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TITLE: “Therapy as well as the tablets”: An exploratory study of Service User views of Community Mental Health Nurses (CMHNs) responses to hearing voices

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ABSTRACT

Mental health nurses have traditionally been discouraged from engaging with service users’ experiences of hearing voices and to reinforce reality. However this may not be a helpful way of intervening in what can be a very distressing symptom. There is little evidence of service users’ experiences of community mental health nurses’ (CMHNs) responses to their voices. This paper presents the findings of an exploratory interview study of a sample (n=20) of service users to ascertain their perception of CMHN responses to their experience of hearing voices. Data are both quantitative and qualitative in nature. Content analysis of the qualitative elements of the study suggests responses can be conceptualised as facilitators, barriers and attributions. CMHNs are considered to be allies and the quality of the relationship is deemed important. The therapeutic repertoire of CMHNs however is seen as limited and rarely extends beyond facilitating access to the psychiatrist for review of medication.

Keywords: service users’ views, auditory hallucinations, community mental health nurses, professional interventions
INTRODUCTION

The mental health service user movement has in recent years begun to play an assertive role in shaping services that reflect experiences of receipt of services. Whilst the development of effective treatments has been a recurring theme in mental health literature, there is also a need to achieve treatment options which recognise and value service user experiences of their conditions. This study was conducted among service users receiving mental health services in South Wales. It was essentially informed by the knowledge that the pre-registration training of mental health nurses has traditionally discouraged engagement with, and acknowledging the existence of, the very real experiences of service users specifically in regard to hearing voices (Lyttle 1991, Martin 1987). Most mental health care is now provided in the community and Community Mental Health Nurses’ (CMHNs) are largest group of health professionals providing specialist mental health care in the community. As such our aim was to ask service users about their experiences of CMHN responses to their experiences of hearing voices.

LITERATURE REVIEW

The rhetoric of service user involvement has persisted for a number of years but as Campbell (2003) has indicated the reality for those receiving care is often somewhat different. Perhaps as a result of this mental health researchers have turned their attention to service user experiences of services in an attempt to better inform professional practice. For example, Cutcliffe et al (1997), surveyed service users’ views on their continuing care in a community mental health service. They found that while many service users were generally satisfied with their care, less than half reported being involved in the development of their plan of care. Concerns about
medication and its side effects also featured in responses. Cutcliffe et al (1997) concluded that perhaps CMHNs had failed to listen to service user concerns about their medication or, it appears, to involve them in their careplans. 

More recently Adam et al (2003) reported the findings of a Scottish study in which a sample of service users were interviewed about the services provided by CMHNs. This study indicated that rather than the technical aspects of care it was the interpersonal nature of the relationship with the CMHN that was most valued. These findings seem to concur with the earlier work of Rogers and Pilgrim (1994) who found that service users valued aspects of the relationship with mental health nurses and the opportunity of having someone listen to their problems. 

This focus on the therapeutic relationship appears to have some beneficial aspects in itself (Frank and Gunderson 1990), however increasingly mental health nurses are additionally required to have a number of technical skills at their disposal to respond to specific symptoms which service users find distressing. Auditory hallucinations are one such symptom that may require professional intervention and which mental health nurses will encounter frequently in practice.

Auditory hallucinations are frequently, but not always, verbal in nature. The person experiences them as hallucinatory voices heard discussing ones thoughts or behaviour as they occur. The voices may maintain a running commentary, or may be heard discussing or arguing in the third person, repeating thoughts out loud or anticipating the thoughts of the person. Voices are experienced as alien and under the influence of some external force. These voices are sometimes distressing to the individual and can cause social withdrawal and isolation. Auditory hallucinations are associated with major mental illnesses such as schizophrenia although they also occur in the general population. Estimates within what are often referred to as ‘normal’ populations vary
between 4-5% annual incidence (Tien 1991), with estimates of those experiencing such experiences at least once varying between 10-25% (Slade and Bentall 1988) and 71% (Posey and Losch 1983).

Standard responses to such symptoms include medication (Gray, et al 2003), cognitive behavioural techniques (Haddock and Slade 1996) and enhancing coping strategies (Yusupoff and Tarrier 1996).

