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Constructing the identity of people who hear voices through language and social interaction

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Formulating a narrative between voices and trauma: An integrative approach

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Declaration

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CHAPTER 1 Preface to Portfolio

A.1 Preface

The portfolio comprises of three elements: an empirical research study, a clinical case study and a publishable article. The theme permeating the three pieces of work, completed for a professional doctorate in Counselling Psychology, is the role of language in identity construction. The social constructionist viewpoint taken in this portfolio, suggests identity is not an essentialist feature residing in the individual, identity resides in the social (Burr, 2003). Moreover, identity is not fixed but continuously constituted and reconstituted in the process of social interaction. This suggests that attempts to construct the self are not always sanctioned, they are negotiated with others in the social domain (Benwell & Stokoe, 2006). In addition, if meaning is the fabric of social life, discourse, the shared cultural meanings and understandings on a subject, forms the backcloth. Discourses provide a rich resource that we may draw upon to talk about things. From this perspective, language is not simply a means of relaying what is within our minds. Language is performative; it does not only just describe social reality, it also changes it (Edley, 2001). Each element of this portfolio places an emphasis on how language is used to construct identity and highlight the processes through which language constructs meaning.

The empirical research adopts a critical discursive analytic approach that looks at how people who hear voices construct the identity of being a ‘voice hearer’[1]. The analysis focuses on identifying the discursive strategies that participants employ as they position themselves in discourse to negotiate their identity. A dual analytic focus is adopted that takes both a micro and macro approach to discourse. At the linguistic level the analysis looks at the rhetorical devices that participants employ to do things with talk, for example justify, persuade, disclaim. Rhetorical devices include the use of metaphor, extreme case formulations, footing and active voicing (Potter, 1996). A micro focus investigates the action orientation of talk: what participants try to do with language and what actions result from the constructions accomplished. At a macro level, the analysis looks at the broader discourses in society on voice hearing, which also includes a genealogical approach to how different understandings of voice hearing have emerged and have been transformed through different historical periods and

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[1] Voice hearer denotes someone who hears voices

times. An analysis of language and discourses plays a crucial part in the analysis of the research data.

The clinical case study describes the therapeutic intervention that I completed with a young teenager who hears voices, on an acute inpatient ward. This work also highlights the importance of language in constructing a preferred identity in therapy and reconceptualising trauma. The therapeutic approach is also social constructionist as it uses elements of narrative therapy to understand and treat the client's difficulties (Rhodes & Jake, 2009). Specifically, the work highlights the narrative approach used to help the client develop an understanding of the voices that she hears, in relation to her own life experiences. This approach suggests that language is where meaning is created and in the case of trauma the therapist helps the client to try to put what is incomprehensible into words. Furthermore, the therapeutic intervention adopts a relativist stance to the theoretical models that inform it (Rhodes & Jake, 2009). The different therapeutic models (Narrative therapy, Solutions Focused Therapy and Cognitive Behavioural Therapy) are integrated to suit the formulation of the client's problems. The approach is flexible and acknowledges the relativist nature of knowledge and theoretical models, particularly in working with clients that have complex needs. No view or approach is viewed as superior to another. Techniques are used to the extent in which they can provide a solution to the client's problems and can be combined and integrated in various ways to suit the client's needs. Furthermore, the intervention took a systemic approach that aimed to understand problems within their interpersonal and social contexts (Rhodes & Jake, 2009). It thus placed an emphasis on the context of these experiences, such as family and social relations.

Another aspect in which the different elements of the portfolio come together is the normalisation of the experience of hearing voices. The research attempts to deconstruct traditional and pathological notions of voice hearing. A critical discursive approach is taken that challenges dominant and oppressive discourses that serve to marginalise, exclude and reinforce the status-quo, allowing people who hear voices to develop alternative and less pathological constructions of their experiences. The focus of the publishable article is the ideological dilemmas inherent in negotiating the construction of voice hearing in the social domain. Furthermore, the findings of the research suggest the need to take an outside-in approach to therapy. The clinical case study illustrates this, by beginning therapy with a normalisation phase where pathological discourses are questioned and challenged. The initial normalisation stage of therapy was the key factor in establishing a therapeutic alliance with the client, allowing her to engage with the process of therapy (Rhodes & Jakes, 2009). This normalisation phase included describing the experience of hearing voices as a common phenomenon, an experience that some people find distressing and others do not, that in some cultures it is even considered to be a gift and hence it is not necessarily pathological. It also involved challenging the dominant discourses of madness and dangerousness, presenting the problems associated with hearing voices as being present on a continuum, a response to life trauma and other life stressors (Cooke, 2014). This stage of therapy was essential in giving the client the courage to talk about her experiences, in a culture that has traditionally tried to suppress these, through the medical model to eradicate 'symptoms'.

It is acknowledged that throughout the portfolio the findings of the empirical research, the clinical case study, and publishable article are also constructions, with the researcher playing an important role in this process. Although every effort was made to put across the personal accounts of people who hear voices, the product of these efforts is a co-construction and was dependent on the approach taken and the prior experiences of the researcher. More saliently, the co-construction in therapy of a new narrative of life experiences, including trauma and what the voices say, was the most effective part of the intervention with the client. Co-construction is a key element of solution focused and narrative therapies (Rhodes & Jake, 2009). Through language the client understood negative experiences and emotions in the context of her life narrative (Rhodes & Jakes, 2009).

