

'You don't talk about the voices': Voice hearers and community mental health nurses talk about responding to voice hearing experiences

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ABSTRACT

Aim: This study aimed to explore the similarities and differences in perspectives between voice hearers and Community Mental Health Nurses caring for them in relation to helpful responses to auditory hallucinations (voices)?

Background: People who hear distressing voices are often in contact with mental health services. Nursing responses to this experience have been limited, although emerging evidence suggests some useful approaches such as discussing the content and meaning of the voices.

Design: Using exploratory interviews, this study investigated the response to voice hearing, with a purposive sample of community mental health nurses (CMHN) (n=20) and service users (n=20).

Methods: This paper reports on a thematic content analysis of transcribed interviews, which highlighted differences in perspectives of voice hearers and the nurses supporting them.

Results: Voice hearers reported that interventions from CMHNs were limited to reviews of medication, access to the psychiatrist and non-directive counselling. They identified alternative needs, which involved talking about the content and meaning of their voices. Conversely, CMHNs regarded their responses to voice hearing as being considered, titrated and demonstrating an awareness of the personal contexts of service users. These responses were however restricted by their perception of skill limitations.

Relevance to Clinical Practice: The contrasting views of nurses and users of services demonstrated in this study, reveal multiple social realities that represent a challenge to accepted professional responses in the provision of

mental health care and suggest the need for nurses to provide help that is more closely aligned to the persons needs.

Keywords: nurses, nursing, mental health, community, user perceptions, interviews

INTRODUCTION

Mental health services in the UK have continued to move towards increased community-based provision. One outcome of this has been the recognition that more should be done to address the views and perceptions of people in receipt of care (Beresford 2000). This may help to determine better health and social care needs leading to improvements in subjective quality of life (Sullivan 2003). Where service user participation and feedback are sought, this can enhance healthcare professionals' understanding of experiences of care (Geekie 2004) and improve service provision (Rutter *et al.* 2004).

Many people receiving mental health care suffer from distressing voices that benefit from a range of professional interventions. Community mental health nurses (CMHNs) as the largest professional group providing mental health care in the community are well placed to provide these interventions (Gournay 2005). However, there appears to be a tension between traditional nursing approaches to voice hearing and effective interventions.

LITERATURE BACKGROUND

Auditory hallucinations are frequently experienced as alien and under the influence of some external force. These are often experienced as voices that are distressing and can cause social withdrawal and isolation. Although voices are associated with major mental illnesses such as schizophrenia, they also occur in the general population. The annual incidence is estimated between 4-5% (Tien 1991), with those experiencing voices at least once estimated between 10-25% (Slade & Bentall 1988) and 71% (Posey & Losch 1983).

The standard professional response to voice hearing has been to label it as symptomatic of illness and to prescribe anti-psychotic medication (Leudar & Thomas 2000). An alternative is to view the hearing of voices as not simply an individual's psychological experience, but as an interaction, reflecting the nature of the individual's relationship to their own social environment (Romme & Escher 1993). In this way, voices are interpreted as being linked to past or present experiences and the emphasis is on accepting the existence of the voices. Romme and Escher (1993) see hallucinatory voices as responsive to enhanced coping and found that those who coped well with voices had more supportive social environments than those who had difficulty in coping.

CMHNs encounter many people who experience voices and who want help to cope with them. Mental health nurses, like other professionals (Leudar & Thomas 2000) have traditionally been trained to reinforce reality with service users who hear voices and, more specifically, not to attend to these experiences (Lyttle 1991, Martin 1987). This appears to be a limited response given the developments in this field.

The roles of help providers and help seekers, and the differing perspectives they hold are important elements in the delivery of health and social care (Walker 2001). Service users and clinicians often differ in their appraisal of quality of life components; Clinicians' concepts of quality of life tend to be more illness-oriented, encompassing the absence of disabilities, whereas service users focus on standard of living and lifestyle (Hewitt 2007).

Mental health service users are able to articulate unique and purposeful perspectives on their condition and the help offered (Crawford & Brown 2002), which may differ to healthcare professionals. Nurses as help providers, working within the dominant paradigm of medicine, may focus on the individual as the source of the problem rather than their social or situational context. The evidence regarding voice hearing however suggests that there is a significant interplay between dispositional and situational factors (Romme & Escher, 1993), where social networks and support are more significant to subjective satisfaction with quality of life than the experience of positive symptoms (Hewitt 2007).