Despite recent guidelines (NICE 2002), many service users are still prescribed neuroleptic medication for their symptoms. This response to psychotic symptoms is predicated on the belief that abnormal structure and/or chemistry in the brain give rise to a vulnerability to hearing voices (Shergill, et al 2000). Although neuroleptics are known to control symptoms in up to 80% of cases, the nature of the improvement varies and a considerable number of those treated continue to experience symptoms (Kane and Leiberman 1987). Therefore, although many people regard the use of medication as helpful, a substantial number may value alternatives that help them.

Some of these alternatives include those suggested in the work of Romme and Escher (1993) who propose that we may view the hearing of voices not simply as an individual’s psychological experience, but as an interactional event reflecting the nature of the individual's relationship to his or her own social environment. In this way we can interpret voices as being linked to past or present experiences. The approach emphasises acceptance of the existence of the voices. Hallucinatory voices are seen as responsive to enhanced coping. Romme and Escher view the hearing of voices not only as an individual psychological experience but as a social experience.
They found that those who coped well were more likely to use selective listening and limit setting than non-copers. Those who coped well also had more supportive social environments, while those who found it difficult to cope had more disruptive social environments. Interventions therefore should be based on enhancing coping abilities, understanding the individual and contextual elements of the experience and facilitating supportive networks.

Cognitive Behavioural Therapy (CBT) has also emerged as a treatment option for those hearing voices (Fowler, et al 1995). This centres not upon the voice itself but on the beliefs that the person holds about the voice and, as such, it attempts to alter these beliefs. It does this through enhancing coping abilities and challenging cognitions held about the voice. Evidence suggests CBT is useful in enhancing problem solving skills, coping skills and altering beliefs about the voices (Kuipers, et al 1997).

Community mental health nurses (CMHNs) are the main providers of specialist community mental health care in the UK and, as such, will encounter many people who experience auditory hallucinations and who want help with them. Mental health nurses more generally have traditionally been trained to reinforce reality with service users who hear voices and, more specifically, not to attend to the experiences. Core textbooks for psychiatric nurse training (Lyttle 1991, Martin 1987) have previously stressed the need to respond and reinforce reality, to constantly direct attention to the real world and assist in the process of adaptation. On the face of it this appears a limited response given that potentially more helpful options are now available.
There is little research into service users’ experiences of community mental health nursing interventions, particularly technical responses to specific symptoms. It would appear therefore opportune to investigate service users’ views of CMHN responses to this particularly distressing symptom.

Our research question for this part of the study was therefore, what are service users’ views of CMHN responses to their voices?

COMBINING METHODS

This study used a mix of quantitative and qualitative methods in an attempt to gain as complete a picture as possible of the views of service users receiving care from CMHNs. This is not without its problems, for example quantitative and qualitative approaches tend to be founded upon starkly different worldviews (Coyle and Williams 2000). Quantitative approaches are often grounded in a positivist paradigm in which objective reality is held to exist and therefore deemed to be measurable. Qualitative approaches frequently eschew such a view of objective reality and instead hold that reality itself is actively constructed in the subjective experiences of social actors and, as such, are open to interpretation. Reconciling these different philosophical and epistemological standpoints may well be impossible. As Brannen (1992) highlights, researchers tend to take a pragmatic view in combining methods rather than attempting to move between paradigms. Brannen (1992 p.3) suggests that it is unusual in practice for theory or epistemology to be sole determinants of method. Combining approaches at the level of methods is increasingly common (Coyle and Williams 2000; Shepard et al 2002). The rationale for combining methods is that this aids triangulation of data. Triangulation refers to the use of multiple methods to examine a single construct and has at least two purposes (Shih 1998): firstly, to confirm findings of one method against the other and secondly to offer completeness,
that is a more accurate picture of the social world. The approach adopted in this study was to use quantitative information to aid description of the sample and to provide snapshot views of the main areas being considered. Qualitative responses were sought to contextualise and add depth to these responses.

**METHODOLOGY**

Local Research Ethics Committee approval was gained for this study. Individual written informed consent was gained from all participants. A summary of the findings of the study was offered to all participants.

The study was piloted with service users in a neighbouring NHS Trust. Minor changes to the wording and the order of some questions were made following piloting. The piloting established that the interview schedule had face validity in that respondents indicated the content to be relevant and pertinent to their experiences.