An important aspect of language, is that despite the flexibility in the way in which it is applied, it is also deterministic in nature. For example, being placed in the category of 'schizophrenia' is associated with certain ways of being that are inescapable (e.g., having to take medication, being turned down from employment opportunities). However, it is also a flexible resource that provides many possibilities for action, enabling individuals to construct themselves to suit each occasion. Undoubtedly this may involve a struggle and negotiation with others. What is important to note from each piece of work in this portfolio is the dual impact of language, where discourse has an impact on individuals as it positions subjects and closes possibilities for action, however individuals are also able to resist and change discourse. There is a tension between determinism and agency, which is something that is evident throughout this portfolio. It is evident in the ideological dilemma encountered by research participants struggling with distressing experiences that they cannot openly talk about to others, whilst at the same time trying to normalise these to attain a proximity with the rest of the population. These discursive strategies are an attempt to construct a more positive identity for people who hear voices, sometimes to their own detriment. Similarly, in the clinical case study, the client re-appraised the meaning of the voices she hears, by linking the content of these with her traumatic past, allowing for a less problematic view of the self. However, it is argued throughout the portfolio that this work is not achieved alone by the individual. Others need to sanction more positive constructions of voice hearing if these are ever to gain momentum and this where the dilemmatic nature of talk is ever present.

The work undertaken in this portfolio is close to my heart. It stems from years of working with people who hear voices, which sadly has now ended as I now embark on a new journey as a counselling psychologist. I have many memories of holding the pain of clients in very difficult and distressing moments, but also some very lovely memories of spending time with them, taking them out in my support worker capacity and getting to know them. I met some amazing people in this process, which I will never forget and these people have been the inspiration for the work that has been undertaken in this portfolio. This journey has not been easy, particularly working on placement at the acute inpatient ward, where I met many people who hear voices that were in a lot of distress. I hope that by empowering them to talk about their experiences through language, allowed them to construct a preferred identity. I would never change this experience and I feel lucky and blessed to have found myself on this journey.

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CHAPTER 2 EMPIRICAL RESEARCH

Discursive strategies in negotiating the voice hearing identity: A critical discursive approach.

B.1 ABSTRACT

Few studies and interventions address the impact of the experience of hearing voices on identity. Identity issues are particularly salient due to the discrimination and stigma that these individuals face. The current study draws on a critical discursive approach to identify discursive strategies that participants use to negotiate the voice hearing identity. Semi-structured interviews were conducted with eight participants recruited from the Hearing Voices Network. Analysis took a micro-focus looking at interpretative repertoires, ideological dilemmas and subject positions, as well as a macro-focus looking at the broader discourses of voice hearing present in society. Two contrasting interpretative repertoires were identified. On the one hand voice hearing was constructed as a distressing and difficult experience. On the other it was constructed as a normal, ordinary experience. Normalising the experience of hearing voices in the interest of establishing a closer proximity with the rest of the population results in the distress that voice hearers experience being missed. In addition, participants used six discursive strategies to negotiate identity. The ‘positioned as object’ strategies of blaming, disclaiming and justifying are overt and reject the social identity on offer, increasing the gap between voice hearers and non-voice hearers. The ‘positioned as subject’ strategies of normalisation, trivialisation and reframing are covert and construct a preferable identity that helps people who hear voices integrate with society. The findings suggest that these discursive strategies have implications in delivering interventions and point towards the need to take an outside-in approach by addressing identity issues in therapy.

B.2 INTRODUCTION

B.2.1 Introduction and research context

The experience of hearing voices has received extensive research attention predominantly due to the distress that is sometimes associated with hearing voices and the need to deliver interventions. Smith et al. (2006) investigated the role of emotion in people who hear voices with a diagnosis of 'psychosis' and found that low self-esteem had a negative impact on distress. During my own experience of working with people who hear voices, I often wondered what factors contribute to low self-esteem. I wanted to know from people who hear voices and through their own accounts how they construct this experience, as opposed to what has previously been investigated by health professionals and academics. Couple to this are findings that suggest, the extent of the secrecy and the lengths that people who hear voices go to hide their experiences from others, results in an isolated existence (Knight, Wykes, & Hayward, 2003).

Furthermore, the phenomenon of hearing voices receives a lot of attention in the media and is a highly-politicised subject (Blackman, 2015). Quite often this publicity is associated with violent acts, instead of positive images (Coombes, 2006). In the western world, the widespread association of this experience with mental ill health and specifically with the diagnoses of schizophrenia or psychosis, limits possibilities for people who hear voices. Recently, concerns have been raised about mental health issues becoming a social problem due to rising numbers seeking help from mental health services, inadequate service provision and worsening outcomes, increased use of medications, long waiting lists, unemployment and depleting resources (NHS – National Health Service England, 2016). Such reports serve to raise fear in the public about social control and safety, reinforcing negative images of people who hear voices. This context made me wonder what impact such discourses have on the identity of people who hear voices.