Walker (2001) indicates that perspectives on the locus of the problem will influence the care that helpers provide. The result is nurses taking responsibility for solving problems while not taking account of the experiences and situational context of the person experiencing them.

The project, on which this paper is based, was prompted by recognition of a scarcity of research into voice hearers' experiences. Developments in seeking participant experiences coupled with emerging evidence on responses to voice hearing in the education of mental health nurses provided the rationale for this study (Trenchard *et al.* 2002). This study, therefore, sought the views of both help-givers and help-seekers to illuminate an under-studied area of nursing practice.

METHODS

Local Research Ethics Committee approval was gained for this study. The purposive sample of voice hearers' was selected from the caseloads of CMHNs in one Welsh NHS Trust. The CMHN participants were selected on the basis that they supported the people who experienced voices. Potential respondents were offered information sheets and asked to contact the researchers if they wished to participate. CMHN participants were approached following service user interviews. Individual written informed consent was gained from all participants.

Data were collected using audio recorded interviews consisting of both forced choice and open questions based upon the literature on voice hearing and coping (Slade 1990, Tarrier *et al.* 1993). An example of a forced choice question used is: 'medication is the most effective means in the management of auditory hallucinations (voices)'. Once respondents indicated their agreement or disagreement with this statement they were encouraged to talk freely about their experiences with a follow-up request: 'please tell me more about how medication helps with the voices'. Brief demographic information was also collected.

Voice hearing participants were purposively sampled to secure a range of respondents of both genders who had been experiencing voices for at least 12 months and those who had longer histories (more than 10 years). This

process identified twenty three voice hearers on the caseloads of CMHNs who initially agreed to participate.

Voice hearers who were hospitalised, currently unwell, or on the caseload of one of the research team were not included in the study. Two interviews were terminated due to concerns about the person's mental health and these data were not used. One voice hearer withdrew before being interviewed. Our research question for this part of the study was what are the similarities and differences in perspectives between voice hearers and the CMHNs in relation to helpful responses to voices?

Data Analysis

Thematic content analysis of transcriptions followed Burnard's (1991) approach, which is adapted from grounded theory (Glaser & 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. This approach can be used to identify, analyse and report patterns in interview data (Braun & Clarke 2006).

In this study, all interviews were fully transcribed and transcripts were read repeatedly. Open coding of each line was used to account for all interview content. The computer programme QSR N6 was used to code and store extracts in a retrievable form. The open codes were then grouped into 32 separate categories. These categories reflected interview talk that addressed a range of experiences of voices, help-seeking and giving. For example

categories included, talk about medication, social support, hope, personal control, acceptance, relationship with the CMHN, discussing content and meaning of voices, reinforcing reality, lack of expertise of CMHNs, hopelessness, stressful life events, insensitive reinforcing of reality and avoidance, explanations for the phenomena, good, evil, retribution and mental illness.

Transcripts of interviews were re-read and extracts were grouped into 10 higher order categories based upon themes discernible in the data. A theme was a descriptor used to capture something important about the data which was relevant to the focus of research (Braun & Clarke 2006). The process of grouping codes into categories was informed by our research question and based upon our theoretical position that nurses may be offering help to people who hold different views about their health needs. For example these categories included a number of intervention focused groupings such as medication and talking, help seeking groupings such as wishing to talk about voices and groupings focused on beliefs about voices and illness.

This process was performed by the two main researchers and categories were then compared, discussed and changes made once agreement was reached (Burnard 1991). An academic colleague, external to the project, reviewed a sample of transcripts and produced a category system as a further check on assigning interview material to identified categories. Finally, all interview extracts in the categories were read again and categories were collapsed into three main thematic threads encapsulating

- how respondents viewed professional helping (professional help)
- how they viewed non-professional helping (self help)
- how they viewed voice hearing itself (illness beliefs).

FINDINGS

Transcripts of interviews with 20 voice hearers and 20 CMHNs formed the material for analysis. Demographic information for both groups are summarised in Tables 1 and 2. Pseudonyms have been used for all participants to prevent them being identified. This paper reports the data from the professional and self help categories as these are directly of relevance to the research question.