The purposive sample was selected from the caseloads of CMHNs (n=34) in a South Wales NHS Trust to include service users aged 18-70 years. The mean number of service users on the caseloads of CMHNs was 29 clients (range 4-61, s.d. 14.4) and of these 23 met the criteria for inclusion and were prepared to be interviewed. The sample was heterogeneous and chosen to ensure that service users with a range of experiences were selected. This included firstly, those who had been experiencing auditory hallucinations for at least 12 months. This period of time was chosen, as it is indicative of a persistent and enduring level of symptoms found in those with serious mental illness. The sample was also selected to include those who had longer histories of hearing voices (more than 10 years) and who therefore had lengthier experiences of CMHN responses to their voice-hearing. Potential respondents were offered
information sheets on the study and asked to contact the researchers should they wish to participate. Service users who were hospitalised, currently unwell, or on the caseload of JH, were excluded from the study. Two interviews were terminated due to concerns about the person’s mental health and the data from these interviews were not used in the analysis. One further service user who met the research criteria and volunteered to be interviewed withdrew before being interviewed. The remaining interviews with 20 service users form the material for analysis. Interviews were tape-recorded and transcribed for analysis. They ranged in length from 30 to 60 minutes and took place in the respondents' homes during 2001 and 2002.

METHODS OF DATA COLLECTION

Brief demographic information was gathered from participants and included recording of gender, age, diagnosis and length of time hearing voices.

A 19-item, structured interview schedule designed for this study was used. The schedule contained sixteen statements requiring scoring on a 5-point likert scale and three open questions seeking further information on CMHN responses and personal coping. This schedule was constructed with particular reference to wording, order of questions, positioning of closed and open questions and reliability (Oppenheim 1992). While there are a number of instruments for assessing auditory hallucinations themselves (Frederick and Reed Killeen 1998) these do not address community mental health nurses’ responses to voice-hearing symptoms. The literature specific to traditional responses to auditory hallucinations and current clinical approaches to these symptoms was of particular importance in this regard. The schedule consisted of statements requiring a response ranging from strongly disagree, through neutral to strongly agree. The scale was scored as follows: strongly agree = 1, agree =2, neutral
= 3, disagree = 4, strongly disagree = 5. This instrument was used to give an initial snapshot of participants’ views on areas relevant to CMHN responses to their voices. Following each statement respondents were asked to elaborate upon their response, and this qualitative material was recorded and transcribed for later analysis. It was therefore possible to gain a more detailed understanding of the context of quantitative responses. Statements focused on the relative value of CMHN responses in the following areas:
• Medication
• Content and meaning of voices
• Therapeutic intervention
• Coping strategies.

Respondents were also asked to complete the Beliefs about Voice Questionnaire-revised (BAVQ-r) (Chadwick et al 2000). This is a standardised instrument that measures respondents’ beliefs about the benevolence, malevolence and omnipotence of the voices they experience. Benevolence refers to beliefs that the voices experienced are helpful. Malevolence refers to the belief that the voices experienced are persecutory and evil. Omnipotence refers to the belief that the voices experienced are all-powerful and controlling. The BAVQ-r was employed in the current study to allow a judgement to be made about how typical this purposive sample was in broad descriptive terms.

Data Analysis
Demographic information, BAVQ-r responses and the responses from the quantitative elements of the interview were analysed using SPSS v.10 to establish descriptive data
such as frequencies. Means and standard deviations were calculated for statements. Lower mean scores indicate a more positive response to the statement.