B.2.2 Defining Voice Hearing

The experience of hearing voices has been understood in different ways across various historical periods. Before embarking on a genealogical approach to the experience of hearing voices, clarification is needed of what 'voice hearing' is, including the associated frameworks from which this experience is understood. There is considerable debate on the terminology used to describe the experience of hearing voices (Cooke, 2014). A simplistic definition includes an individual hearing voices speaking when there is nobody present (Cooke, 2014). Hearing voices is a common experience, which despite traditional views describing this experience as a psychiatric symptom of the diagnosis of schizophrenia or psychosis, is not always associated with pathology. It is estimated that 10 percent of the population hear voices or have unusual experiences (Cooke, 2014). Traditionally in the West this experience is associated with illness and the diagnosis of schizophrenia or psychosis; a view also reinforced by institutions and their practices. However, there are many competing frameworks for understanding this experience, not all of which are pathological. It is also important to note that not all people who hear voices seek support from mental health services (Cooke, 2014). The following section begins by presenting a genealogical approach to the emergence of some of these understandings. It is followed by a description of the most prominent discourses on voice hearing today including their empirical bases.

B.2.3 Genealogical approach to the experience of hearing voices

Up until the 17th century in Western Europe, the experience of hearing voices was attributed to the supernatural; witches, demons, magicians or deity (God, Devil) (McCarthy-Jones, 2012). Following this period, the establishment of the church was threatened by an increase of individuals claiming to hear voices and declared this experience, outside of the church, to be a sign of madness (McCarthy-Jones, 2012). In addition, the decline in the power of the church gave rise to the ‘Age of Reason’, an eighteenth-century movement in Europe, which questioned the authority of the church by seeking to find rational ways of explaining phenomena and bringing new conceptualisations of voice hearing. The ‘Age of Reason’ led to the advancement of physical science and all phenomena were primarily understood through reason alone (Locke cited in Schouls, 1992). Madness began to be associated with unreason and medical accounts prevailed over other explanations of hearing voices. Voice hearing was explained in physiological terms of illness, for example an excess of black bile (humours) (Matthysse, 1973). Anyone claiming to hear voices was thought to be mentally ill. In addition, the mentally ill were confined to buildings that hosted lepers and this marked the beginning of mental ill health being attached to the stigma with which it is associated today (McCarthy-Jones, 2012). The disordered were constructed as the inferior ‘other’ and confinement was a way of controlling the social problem of poverty and vagrancy.

The industrial revolution of the 18th and 19th century saw the emergence of the labour market and anyone not able to contribute to this was considered defective (McCarthy-Jones, 2012). Asylums arose in response to the need to rehabilitate people to the market place and psychiatry (the medical model) gained prominence. Madness was constructed as something getting out of control and in need of being restrained, thus giving those with power the authority to section people and enforce treatment, as a way of controlling the problem. Experiences that were out of the ordinary were considered a sign of madness, an illness of the brain to be cured through medical remedies. There was a gradual move away from the church to the medical profession to treat the mentally ill (Goldstein, 2001). Tamburini's neurological approach to voices (1881, 1990), which linked the experiences to excitation of grey matter in the brain, was a key catalyst to the medicalisation of hearing voices as a disease of the brain. There was little interest at this point in deciphering the meaning of voices.

In 1911, Bleuler came up with the term 'schizophrenia' and psychological understandings of the experience began to emerge (McCarthy-Jones, 2012). His initial conception was influenced by psychoanalytic ideas and was based on emotional abnormalities (Cromby, Harper, & Reavey, 2013). There was an attempt again to understand the meaning of voices, as opposed to relying on neurological explanations. Initially there was an attempt by Freud to link voice hearing to environmental factors, such as child sexual abuse, claims which he subsequently repudiated (McCarthy-Jones, 2012). This lead to the development of essentialist notions of the experience, locating the problem in the individual and affecting the course of treatment over many years to come. Nevertheless, Jung (psychiatrist and psychoanalyst) and Jaspers (psychiatrist and philosopher), tried to contribute to developing an understanding of voices in relation to someone's life experiences (McCarthy-Jones, 2012).

With the emergence of the DSM (Diagnostic and statistical manual) of disorders after the war, voice hearing began to be associated with psychotic disorders such as schizophrenia, first mentioned in the DSM III in 1980 (APA – American Psychological Association) and this association continues today in current editions (APA, 2013). The resurgence of the medical model began in the 1950s following the discovery that antipsychotic medications provided some relief to people that hear voices (McCarthy-Jones, 2012). These medications originally were developed for use in anaesthesia and epilepsy. In the 1960s, more and more antipsychotics came onto the market and advertisements for antipsychotics constituted 65% of all advertisements in the British Journal of Psychiatry (Allison & Moncrieff, 2014). Initially, antipsychotics were marketed as drugs for emergencies with the purpose of containing aggressive and violent behaviour (Allison & Moncrieff, 2014). In 1975, different drugs were recommended for different disorders; antipsychotics were suggested to treat the challenging and violent behaviour present in schizophrenia (Allison & Moncrieff, 2014). They were also used (and still are) in autistic, epileptic and brain-damaged patients to manage challenging behaviour (Allison & Moncrieff, 2014). Gradually there was a shift in their utility from medication that controls behavioural disturbance towards controlling the symptoms of illness and to reframe their use in therapeutic terms to cure underlying causes of disease (Cromby et al., 2013). This shift was supported by the 'dopamine' hypothesis, which proposes a chemical imbalance in the brain and provided the theoretical background for the application of antipsychotic drugs to the treatment of schizophrenia (Matthysse, 1973).