Professional Help

The professional help theme includes responses from participants that report experiences of help seeking and help giving. Voice hearers were asked about CMHNs responses to their voice hearing experiences. They reported that CMHNs had little direct engagement with their voice hearing but remained open to this. Categories are indicated in brackets. Ted who was diagnosed with a psychotic illness and had been hearing voices for 2 years noted: 'because uh the when this is actually happening it can be very frightening and if you can talk to someone who's got some kind of understanding about it, it would help as well as medication it would help...' [positive intervention]. Colin who was diagnosed with a schizoaffective disorder and had been hearing voices for four years agreed: 'yeah I think it's important that you talk to them because it it's a good way of getting things out into the open and analysing

them and sort of making assumptions as to what's causing this to happen' [positive intervention].

Derek who had been diagnosed with schizophrenia and has been hearing voices for 17 years saw benefits of nurses discussing the content of the voices with him: 'I think it is good that nurses do because 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 and eh, I thought that was really good what he said, like it really was encouraging' [content]. For Derek this opportunity to talk about the content of his voices enabled him to receive the reassurance and encouragement he needed to live with his voices. A clear caveat expressed by voice hearers in this study was that discussion of voices should occur in the context of a therapeutic relationship with the nurse. For example, Bethan who had a diagnosis of schizophrenia and had been hearing voices for 24 years: '...you can't always talk ...about it to um to everybody it has to be someone who's well familiar with you and knows all your history' [talking].

When CMHNs were asked how they responded to voice hearing experiences they indicated that while supportive of the idea of talking about voices they saw limitations in their ability to offer this treatment. For example, Lucy who had been a mental health nurse for 11 years said: 'I think sometimes....um for some clients we can make the situation worse. But I think the majority do need to talk about them' [negative intervention]. A tension appears to exist for nurses in that there was a sense of frustration with the focus of interventions.

For example, Ben who had been a mental health nurse for 11 years said: 'I do feel like we're fighting with one hand behind our backs in all honesty because we're slaves to the medical model' [negative intervention].

Voice hearers were asked about discussing the meaning of voices as a helpful intervention and reported that this was one way of improving coping. For example, Janet who had been diagnosed with schizophrenia and had been hearing voices for 13 years said: '...they've all got something that has upset them through their lives and it's going up in their minds and there's always a meaning to their voices' [meaning]. Mary who had been diagnosed with schizo-affective disorder and had been hearing voices for 9 years saw the opportunity to discuss meaning as a way of reducing the power of the voices: 'cause as I say it can be very frightening and sometimes you get the wrong end of the stick and by talking about it um and saying what's going on and how you think it affects you and what it means you know then again the strength can be taken out of it...' [meaning].

When asked about discussing meaning of voices CMHN respondents dismissed the possibility that voices had meaning located in past experiences. They did this with astonishing assurance. For example, Tina who had worked as a mental health nurse for 20 years said: 'um I think looking at some of the clients I've got, it's um, it's got no bearings sometimes on their past experiences, it's got nothing to do with their past experiences' [meaning]. This response was based upon their view of the voices. For example Steve who had been a mental health nurse for 11 years said: '....'cause I mean some of

them can be quite bizarre and, you know, you look at perhaps their life experiences before, it's...there's no real connection with that. Maybe things have happened in the past but I wouldn't say it was directly related to those experiences' [negative intervention].

The responses of CMHNs suggested that they were aware of a move towards discussing the content and meaning of voices and recognised that they will have to overcome their own anxieties. Siobhan who had been a mental health nurse for 22 years said: 'My training was definitely you don't talk about the voices. But now I think it's an idea that you should let clients talk about them. I don't, some clients want to talk about it and I think it's unfair if you say to them sorry no we don't really talk about...things like that, for fear of it becoming worse' [negative intervention]. Traditional approaches to voice hearing predominated among the nurse respondents and as Siobhan admits this was despite clear help-seeking signals from voice hearers.

Voice hearers were asked about responses from CMHNs when they reported an increase in voices and the universal response was that an increase in medication was offered. For example Lil who had a diagnosis of schizophrenia and had been hearing voices for 20 years said: 'well I don't get any, what she would do is that she would probably tell me to see Dr Q, to get an increase in medication or something perhaps go up to 40 mgs or whatever' [medication]. In most cases the only other intervention identified was non-directive intervention such as talking. For example, Mary who had a diagnosis of schizo-affective disorder and had been hearing voices for 9 years said: 'Um...

just talk to me more than anything you know and explain what she thinks from her experience what what is what's going on you know and try and look for reasons in my life at that time for why it's happening...' [positive support]. While this was clearly valued by voice hearers they remained concerned that the underlying symptom was not being addressed.