Thematic content analysis of transcriptions followed Burnard’s (1991) approach, which is adapted from the grounded theory approach (Glaser and Strauss 1967). The aim was to produce a detailed and exhaustive category system of issues raised in each interview and to link interviews and categories together. Open coding was used in the first instance to account for all the interview content. Transcripts of interviews were read again and grouped into 10 higher order categories based upon themes emerging from the interviews. This process was performed independently by the two main researchers. Categories were then compared, discussed and changes to categories were made once agreement was reached (Burnard 1991). A mental health nursing colleague external to the project was asked to review a sample of transcripts and produce a category system as a further check on validity. Further minor adjustments were made at this point to the category system. The categories were: ‘medication’, ‘content and meaning of voices’, ‘therapeutic intervention’, ‘coping strategies’, ‘personal interventions’, ‘professional interventions (supportive)’, ‘professional interventions (non-supportive)’ ‘relapse beliefs’, ‘personal beliefs’ and ‘miscellaneous replies’. Categories were collapsed until three main themes were identified. These themes illustrated respondents’ experiences of successful or unsuccessful attempts at coping with voices within the context of the help offered by CMHNs and are clearly discernible within the interview transcripts. The themes were, “Facilitators” – experiences of interventions that help respondents cope with voices; “Barriers” – experiences of interventions that prevent or hinder respondents coping with voices, and “Attributions” – understanding and meaning of the voice-hearing experience.
FINDINGS

Demographics
There were 22 service users interviewed, 12 male and 10 female. The data from 2 (male) subjects was excluded leaving data from the final sample of 20. Respondents ranged in age from 22-68 years (mean 43.3 years). These respondents had lived with their voice-hearing for a considerable number of years, 18 months-48 years (mean 12.8 years). Half the sample had experienced hearing voices for 10 years or more. Some respondents (n=2) were uncertain of their diagnoses. Most (n=15) reported that their diagnosis was schizophrenia or a schizophrenic-type illness, two respondents reported their illness as psychotic episodes and one gave a primary diagnosis of bipolar disorder.

BAVQ-r
The full range of scores was used by the participants for the sub-scale of malevolence with four participants scoring the maximum score and one participant scoring 0. There were no scores above 9 on the benevolence sub-scale and 2 respondents scored the maximum on the omnipotence sub-scale. Descriptive statistics are summarised in Table 1. Omnipotence featured prominently among respondents' beliefs about their voices. A relationship between omnipotence, malevolence and resistance is evident. Generally voices were perceived as powerful and malevolent with the behavioural response of resistance indicating a negative experience. For a minority of individuals, voices were perceived as benevolent and were engaged. These findings suggest that this sample of service users have similar beliefs about their voices as those in Chadwick et al’s (2000) sample of 73 voice hearers.
Interview responses

Quantitative findings to interview 15 of the 16 statements are summarised in table 2. One statement “Cognitive Behavioural Therapy helps me cope with my voices” is not included in this analysis as only two service users had experience of this intervention. Substantive quotes from service user interview transcripts are italicised. Some respondents felt able to address their voice-hearing within the context of a trusting relationship with the CMHN. Other respondents, however, indicated that the limited clinical repertoire of the CMHN prevented them from addressing their voice-hearing. Findings from analysis of transcriptions of interviews are reported under the 3 themes of Facilitators, Barriers and Attributions. The names of respondents have been changed to ensure confidentiality.

Facilitators

Facilitators to coping with voices included making use of both professional and personal strategies. Professional strategies included medication, discussion of voices and coping skills. Personal strategies included use of social supports and achieving personal control.

Respondents gave accounts of professional input that assisted them in coping with their voices. Medication was broadly favoured as a coping tool by respondents (n=13) in this study although this was often qualified. Many, while recognising the limitations of medication, seemed to find it at least of some benefit, for example Matt who has been hearing voices for 10 years argues,

“I think they’re vital and I mean without them it would be appalling but at the same time I think there’s other factors …basically you know therapy as well as the tablets (interview 3)
This benefit, while not removing the voices, seemed to make them more bearable and this was often accompanied by an assertion of the need for combinative approaches to voice hearing, for example Mary who has been hearing voices for 9 years says, “... *I think that talking to somebody can also help you know. I think medication is only one part of the treatment that should be given.*” (interview 23)

Not surprisingly some respondents tended to see CMHNs as a primary resource when unsure about their medication and placed value on the relationship. This was summed up by Joan who has been hearing voices for 10 years, “... *you get used to your nurses and trust them...if they come to give you your injection, you’re comfortable with them*” (interview 4). There also appeared to be a pragmatic stance adopted in relation to side-effects of medication, with the CMHN being seen as the quickest route to the consultant psychiatrist. For example, Adam who has been hearing voices for 18 months gives his rationale “...*cause it tends to get back sooner to the doctor and then sorted out...*” (interview 13).