Marius Romme, a prominent psychiatrist from the Netherlands, suggested that diagnostic categories should be abolished and together with his work on emancipating voice hearers, began the new movement of hearing voices (Maastricht Web, 2014). Until the 1980s people who heard voices were not encouraged to talk about their experiences and little was offered in terms of treating 'symptoms' aside from medications (Frank, 1995). Up to this point, the experience of hearing voices was dominated by the medical model and psychiatry. Postmodernism however in Western society and culture (mid to late 20th century) reacted to the proposition that objective and scientific ways of explaining phenomena are the only valid methods of describing reality (Harré, 2001). The movement caused traditional views of understanding the experience of hearing voices to change and people who hear voices were encouraged to share their stories (Frank, 1995). The hearing voices movement (service user movement) was an emerging approach developed as an alternative to the medical model of hearing voices and was established in the Netherlands in 1987 by Marius Romme and Sandra Escher (Escher & Romme, 2012). It aimed to promote alternative understandings of the experience of hearing voices based on the personal accounts of those who share these experiences. The Maastricht approach they proposed came in response to the medicalisation of distress and the medication enterprise of the pharmaceutical industry, placing an emphasis instead on accepting and making sense of voices (Maastricht Web, 2014). Organisations emerged due to the resurgence of the need of voice hearers to talk about their experiences (e.g., Intervoice Web, 2016; HVN- Hearing Voices Network Web, 2016). They espouse multiple understandings for the experience of hearing voices, one of which is the idea that this experience is a response to traumatic life events (Longden, Madill & Waterman, 2012b).

B.2.4 Discourses pertaining to voice hearing

The term 'discourse' carries different meanings in the social sciences and is dependent on the methodological approach adopted. In this study, discourse is viewed as an historically specific system of meanings, which forms the identities of subjects and objects (Foucault, 1972). In addition, discourse is a cultural system of shared meaning that enables us to categorise and understand the world around us. The next section delineates discourses pertaining to voice hearing.

B.2.4.1 Madness

The term ‘mad’ to describe people who deviate from the norm and especially people with mental health problems, has been around since the 13th century where even from these early years, madness was associated with fear (Cromby et al., 2013). Foucault (2006) describes madness as a social construction, a way that dominant intellectual and cultural forces exert power over society. As the genealogical approach to hearing voices indicates above, the phenomenon of hearing voices has been understood differently in various historical periods and cultures. As we saw during the classical period (between 1730-1820) in Europe, reason came to exert influence over unreason (those considered to be mad, lazy or bad). Those unable to contribute to the work force were incarcerated, as a way of controlling and preserving order. Confinement pathed the way to increase the power of the medical profession to diagnose and treat the ‘mad’ (Foucault, 2006). Foucault attempted to combine the subjective experience of the mentally ill with the sociocultural context of mental illness of the time (Joranger, 2016). He was concerned with how phenomena such as mental illness and the experience of hearing voices changed historically, and he criticised philosophy and psychology for not adopting an historical approach (Joranger, 2016). Specifically, he highlighted the inability of psychology to account for notions of deviance and madness, how these emerged over time, and how these serve to marginalise those so labelled. Foucault also believed that mental illness was caused by the ills of society and continuous conflict through rivalry, class, competition and exploitation (Joranger, 2016). He attributed problems to society as opposed to the ‘mad’. Notions of madness are still highly prevalent in the Western culture. These are observed in the way that madness is depicted in the media for example newspaper articles - *Psychopathic killer: the homicidal boy next door* (Bonn, 2014), and films: *Psycho* (Hitchcock, 1960), *One flew over the cuckoo’s nest* (Douglas & Forman, 1975), *Shutter Island* (Brigham & Scorsese, 2010). Lawson & Fouts (2004) have also shown how images in Disney films depict people with mental illness as ‘crazy’ or ‘nuts’, and suggest that children are being socialised into a discourse of madness.

B.2.4.2 Danger and Violence

There are many misconceptions in the public about mental health (Angermeyer & Dietrich, 2006; Darrell-Berry, Berry, & Bucci, 2016). One of these is the misconception that the experience of hearing voices is linked to violence. The public have been shown to hold exaggerated perceptions of danger in relation to mental illness and a tendency to seek social distance from such individuals (Dennenny, Bentley, & Schiffman, 2014; Silton, Flannelly, Milstein, & Vaaler, 2011). The media frequently portray violence as linked to mental health and the diagnosis of schizophrenia and psychosis (Allen & Nairn, 1997; Coverdale, Nairn, & Claasen, 2002; Coombes, 2006). Aoki et al. (2016) in a review of newspaper articles on the diagnosis of schizophrenia found that 53% of articles were categorised as 'negative' and 38.9% were included in the sub-category of 'danger'. Violence occurring in the context of mental illness is often constructed as a significant concern for the public and health professionals. This discourse is also widely present in institutions and through the practice of risk management associated with certain symptoms or diagnoses (Buckley, Noffsinger, Smith, Hrouda, & Knoll, 2003; Darrell-Berrill et al., 2016; Elbogen, Swanson, & Swartz, 2004; Wilson, 2007). Health professionals have also been found to hold negative attitudes towards mental health (Jorm et al., 1999). These practices are further reinforced in England and Wales by the law and the Mental Health Care Act 1983 (amended in 2007) (Legislation.Gov Web, 2007) which allows approved mental health professionals (AMHP) to section (incarcerate) people who are deemed to be of danger to themselves and/or others. Some argue that such measures are also the consequence of inadequate care in the community, due to increasing pressures faced by services having to work with continuously depleting resources (Arbolita-Florez, 2009).

