Dillon, J., Corstens, D., & Morris, M. (2009). *Living with voices: 50 stories of recovery*. PCCS books

Romme, M., & Morris, M. (2013) The recovery process with hearing voices: accepting as well as exploring their emotional background through a supported process, Psychosis, 5:3, 259-269, DOI: 10.1080/17522439.2013.830641

Romme, M. A., & Escher, A. D. (1989). Hearing voices. Schizophrenia Bulletin, 15(2), 209–216.

Smith, J. A., Osborn, M. (2008). Interpretative phenomenological analysis. In: Smith, J. A., (Ed.), Qualitative psychology: A practical guide to research methods (pp. 25-52). Sage Publications.

Subandi, MA., Bangkit (2015) the processes of recovery from first episode psychosis in Java. Culture, *Medicine and Psychiatry, 39,*:597–613

Tait, L., & Birchwood, M. (2004). Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies. *The British Journal of Psychiatry*, *185*(5), 410-415.

Tanskanen, S., Morant, N., Hinton, M., Lloyd-Evans, B., Crosby, M., Killaspy, H., ... & Johnson, S. (2011). Service user and carer experiences of seeking help for a first episode of psychosis: a UK qualitative study. *BMC psychiatry*, *11*, 1-11.

Ventegodt, S., Andersen, N. J., Neikrug, S., Kandel, I., & Merrick, J. (2005). Clinical holistic medicine: mental disorders in a holistic perspective. The Scientific World Journal, 5, 313–323.

Valavanis, S., Thompson, C., & Murray, C. D. (2019). Positive aspects of voice-hearing: A qualitative metasynthesis. *Mental health, religion & culture*, *22*(2), 208-225.

Wahl, P., Bruland, D., Bauer, U., Okan, O., & Lenz, A. (2017). What are the family needs when a parent has mental health problems? Evidence from a systematic literature review.