When CMHN respondents were asked how they responded to an increase in voices they implied allowing time for detailed analysis of events. This is indicated by Liz who had been a mental health nurse for 31 years: 'I think it can sometimes just be because they're just stressed and things will settle back down, sometimes if you look at what's going on around their life, you know, perhaps, perhaps they've got a bit of financial problems or they've had a quarrel with somebody or there's been a bit of upset within the family and when you look at what's been going on and discuss it with them...and examine things that are going on and and they realise then that they've been perhaps under a little bit more stress and things can settle back down' [positive intervention]. It seemed that an awareness of situational factors informed the help-giving of nurses.

The interview responses of nurses referenced a normalising rationale to the experience of voices. For example, Neil who had been a mental health nurse for 20 years said: 'I suppose, you know, everybody has fluctuations in their sort of how they feel, their mental state and what have you and um just because there's an increase in the hallucinations doesn't necessarily mean that um, you know, they're relapsing, you know?' [positive support]. CMHN interview responses imply subtle titrated responses that voices hearers

appear to experience as 'just talk' not specifically directed at the distressing symptom. Table 3 summarises the range of interview responses by CMHNS related to help-giving for an increase in voices.

Self Help

This theme includes responses from participants that address help-seeking and help-giving from non-professional perspectives. Voice hearing participants were asked about what helped them cope. Self help included using social support networks, self-help initiatives such as challenging the voice and establishing control over the voice hearing experience. Discussing experiences of voice hearing with other voice hearers was reported. For example Colin said: 'Yeah you get identification with people who hear voices and if you talk to people who are also schizophrenic or have a schizo-affective disorder then um you can get benefit from what they hear the kinds of things that they hear and compare things and you can feel that you're not the only one in the world suffering from this illness' [social support]. This opportunity to benefit from social supports offered reassurance which many found helpful. For example Mary said: 'if you're sitting opposite somebody and they've experienced something similar to you, you don't feel as though you're on your own then, you know and you [are] not as...isolated then you know' [social support].

Importantly, not everyone agreed with this view as Eric, who had a diagnosis of bipolar disorder and had heard voices for 20 years noted: 'the last bloody thing I'd want to do is talk about... somebody else's ... illness...I have enough

of my own' [social support]. Eric was concerned that talking to other voice hearers would add to the burden of his symptoms.

Nurses were asked about helping people use supports such as discussing their symptoms with others who hear voices. Some shared the opinion of voice hearers in perceiving social support benefits from this activity. For example, Meg who had been a mental health nurse for 17 years said: 'With any illness I have found that people who have like problems gain support and understanding from each other. They realise that they are not alone, that there's somebody else who's suffering as they are' [social support]. There was also agreement that this should be dependent upon individual choice. For example, Rachel who had been a mental health nurse for 23 years said: 'they can benefit from talking to others in that they develop different coping strategies from one another. But it has to be because that's what the client wants'. There was a concern from some participants that self-help groups for voice hearers would add further to distress. Lucy a mental health nurse for 11 years said, 'I think sometimes they take on board the other persons hallucinations and (intake of breath).....[it]could exacerbate their illness' [social support].

Voice hearers reported establishing personal control over the voices by challenging them as another way of coping. For example Adam who had a psychotic illness and had been hearing voices for 18 months said: 'I have, I have tried that myself, challenge it and challenge it and other times you just give into it and just go the other way thinking somehow it will go away

depends which, you don't know which way... if you keep challenging and challenging will it go away and other times you think if I don't challenge it and just let it wash over me will it go away' [personal intervention]. Gareth who had been hearing voices for 17 years emphasised the negative consequences of not exerting control: 'Because the one thing about it you know if you leave the voices you know take control of you, you know, you know it might get out of hand you know and you might get into trouble' [personal intervention]. Voice hearers articulated the need to take personal responsibility for their own experiences. This contrasts with the nurse participants.

For instance CMHNs indicated a conviction that people are not interested in confronting their voices as a coping strategy. For example Bill who had been a mental health nurse for 15 years said: 'I suppose people will talk about them but they won't really want to look into them with any depth they just want them gone because it's so um...so horrendous for them' [personal intervention]. Selma who had been a mental health nurse for 12 years invoked the notion of risk: 'that could be dangerous, do you know what I mean? Sort of like, telling them to be quiet sort of thing, voices, you know, some people... it might not be appropriate...' [personal intervention].