Despite such widespread assumptions, the most important risk factors associated with violence are gender, alcohol and/or drug use, and a prior history of violence, as opposed to having mental health issues (Cooke, 2014). In a quantitative study, Elbogen and Johnson (2009) investigated the relationship between mental health, substance misuse and/or dependence, and predicted risk of violence. The results provided evidence that schizophrenia does not predict future violence. The findings also indicated that other variables such as individual or situational factors increase the risk of violence (e.g., physical abuse, parental criminality, unemployment, victimisation, environmental stressors). However, despite empirical evidence to suggest otherwise, the media continue to link the experience of hearing voices with violence: *Man with paranoid schizophrenia who murdered his parents is detained for life* (Ferris, 2015); *Schizophrenic murderer 'possessed by the devil' freed from prison to kill girlfriend jailed for life* (Armstrong, 2014); *Schizophrenic murders his mental health advocate* *mom, 63, and 91-year-old grandmother* (Parry, 2016); *Guilty of murder in schizophrenic knife rampage* (Cheston & Randhawa, 2013).

B.2.4.3 The medicalisation of distress (Biomedical discourse & psychiatry)

In the last few decades, the biomedical model has been the predominant model used to treat the experience of hearing voices under the diagnoses of schizophrenia and psychosis (Deacon, 2013). This model is based on the presumption that unusual experiences such as hearing voices are caused by a chemical imbalance in the brain (Seeman et al., 2005; Wang et al., 2010). However, there is no empirical evidence in support of the imbalance hypothesis with evidence suggesting that antipsychotic medication has a general effect, unable to target all the dimensions of the experience of psychosis that cause distress (Mizrahi et al., 2006). Proponents of the medical model also argue for the presence of a susceptibility gene implicated in the development of schizophrenia transmitted across generations (Williams, McGuffin, Nöthen, & Owen, 1997). This susceptibility however is one of many factors that can lead to the development of psychosis and is relatively small (Cooke, 2014). Due to the significance that this model places on treating the experience of hearing voices as an illness, the predominant treatment is the use of medication. This model has a longstanding tradition originating back to the medical work of Hippocrates (460-370BC) based on humoral medicine, where humours of the body were understood to be the source of distress (McCarthy-Jones, 2012). The chemical imbalance hypothesis originated from this early humoral medicine (Matthysse, 1973).

In the 20th century, psychiatry integrated with medicine to legitimise the profession, gaining power over treating the mentally ill and using classification in terms of symptoms and aetiology to exert control (Cromby et al., 2013). An important change during this period was the increased use of antipsychotic medication (Cromby et al., 2013). The pharmacological industry gained a lot of prominence as medication allowed a reduction on inpatient admissions by treating persons in the community. Pharmaceutical companies thus have an interest in continuing to promote schizophrenia as a brain disease (Cooke, 2014). Nevertheless, some people benefit from the use of medication in reducing distress, but others do not (Cooke, 2014). It has been argued that the effectiveness of antipsychotic medication is overestimated and negative side effects underestimated, proposing that individuals are given choice as to whether they want to take these or not (Morrison, Hutton, Shiers, & Turkington, 2012).

More recently with the emergence of neuroscience and modern neuroimaging techniques, new claims are made to try to strengthen the neurobiological model of distress (Shenton et al., 2010). The biomedical model, originating from medicine, suggests that biology plays an important role in the experience of hearing voices. However, some argue this evidence does not imply causation as to date there is no evidence to show that psychosis is caused by a dysfunction of the brain, suggesting instead that a biopsychosocial approach is more useful to understand these experiences (Cooke, 2014). Many studies suggest that changes in brain chemicals observed in schizophrenia may also be the result of traumatic life experiences that affect the hypothalamic-pituitary-adrenal axis (Cooke, 2014; Read, Perry, Moskowitz, & Connolly, 2001). Hoy et al. (2012) explored the association between the experience of childhood trauma and hippocampus and amygdala volumes in first episode psychosis. A high prevalence of childhood as well as lifetime trauma was found in the sample, with childhood trauma being a significant predictor of hippocampal and amygdala volumes. Furthermore, contrary to the popular belief that conceptualising the experience of hearing voices as an illness is less stigmatising, a recent review found that 90% of studies examined indicate that bio-genetic explanations of psychosis were linked to negative attitudes, whereas psychosocial explanations were linked to more positive attitudes towards individuals (Read, Haslam, & Magliano, 2013).