The flexibility of the CMHN was seen as important. Eric, who has been hearing voices for 20 years, notes, “*normally he’s [the doctor] looking at three weeks before an appointment where, [CMHN]‘s available virtually everyday,...even if he’s busy he’ll fit you in sometime during the day*” (interview 5).

Most respondents believed that CMHNs should discuss the content (n=17) and meaning (n=20) of their voices with them. Most (n=17) felt that voice hearers should be encouraged to discuss their voices. Respondents (n=17) also valued reinforcing of reality as an intervention. In most cases (n=17) respondents viewed CMHN input as helpful in coping with the voices.
Respondents are positive about CMHNs engaging with their voice-hearing experience and see this as being helpful. Ted, who has been hearing voices for 2 years states, “because ...it can be very frightening and if you can talk to someone who’s got some kind of understanding about it, it would help” (interview 7). Another respondent, Colin, who has been hearing voices for 4 years argued, “…it’s a good way of getting things out into the open and analysing them” (interview 6).

Benefits of this engagement are offered by Derek who has heard voices for 17 years, “…the voices are telling you you’re going to go to hell and one nurse in [local hospital] said to me no you’re not going to go to hell and I still remember that…like it really was encouraging” (interview 14).

Discussion of the meaning of voices with CMHNs was also seen as helpful in coping with the experiences. For example, Janet, who has heard voices for 13 years says, “…they’ve all got something that has upset them through their lives...and there’s always a meaning to their voices” (interview 21). Mary saw the opportunity to discuss meaning as a way of reducing the power that the voice holds over them, “…by talking about it...and saying what’s going on and how you think it affects you and what it means...the strength can be taken out of it...” (interview 23).

Respondents expressed support for CMHNs reinforcing reality as one way of returning to what Sue, who has heard voices since childhood, referred to as “normalness” (interview 9). For example, Adam highlights the process of trying to make sense of the experience and the possibility of adopting what he sees as alternative, less reality-based conclusions: “there is a possibility of just taking off with everything and anything. I’ve gone through everything that’s not real, is imaginary or people believe to be true, you know you got demons, God, clairvoyant, telepathic,...”
(interview 13). Some respondents implied that sensitive handling of the process of reinforcing reality was important as Colin indicates, “I think it’s important that we have an awareness of what reality is rather than be in this sort of like dreamlike state” (interview 6).

This need for what some refer to as “reality checking” is summed up by one service user who recalls a sense of great relief in finding that someone was able to explain the experience. For example Mary recalls this being helpful: “when…they asked me … questions that were relevant to what I was experiencing…I was smiling you know, crying at the same time, but smiling because I realised that they knew what was going on that it wasn’t real” (interview 23).

Personal strategies include accessing and benefiting from social support networks, for example discussing and comparing experiences of voice hearing with other service users. Colin recounts: “you get identification with people who hear voices and ... compare things and you can feel that you’re not the only one in the world suffering…” (interview 6).

For some service users there is an attempt to gain personal control over the voices by challenging them and a recognition that this may not always work. For example Mary argues, “I think you can’t run away from something that’s happening … you’ve got to face up to it...” (interview 23). Gareth, who has heard voices for 17 years, expressed clear anxiety of the potential negative consequences of not exerting personal control: “Because … if you leave the voices … take control of you, … it might get out of hand … and you might get into trouble...” (interview 24).
Barriers

Respondents also described experiences that were illustrative of barriers to coping with voices. Whilst medication was seen as helpful by many it was also seen as a barrier to coping with the voices in that the effects were limited. For example Janet argues, “they might help me as far as keeping myself together but it don’t help as far as hearing voices” (interview 21).

The response of CMHNs was also perceived as limited and as such reinforces the notion that medication is the sole available method of coping. Respondents suggested that an increase in medication was the main response from CMHNs when they reported increases in voices. For example Colin recalls, “usually when I've spoken to [CMHN] he’s had a word with [doctor] and sometimes it’s resulted in an increase in medication…” (interview 6).

In most cases respondents were unable to identify any other intervention used by CMHNs when the voices increased beyond an appointment with the consultant. Ted recounts “she normally … tries to make an early appointment…to see the consultant” (interview 7) or non-directive counselling, for example Diane, who has been hearing voices for 2 years recalls the main input from her CMHN was “just listen to and talk and discuss things with you” (interview 15).