CMHN participants were generally concerned about the outcome of people challenging their voices as they did not feel sufficiently prepared to help support voice hearers in this endeavour. For example Ben said: 'I don't feel ... in a position to have enough weapons in my armoury to be able to support them when the wheel comes off sort of thing, you know?' [coping]. Others

were reluctant to accept a role for nurses in providing this support, for instance Meg said: 'If they choose to do, to umm confront their hallucinations then it's up to the individual. I wouldn't see it as being my role to encourage people to face up to their voices. I think I'd be quite wary of doing that' [personal intervention].

This negative view contrasted with voice hearers talk who saw gaining control as a source of hopefulness for the future and achieving recovery. For example Matt who had a diagnosis of schizophrenia and had been hearing voices for 10 years said: ' eventually I I should think I won't be relying on voices for anything you know by which time they might go cos I've had opportunities over the years when they've receded you know, ...so they do get better' [coping].

In summary voice hearers saw the care they received from CMHNs as limited in its range with a clear emphasis on a medical paradigm. They reported access to the doctor, adjustment of medication and sometimes talking as responses offered by CMHNs. Voice hearers however were open to discussing their experience with a trusted professional and felt more could be done to help them.

Some CMHNs indicated that they saw voice hearing as an interactional event reflecting the person's relationship with their social environment but they reported limited expertise in responding to help-seeking of voice hearers. They indicated a relatively orthodox view of the experience as being

essentially biochemical in nature. This highlights a clear difference between how voice hearers report their needs for help and what nurses are able to offer.

DISCUSSION

Evaluations by service recipients of CMHNs in the wider literature are generally positive (Adam *et al.* 2003) although for the most part these do not focus upon responses to specific problems. Crawford *et al.* (2002) have noted that CMHNs may be reluctant empiricists, resisting the overtures of evidence based practice as a means to retain a sense of control over their work. Our findings suggest that this reluctance may be evident in limited responses to voice hearers help-seeking. As a result voice hearers are not fully informed of the range of helping initiatives that enable more effective coping. This mismatch between help seeking and the help provided highlights a lack of awareness of evidence in the field. One example of this is the opportunity for voice hearers to benefit from approaches such as examining cognitions about the voices. A combinative approach to mental health problems is considered essential in promoting recovery from mental illness (Davidson & Strauss 1995) and may contribute to reduced isolation and social exclusion (Davidson *et al.* 2001). Integrating voice hearers help needs and coping experiences into individualised treatment approaches will help clinicians provide more successful help (Boyd Ritsher *et al.* 2004). Voice hearer respondents to this study appeared more attuned to such possibilities than the nurses working with them.

To enable CMHNs to promote recovery from serious and enduring mental health problems a range of helpful values, beliefs and technical skills are deemed necessary (Anthony 1993, NIMHE 2004, Repper 2000). The responses from nurses in this study suggest that contrary to the literature (Romme *et al.* 1992) they are not prepared to respond to voice-hearers help-seeking. The concern is that uncertainty about the help that should be offered can lead to reduced opportunities for recovery. In some instances the tension between perspectives on voice hearing was directly alluded to and some nurses reported feeling limited in their practice.

A picture of logical, considered and expert practice is displayed in the talk of CMHNs. The respondents positioned themselves as experts offering titrated interventions commencing with detailed assessment of changes, progressing through options including revising coping, variation of medication, consultation with the psychiatrist and possible hospitalisation. This allows voice hearers the opportunity to practice a repertoire of coping strategies while engendering a sense of empowerment and control (Caplan 1970). However voice hearer responses indicate a different perception and in many cases they report an inadequate response to their distress. The repertoire of informal coping used by voice hearers was developed without input from nurses. Both groups view the voice hearing experience differently and therefore see the need for different ways to address it. This finding illustrates the potential of gathering multiple perspectives of recipients and deliverers of care. These different perspectives suggest the rationale for care responses was not adequately

communicated to voice hearers during periods of increased distress when they are seeking increased support and care.