B.2.4.4 The psychology of voices

Psychologists began to develop an interest in the experience of hearing voices during the first and second world war (McCarthy-Jones, 2012). The beginning of the ‘Age of Reason’ between 1600-1800 valued positivism and scientific endeavour, and distress began to be understood in cognitive terms, as errors in cognition (Locke, 1690). Any behaviour out of the ordinary was viewed as irrational and the treatment was to reinstate rationality, through correcting cognitive errors or maladaptive appraisals (Cromby et al., 2013). An emphasis was placed on understanding these experiences in the same way that psychologists attempt to understand thoughts and feelings (Cooke, 2014). Through this revolution emerged the Cognitive Behavioural Therapies (CBT), which have been adapted for clients with psychosis and have come to be known as CBT therapies for Psychosis (Chadwick & Birchwood, 1994; Fowler, Garety, & Kuipers, 1995; Garety, Kuipers, Fowler, Freeman & Bebbington, 2001; Kingdon & Turkington, 1994; Morrison, 2003, 2010). These therapies share the assumption that the distress associated with hearing voices is caused by the way these experiences are appraised, rather than having the experience itself. These therapies are revolutionary, in a sense that, they offered an alternative or supplementary treatment to hearing voices other than the use of antipsychotic medication, and is now recommended by NICE (The National Institute for Health and Care Excellence) guidelines for all individuals with psychosis or schizophrenia (NICE, 2014). There is evidence to suggest that cognitive therapy is an effective treatment when medication is not taken and thus provides an alternative approach to treatment (Morrison et al., 2014). The cognitive model of psychosis, from which these therapies originate, arose from cognitive psychology where all behaviour is reduced to cognitive processes. It proposes that distress originates from bias in cognitive processing which is further compounded by emotional changes (Garety et al., 2001). However, placing an emphasis in therapy on changing appraisals, sometimes leads to downplaying the role of emotions and wider contextual issues in interventions. A meta-analysis conducted by Gaag, Valmaggia, & Smit (2014) of 18 studies, revealed that CBT is an effective intervention in the treatment of hallucinations.

The cognitive model shares some similarity with narrative models, discussed further below, because it is concerned with the meaning of voices, beliefs about the self and potential links to life experiences (Morrison, 2010). In addition, an essential part of this intervention is the normalisation of experiences, akin to the approach taken by the Hearing Voice Network (HVN Web, 2016). More recent third wave CBT therapies (ACT-Acceptance and Commitment Therapy) have incorporated mindfulness practices in interventions to help alleviate the symptoms of distress associated with hearing voices (O'Donoghue et al., 2013). The primary assumption in these therapies is that fusion with distressing experiences is unhelpful, and advocate instead an acceptance of experiences and commitment towards valued goals. There is preliminary evidence that mindfulness as an intervention provides some clinical benefits to people with psychosis (Chadwick et al., 2009). In addition, researchers and practitioners are beginning to integrate therapeutic models in the treatment of psychosis for example CBT and Mindfulness (Chadwick et al., 2016), narrative therapy and CBT (Rhodes & Jake, 2009) and person-centred and cognitive therapy (Chadwick, 2006). The rationale for integrating therapeutic models is based on the idea that more flexible models are needed to target the needs of this client group (Rhodes & Jakes, 2009). Another important development in psychological theories of voice hearing was the establishment of a link between this experience and emotion (Cooke, 2014). A two-way process is conceptualised whereby intense emotions lead to the experience of voices and/or the experience of hearing voices triggers intense emotions (Cooke, 2014). These findings provided further support for the use of psychological therapies to treat these experiences.

CBT is the most researched psychological therapy, however psychoanalysts, Bleuler, Freud, Jung, Federn and Lacan, have contributed to the development of psychoanalytically oriented psychotherapy for schizophrenia (Alanen et al., 2009). Freud did not think it possible to form a transference relationship with ‘psychotic’ clients in therapy, however one of his students, Federn, demonstrated that through empathic countertransference it is possible to form a transference relationship[2] (Alanen et al., 2009). A brief discussion of Lacanian psychoanalysis is provided here due to the importance that it places on language in the treatment of psychosis. Lacan’s understanding of psychosis presents a challenge to traditional bio-psycho-social models of psychosis that conceptualise the problem to be a deficit or dysfunction of the brain (Vanheule, 2011). Lacanian psychoanalysis does not attempt to eradicate the ‘symptoms’ of psychosis. Psychotic phenomena are re-conceptualised as speech events resulting from the disturbance of language in psychosis and specifically, the difficulty of the subject in producing meaning (Vanheule, 2011). Lacan suggested that normal development requires the presence of the father, who plays an important role in breaking the mother child dyad. He claimed that an inability to establish a symbolic ‘Other’ in childhood through the symbolic world (the wider world of culture, language, institutions and social reality) can lead to the development of a psychotic structure and an inability to verbalise (a language disorder) (Fink, 1999). Future events triggering painful material are subsequently expelled from the unconscious (in neuroticism they are repressed) as a defensive manoeuvre leading to foreclosure. Foreclosure in psychoanalysis is understood to be the origins of psychosis. More simplistically, there is a failure in symbolic meaning, an inability to access the symbolic, to verbalise and create meaning through language (Bailly, 2009). Imaginary relationships predominate and a collision occurs with reality leading to symptoms of psychosis, for example, hallucinations (Vanheule, 2011). Therefore, psychotic experiences are understood as arising from signifiers present in the environment that the subject is unable to assimilate, leading to foreclosure and an excessive over-reliance on the imaginary (Fink, 1999). The individual cannot make meaningful symbolic sense of the experience, resulting in the experience of hallucinations or delusions. Psychoanalysis thus seeks to attain a move between the ‘Real’ (the unspeakable) to the ‘Symbolic’ through language.