Most respondents have no experience of Cognitive Behavioural Therapy (CBT) and many expressed clear interest in knowing more about this approach. This appears to act as a significant barrier to developing and refining coping strategies. Speaking with other service users who hear voices is valued by some but raised anxieties for Eric who saw it as potentially detrimental, “the last bloody thing I’d want to do is talk about… somebody else’s … illness…I have enough of my own…” (interview 5).
Attributions

Many respondents in our study appear to have spent considerable time trying to understand their experiences and as such have developed attributions for the voices they hear. These attributions appear to be important because they may influence ways of coping with the voices. Many have dismissed a number of alternative constructions in the process of achieving meaning within their experience while others have adopted these alternative constructions. For example, Eric recounts how some people seek out alternative meanings: “…they start going to spiritualists and start getting into tarot cards …” (interview 5).

Attributions include acceptance of bio-medical constructions of mental illness for example, which Eric is prepared to accept: “I mean I knew I was schizophrenic as I heard voices and hallucination and other sort of thought disturbances” (interview 5). There also appears to be a refusal of these constructions for example, Adam, while prepared to accept a biochemical explanation for his symptoms, is less ready to accept the socially disabling label of schizophrenia itself as an explanation for his voices, “its difficult, paranoid maybe a little bit but not schizophrenia no” (interview 13). The experience of auditory hallucinations as omnipotent leads easily to them being experienced as the work of God as Derek details: “the voices that I hear now are great ones. They tell me I’m going to heaven and they say you’re a good boy” (interview 14). This works both ways however and Derek recalls previous voice-hearing experiences less favourably: “I do believe that a lot of the voices that I was hearing were like an evil spirit…” (interview 14).
Auditory hallucinations are sometimes seen as a consequence or retribution for previous life events. Eric recalls his particular difficulties: “I hear them a lot because... I was illegitimate when I was born... my father... resented me....” (interview 5).

DISCUSSION

We postulate that to a certain extent attributions accorded to the experience of hearing voices are socially constructed. These constructions may have an impact upon how individuals see attempts to help them with their voices. We note that the themes of facilitators and barriers have common elements. For example, some see discussion of content and meaning of voices as helpful while others dissent from this view.

If we consider these findings in the light of work by Lazarus and Folkman (1984) it is possible to reconcile this overlap. Lazarus and Folkman argue that individual ability to cope (and perhaps what is seen as helpful or unhelpful) is dependent upon a number of inter-linked factors. These include how the person appraises (constructs) the stressor and previous experiences of the success or otherwise of coping with similar stressors.

It is of course even more complex than this as individuals, depending upon their current psychological and physiological state, may succeed or fail in their attempts to cope with familiar stressors. If an individual constructs their voices as good or evil (omnipotent in Birchwood and Chadwick’s (1997) study) then the meaning of this to them and their consequent attempts at coping may be influenced positively or negatively.

Additionally the influence of personal control and beliefs about events or stressors may further influence coping abilities (Folkman 1984). Respondents in this study
tended to view their voices as malevolent and omnipotent and consequently demonstrated resistance to the voices as measured by the BAVQ-r.

The desire to gain personal control over the experience is emphasised by respondents and may be a consequence of resistance, that is a wish to resist further. Personal control is an essential aspect of recovery and CMHNs should be facilitating it (Young and Ensing 1999). Service users elsewhere have expressed a desire to regain control over their lives in general (Campbell 1996) and more specifically to have a measure of control over the recurrent nature of their illnesses (Lindow 1996). CMHNs should be directing their efforts towards supporting service users in developing coping methods to enable this control.

Respondents tended to view the CMHN as the best person to talk to when unsure about taking medication and for advice on side effects. Respondents indicated they would prefer to speak with doctors about side effects but instead express concerns to CMHNs because it will be communicated to the doctor more quickly. Debates among the CMHN profession on the relative merits of whether they should be involved in medication issues (Clarke 2000, 2001; Gray and Gournay 2001) may be irrelevant to service users when expressing their health needs. What is clear is that CMHNs have been found to be lacking in medication expertise (Bennett et al 1995) and that service users (Lindow 1996) want them to be knowledgeable and to provide information in this area.