The desire for establishing control over ones own life has in part led to the development by voice hearers of self help groups offering peer support, shared experiences and enhanced coping (Coupland 2000). This was one area where voice hearers and CMHNs agreed that benefit would be derived from talking to others who hear voices. The social support aspect of such encounters was emphasised by respondents. Less formal more eclectic approaches to self-help and illness management by voice hearers is an acceptable approach and one which is likely to challenge professional helping paradigms (Coleman & Smith 1997). An important caveat however is that decisions about support groups should be individualised and not applied as a standard response to all voice hearers.

The professional imperative has been to deny the existence of voices and re-orientate individuals to a more objective reality (Leudar & Thomas 2000). Voice hearers however reported adopting their own coping methods such as confronting the voice to assert personal control. The acquisition of personal control over the experience is seen more widely as an essential aspect of recovery (Young & Ensing 1999). It reflects an expressed desire by recipients of mental health care 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). The challenge for CMHNs is to

sensitively support this recovery so that their help-giving is informed by the experiences of voice hearers and the developing evidence.

LIMITATIONS OF THIS STUDY

The limitations of this study include its restricted focus to one health-care organisation and one group of nurses and voice hearers. It is, therefore, not possible to predict how similar or different practice responses are to voice hearing in community mental health nursing more generally. We have however attempted to give as much information as possible within the confines of confidentiality and anonymity to allow other researchers to determine how typical our groups are within the broader nursing and voice hearing communities. The focused interview approach may restrict alternative and perhaps more fruitful avenues of investigation which may not be examined in detail due to being outside the central focus of the study. For example, this method was not adequately flexible to pursue the issue of social support and its context once this became apparent within the study. Given the exploratory nature of this work, a less structured, non-directive approach to investigation may have been more appropriate.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

Helping people cope with their experiences of voice hearing requires a mental health nursing response, which focuses on the expressed needs of service users rather than the bio-medical edicts of psychiatry (Hewitt & Coffey 2005). The recovery model has challenged the perception of mental illness associated with inexorable decline, and has advocated a change in emphasis

from concentrating on the objective measurement of symptoms, to listening to the expressed needs of people with serious mental illness (Repper 2002).

The mental health nursing response to voice hearing should include an exploration of the content and meaning of voices, their links to past and present experiences and the patient's interpretation of the phenomenon. Meaningful engagement with people requires a commitment to the establishment of collaborative therapeutic relationships, which encourage client autonomy and lead to the development of self-management strategies (Nelson-Jones 1997, *Townsend et al.* 2000). Peer support groups may provide one means of returning autonomy and may also play a key role in providing social support.

The education and preparation of mental health nurses for practice should focus on specific techniques for voice hearing, including supportive challenging and catalytic interventions. Service user input into nurse education is required to assist nursing students to identify the help seeking needs of people with serious mental illness.

Differing perspectives about the adequacy of care responses suggests the need for CMHNs to bracket assumptions derived from professional conditioning and to identify with help seeking needs of voice hearers identified through narrative.

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	Frequency		mean	Sd (range)
Gender	female	(n=10)		
	male	(n=10)		
Age	20-40 years	(n=9)	43 years	13 (22-68 years)
	>41 years	(n=11)		
Years hearing voices	2-9 years	(n=10)	12.8years	12.1 (2-48 years)
	>10 years	(n=10)		
Diagnosis	Schizophrenia	(n=15)		
	Bipolar illness	(n=1)		
	psychotic episode	(n=2)		
	Unknown	(n=2)		

Table 1: summary of voice hearer (n=20) demographic information

	Frequency	mean	Sd (range)
Gender	female (n=11) male (n=9)		
Grade	F grade below (n=11) G grade or above (n=9)		
Years in nursing	10-20 years (n=13) 21-31 years (n=7)	18	5.7
Years in current post	1-5 years (n=8) 6-10 years (n=9) 11-19 years (n=3)	7	4.6 (10-31 years)
Post registration qualifications	diploma (n=5) BSc (n=2)		
Caseload size	<20 (n=6) >20 (n=14)	29	14.3 (4-61)
Numbers on caseload who hear voices	<11(n=9) >11 (n=11)	17	13 (1-40)

Table 2: summary of CMHN (n=20) demographic information

Table 3: CMHNs talk of their responses when voice hearers report a change in their voices