B.2.4.5 Service User Movements (Trauma based and Recovery discourses)

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[2] Transference is the unconscious transference of feelings from one person to another. It usually involves the repetition in the presence of a relationship that existed in the client’s past.

Romme and Escher in collaboration with other professionals and in response to voice hearers wanting to talk about their experiences, began a project in the Netherlands and the UK, the Maastricht approach. The purpose was getting the message across that the experience of hearing voices is a normal non-pathological experience, imbued with personal meaning relating to sufferers' lives (HVN Web, 2016). The link between hearing voices and the prevalence of trauma is also supported by empirical evidence (Escher, 2004; Read & Ross, 2003; Read, Van Os, Morrison, & Ross, 2005; Romme & Escher, 1989). Varese et al. (2012) examined in a meta-analysis the association between childhood adversity and psychosis. Significant associations were found between childhood adversity and psychosis, indicating that people with psychosis are more likely to have been exposed to childhood trauma. The evidence that such experiences occur in response to trauma, presents a challenge to traditional views of treating the experience as a symptom of illness to be eradicated.

The aim of the hearing voices movement was to allow the voices of those encountering these experiences to be heard. Self-support groups emerged in response to sufferers not being included in their care, to challenge traditional views of voice hearing. The first attempt to form peer support groups came from the Mental Patients Union (MPU) in 1972 (Cromby et al., 2013). The first service user movement was subsequently established in 1988 (Cromby et al., 2013). There are two primary networks currently founded for people who hear voices: The Voice Hearing Network and Intervoice (HVN Web, 2016; Intervoice Web, 2016). They encourage different explanations for the experience of hearing voices, which is unique to each person. This approach bears some similarity to narrative based psychological therapies that use narrative approaches to explore the meaning of voices in relation to an individual's life (Rhodes & Jakes, 2009). Although this is a psychological approach, I have included it under this section because of the similarities that it shares with the trauma based approach of the Hearing Voice Network.

The Recovery model similarly arose from the service user movement in the late 1980s and early 1990s (Recovery Web, 2016). Many service users joined to share their experiences and develop coping strategies to deal with mental health issues (Copeland, 2016). Interestingly, the assimilation of the model in mental health services coincided with the deinstitutionalisation and the subsequent treatment of individuals in the community (Cromby et al., 2013). The main purpose of the recovery model is to instil hope and empower people with mental health problems to lead a good quality of life, despite distressing experiences. The integration of the recovery model into mental health, has led to an abundance of research on recovery and the development of new initiatives such as the introduction of 'recovery colleges', where people with mental health issues are assisted to reintegrate back into the work force (Taggart & Kempton, 2015). Part of the recovery model involves tackling the stigma attached to mental health issues. Recent campaigns seek to address the stigma associated with mental health through the mental health drive "New understanding, new hope", which encourages governments to take strategic decisions to bring about positive changes in the acceptance and treatment of mental health (WHO – World Health Organisation, 2016).

B.2.4.6 Voices and spirituality

During the middle ages, the experience of hearing voices was thought to be a divine experience originating from God (McCarthy-Jones, 2012). The 15th century decline in the power of the church coupled with the rise of technology and scientific enquiry, led to a decline in religious beliefs and spirituality. Out of the ordinary experiences were understood to be symptoms of psychiatric illness. Nevertheless, although religious beliefs began to decline during the 17th century, some people who hear voices today believe their experiences are religious and/or spiritual (HVN Wales Web, 2016). More recently, there has been a new initiative in mental health to acknowledge the role that religion and spirituality plays in mental health and recovery (HVN Wales Web, 2016; Loewenthal & Lewis, 2011). Studies have compared religious psychotics, religious non-psychotics and non-religious non-psychotics and found that all groups have had religious encounters with voices, however only the psychotic group became distressed by these (Davies, Griffiths, & Vice, 2001; Peters, Day, McKenna & Orbach, 1999). This highlights the issue that historically, when religious beliefs and practices are perceived to be out of the ordinary in the culture in which they are exhibited, such experiences could potentially be understood as psychiatric symptoms (Loewenthal & Lewis, 2011). In some cultures, people who hear voices are perceived to be gifted, as opposed to having a mental health problem (HVN Wales, 2016). However, there are people with unusual beliefs for example that believe in the existence of the paranormal, have out of body or profound religious experiences, who do not seek help from mental health services. Some propose that these experiences exist on a dimension and are thus normal human experiences present at various degrees (Peters, 2010). It is now generally thought that a best practice approach should take into consideration the client's spiritual and religious beliefs in any therapeutic endeavour (Cook, Powell, & Sims, 2009) and this should also include religious or spiritual beliefs held by people who hear voices.

B.2.4.7 Technological advancement and conspiracy theories

The digital revolution in the West (late 1950 to 1970s) marked the beginning of the information age, with new technologies (computers, digital cellular phones, the internet) being introduced in commerce, industry and private spheres profoundly affecting our lives (Chodos, 2012). Rapid technological change brought on advancement and efficiency becoming the landmark of the digital era. Part of the advances in technology was computer microminiaturisation; the tendency to produce even smaller digital devices for example phones, chips, processors (Kluver, 2000). Coupled to the digitalisation of technology was the emergence of conspiracy theories, which claim that humans are governed by greater forces outside of their awareness and control. Usually these are political but could also be supernatural or extra-terrestrial in kind. Conspiracy theories have been linked with mental illness and in specific the symptom of delusions. There are some however who take an alternative perspective to the medical model on these experiences, believing that conspiracy theories are widespread across the population, they have a rational basis and should not be easily dismissed as symptoms of psychiatric illness (Basham, 2011; Coady, 2012).