Most respondents in this study saw reinforcing reality as a facilitative intervention. They want this to be done sensitively and value highly what one described as “reality checking” with the aim of returning to what another described as “normalness”. This aspect of mental health nurse training appears to receive qualified support from
respondents. Voice hearers do not want their experience ignored but consistently stated that being reminded of real things or being presented with reality-based challenges was helpful. There is an important and perhaps subtle distinction here. Reality can be reinforced while not ignoring the person’s experience. Ignoring or dismissing the person’s experience is viewed negatively by respondents and may create barriers to coping. Respondents are well aware of the difficulties here in that they recognise that their experiences are hard for them to dismiss. Accepting another person’s version of reality can be difficult and there is explicit reference to the quality of the relationship with the CMHN to allow this intervention to be successful. This emphasis on the relationship with the CMHN appears to be consistent with findings elsewhere that service users see value in the relationship they have with the nurse (Adam, et al 2003; Rogers and Pilgrim 1994). It may also however indicate that, while necessary, the relationship itself is not sufficient on its own to facilitate the changes in symptoms that service users’ want such as a reduction of distressing symptoms.

Respondents perceived CMHNs as being limited in their range of responses to voice hearing. This finding is surprising in light of continuing literature on what is helpful in such circumstances although perhaps not so when local context is considered. The CMHNs in local teams at the time of this study had not been exposed in sufficient numbers to specific training in working with psychosis. Even in areas where this training is available there remain problems in transferring into practice potentially helpful interventions (Fadden 1997).

Only half of the respondents in this study believed that talking to others who hear voices might be beneficial. The remaining respondents either believed it to be
detrimental or were unsure as to its value. The statement posed was related to the literature regarding the ‘Hearing Voices Network’ (http://www.hearing-voices.org.uk) (2003). One of the aims of the network is to promote self-help groups of voice hearers to share experiences and discuss strategies in coping with voices. It would seem that while helpful for some, other voice hearers may have anxieties about this. Service users have been socialised into a regime of psychiatric care in which they have actively been discouraged from discussing their symptoms (Leudar and Thomas 2000). In such circumstances it is hardly surprising that respondents expressed some ambivalence. Service users may require sensitive support from CMHNs in their efforts to establish and gain benefit from this type of social support system. There is emerging evidence that such an approach may have a number of benefits for voice hearers and further evaluative studies will prove useful (Coupland 2000).

**LIMITATIONS OF THE STUDY**

This study used a mixed method approach to develop a more complete picture of the views of service users of responses to their voice-hearing experiences. This method of using quantifiable structured questions to provide a snapshot view was followed by additional subjective and contextual responses. Assuming we can accept the epistemological conflicts of such an approach and as indicated this has its problems, there remain a number of issues to be resolved. Firstly the study can be criticised for failing to provide a sufficiently powered sample to facilitate more in-depth statistical analysis and perhaps even generalisable outcomes. The flip side of this criticism is that responses to questions seeking more detailed qualitative type data are in effect corralled by the highly structured nature of the interview schedule so that alternative and perhaps more fruitful avenues of investigation are only treated superficially. For
example, the method was not adequately flexible to pursue the issue of social support and its context once this became apparent within the study. The notion of completeness itself, using differing methods to capture a more accurate picture is perhaps, as Hammersley and Atkinson (1994) suggest, naïve. Generalisation from this study can only be speculative in nature due to the sampling method, sample size and the method of data analysis. Despite these limitations the study has provided useful insights into the views of these voice hearers of professional responses to their symptoms.

CONCLUSIONS

Respondents in this study see value in their interpersonal relationships with CMHNs but also express a need for additional technical assistance with their symptoms. They want to explore the content and meaning of their voices and expect CMHNs to facilitate this.

Further research aimed at establishing the influence of personal control upon attempts at coping with hearing voices may highlight an area in which CMHNs could offer help. Respondents in this study have engaged in many attempts at coping with their voices and express the need for support in doing this. Enhancing personal control and personal efficacy may be a fruitful avenue to pursue.