Category	Verbatim quotes from CMHNs
Assessment of what the change is	<ul style="list-style-type: none"> • ‘I look at what the changes in the voices are, what the voices are saying..um.....’ • ‘well I would talk to them about what the change was about, any increase and I would assess their level of distress’ • ‘discuss the content um find out if there are any, sort of, um external um changes in their circumstances I suppose’ • ‘discuss what the change or increase is’ • ‘is there anything else going on in their lives which is creating stress which would increase maybe their voices’ • ‘find out maybe why? Is there any particular stresses going on in their lives’ • ‘First off as I’ve said I think um we look at what’s been happening usually, what’s going on at the moment or what’s happened recently.’ • ‘if you can say well look, you know, you’ve had a lot of stress recently, bear with it, I’m sure this is, you know, this <i>may be</i> something to do with it’ • ‘Obviously some sort of assessment as in, you know, look at why they are more frequent, maybe sort of how is it more frequent..um.....how much of a problem is it causing to them.....what they would like to do about it....’ • ‘um or maybe looking at some sort of stress factors that might be, you know, sort of contributing to them in dealing with those maybe’ • ‘Ummm problem solving really. Trying to find out what the antecedent is, what’s happening in their life?’ • ‘You’ve got a duty to pursue it and you try and sort of gather more information really as well.’ • ‘It all depends on the content..... And their ways of coping’ • ‘Um I tend to explore with them if there were any sort of precursors to this change, you know, again with the stress or if anything had happened within the family or within the home environment’
Use own coping strategies	<ul style="list-style-type: none"> • ‘I’d encourage them to find any strategies or any times when strategies or any things that they do reduce this or’ • ‘And if it continues then you may uh well get an early outpatient appointment with the consultant. You try to get the patient to manage it themselves first’
Increase medication	<ul style="list-style-type: none"> • ‘I would also look to medication etcetera’ • ‘probably increase their medication.’ • ‘increase the medication’ • ‘...um if it continues then we would review their medication as well’ • ‘maybe try your medication a little bit later or earlier and see what goes on then rather than look for a straightforward increase.’
Monitoring for change	<ul style="list-style-type: none"> • ‘if the client is reporting an increase in the voices but nothing else seems to have changed I’d just monitor it for a while.’

Refer to psychiatrist	<ul style="list-style-type: none"> • ‘I’d refer them to the consultant I’d get an assessment done very quickly.’ • ‘get them to see the doctor and...’ • ‘I’d suggest an appointment with the doctor’ • ‘if necessary if they were particularly disturbing I would arrange for a review with the doctor’ • ‘consider possibly maybe looking at um some sort of medical review....’ • ‘And if it continues then you may uh well get an early outpatient appointment with the consultant.’
Non-directive counselling	<ul style="list-style-type: none"> • ‘It’s probably just general talking about it’ • ‘Um, discussion, support, reassurance...’
Increase visits	<ul style="list-style-type: none"> • ‘perhaps I’d call more often’ • ‘obviously I would see them more and what I would normally do uh...if that’s what they wanted I would offer more time, make myself more available’ • ‘increase support, might um the first thing I probably would do’ • ‘Lots of support really, a bit of reassurance. Um and there’s closely monitor I will, you know, perhaps I’ll do a few more visits regularly just to see what’s going on.’ • ‘you make sure that, you know, the persons having a bit more support and allow them to talk about it if that’s what they want to do.’
Collaborate with service user	<ul style="list-style-type: none"> • ‘it’s negotiation with the client about what they want’
Diary	<ul style="list-style-type: none"> • ‘Um and then possibly ask them to write it down.... um keep a diary then.’ • ‘Um I’ve also started telling them to sort of keep a little bit of a diary really to sort of see when, although a few people have been, because it’s probably having been on a course obviously I’m a bit more up, up to the speed on it. But I sort of thought well if we could see when it was, but they seem, but they’ve not liked that idea really, they’ve found it quite difficult, two of them have found it quite difficult to actually’ • ‘Get the patients to keep diaries so we can discuss what’s happening’
Make use of own support networks	<ul style="list-style-type: none"> • ‘getting a bit more support as well if there’s someone else involved’
Other intervention	<ul style="list-style-type: none"> • ‘um after that, after we’ve sort of explored whether or not there is a reason for it I tend, I tend to sort of work with them and try and get them to sort of try some distraction methods really is the way I tend to approach it. Just to sort of see if they’re able to distract themselves from it,’ • ‘There’ll be a planning, contingency planning if there are any problems if um there is any risk of self harm or deterioration’