Respondents value social supports and may benefit from support of service users in similar circumstances. Formal therapeutic groups are just one option and may be unhelpful to some service users. Consideration should be given to providing the necessary financial supports to allow service users to develop social support networks
including symptom specific support groups where they find this helpful. Respondents to the current study expressed some anxiety in regard to discussing their symptoms in such groups and the benefits of such an approach will have to be clearly explicated.

Rather than seeing approaches to voice-hearing as the adoption of any one formulaic response, community mental health nurses will need to acknowledge the individual’s personal experiences of the voice, its context, its meaning and what helps. In doing so they may further develop responses to ensure that they are truly informed by those in receipt of mental health services.
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This project was funded by a Wales Office of Research and Development small grant. The views expressed here however are those of the authors and do not necessarily represent those of the funding organisation. We would like to express our gratitude to all the service users who spared the time to speak with us. Our thanks also to our colleagues Mick Coleman, Emrys Jenkins and Ben Hannigan for comments on earlier drafts of this work, to two anonymous reviewers for their constructive comments and to Paul Chadwick for permission to use the BAVQ-r.
References


<table>
<thead>
<tr>
<th></th>
<th>malevolence</th>
<th>benevolence</th>
<th>omnipotence</th>
<th>resistance</th>
<th>engagement</th>
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<tr>
<td>N Valid</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Range of possible scores</td>
<td>0-18</td>
<td>0-18</td>
<td>0-18</td>
<td>0-27</td>
<td>0-24</td>
</tr>
<tr>
<td>Mean</td>
<td>10.25 (10.1)</td>
<td>2.45 (3.7)</td>
<td>10.6 (11.1)</td>
<td>18.0 (19.4)</td>
<td>4.3 (5)</td>
</tr>
<tr>
<td>Median</td>
<td>9.0</td>
<td>1.5</td>
<td>9.5</td>
<td>18.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>5.7</td>
<td>3.0</td>
<td>4.5</td>
<td>4.8</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Table 1: Descriptive stats for BAVQ-r in voices study with means for Chadwick et al 2000 included in brackets for comparison
<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>mean</th>
<th>sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voices tend to increase under situations of increased stress in my life</td>
<td>1.35</td>
<td>.49</td>
</tr>
<tr>
<td>CPNs should reinforce reality when dealing with clients experiencing voices</td>
<td>1.70</td>
<td>1.13</td>
</tr>
<tr>
<td>An increase in voices indicates a relapse of my illness</td>
<td>1.75</td>
<td>.72</td>
</tr>
<tr>
<td>CPNs should talk to clients about the meaning of their voices</td>
<td>1.75</td>
<td>.44</td>
</tr>
<tr>
<td>The CPN helps me cope with my voices</td>
<td>1.80</td>
<td>.83</td>
</tr>
<tr>
<td>CPNs should talk to clients about the content of their voices</td>
<td>1.80</td>
<td>.83</td>
</tr>
<tr>
<td>People who hear voices should be encouraged to face up to (confront) them</td>
<td>1.95</td>
<td>.76</td>
</tr>
<tr>
<td>Voices are a sign of schizophrenia</td>
<td>1.95</td>
<td>1.00</td>
</tr>
<tr>
<td>People who hear voices should be encouraged to discuss the content of their voices</td>
<td>2.00</td>
<td>1.08</td>
</tr>
<tr>
<td>People who hear voices should be encouraged to adopt their own coping methods</td>
<td>2.00</td>
<td>1.08</td>
</tr>
<tr>
<td>Nurses are the best person to talk to when I am unsure about taking my medication</td>
<td>2.10</td>
<td>1.02</td>
</tr>
<tr>
<td>Medication is the most effective means of managing voices</td>
<td>2.10</td>
<td>1.02</td>
</tr>
<tr>
<td>Nurses are the best people to deal with side-effects of medication</td>
<td>2.20</td>
<td>.95</td>
</tr>
<tr>
<td>Voices represent an individuals past experiences</td>
<td>2.40</td>
<td>1.19</td>
</tr>
<tr>
<td>People who hear voices benefit from talking to others who hear voices</td>
<td>2.45</td>
<td>1.28</td>
</tr>
</tbody>
</table>

Table 2: Rank order of responses to statements by mean and standard deviation (lower mean scores indicate greater agreement with the statement)