Conspiracy theories within a clinical context and the medical model, are viewed by health professionals as symptoms of psychosis, part of the unusual and/or paranoid thoughts that clients experience. It is important to mention this discourse because some people who hear voices have the belief that their voices are being transmitted through an undetectable chip implanted in the brain. De Hert et al. (2004) wrote a self-guide book to help people with a diagnosis of psychosis, who believe they are being controlled by a chip implanted in the brain. This publication tries to medicalise the experience, presenting it as a symptom of the illness of psychosis. Peters (2010) presents many studies and evidence looking at the experience of delusions and unusual experiences, suggesting that these do not vary in kind between clinical and non-clinical groups. He proposes that it is the way that these beliefs are experienced, as opposed to what is believed, that determines whether they will be perceived to be abnormal or not. In addition, conspiracy theories are also made popular through the media and film, with the release of productions such as ‘The Matrix’ (Berman & The Wachowskis, 1999), a film depicting reality as a ‘simulated reality’ built by machines to subdue the human population. Some authors have even published books on the threat that technology poses on our liberty through cybernetic technology, claiming that the brain of humans is linked to super computers using microchips and satellites (Luukanen-Kilde, 1999).

B.2.5 Voice hearing across cultures

As was previously mentioned the experience of hearing voices is traditionally understood, specifically in the West and based on the medical model, to be a symptom of illness. However, in different cultures this experience is not always understood to be a pathological symptom that needs to be eliminated (Cooke, 2014). Cultural anthropologists have found that in many societies, hallucinations play a crucial part in religious practices (Cromby et al., 2013). The Maori in New Zealand regard this experience to be a gift (Taitimu, 2007). In an interpretative methodological analysis, Heriot-Maitland, Knight, and Peters (2012) found that wider personal and interpersonal contexts influence how the experience of hearing voices is appraised. Specifically, validation from others was identified to be an important factor in clinical outcomes. Furthermore, Luhrmann et al. (2015) investigated how the experience of hearing voices shifts across cultural boundaries. The authors concluded that Americans were more likely to attribute pathological labels and understanding to their experiences, in comparison to those in India and Ghana, who were more likely to view these experiences as rich and life-enhancing. These findings suggest that these experiences are shaped by the local culture. Larøi et al. (2014) conducted a review of many studies focusing on the role that culture has in shaping hallucinations. They found that culture has a significant impact on these experiences revealing different patterns between clinical and non-clinical groups across cultures, differences in what is and what is not considered to be a hallucination across cultures, a differing impact of culture on the meaning and characteristics of hallucinations, and the impact of cultural variation on clinical outcomes. In addition, the findings of WHO studies investigating the incidence and course of schizophrenia suggest that the course and outcome of schizophrenia over time varies between ‘developed’ and ‘developing’ countries (Cromby et al., 2013). These differences have been attributed to the nature of familiar relationships, community support, response and integration. The evidence indicates that social support and low stigma in developing countries improve outcomes (López et al., 2004).

B.2.6 Literature Review

B.2.6.1 Definitions and models of the self

Before reviewing the literature on hearing voices, it is important to clarify some definitions. The term ‘voice hearing’ is recent and has emerged with the service user movements (Cromby et al., 2013). Only recently such experiences are discussed in less pathological ways due to a drive to reduce the stigma associated with mental health (WHO, 2016). Traditionally in the West the experience of hearing voices has been associated with pathology and the diagnoses of schizophrenia or psychosis. Prior research has focused primarily on pathological aspects of this experience and samples mainly include clinical groups. Very little research has been carried out with voice hearers who do not experience distress and this is one of the main limitations of these studies as they ignore the more positive aspects of this experience. However, it is acknowledged that not all individuals who hear voices experience distress or have a mental health diagnosis and in other cultures this experience is not always associated with pathology. Hearing voices is still an experience shared with these diagnoses therefore a review of this literature will follow.

Identity is a difficult concept to define. Prior studies have used different definitions interchangeably, for example, self, identity, personhood, self-concept and sense of self. It is also important to clarify different models of the self. These are present on a continuum between models that focus exclusively on the person and those that focus exclusively on the social (Benwell & Stokoe, 2006):

- The sovereign self. A modernist perspective.

  Industrialisation and urbanisation have had a significant influence on the modern self. This model suggests that identity is coherent and stable, characterised by individuality, reflexivity and autonomy. The modern self is a self-defining entity whereby the internal self is distinctively separated from the external world (Hermans & Gieser, 2011). This model of self, values personal goals, inner strength, personal achievement and progress. Rationality and empiricism, characteristics of modern Western technological society, influence this model of self, where the individual is given responsibility for her/his own self-fulfilment.

- The dynamic self. A social psychological perspective. (Greenberg & Pascual-Leone, 1995; Markus & Wurf, 1987; Thelen & Smith, 1994)

  A social psychological perspective proposes that the self is continuously changing. The self-concept is dynamic, active, self-organising and capable of change. This model of self, in contrast to a modernist perspective, attempts to incorporate the social. However, the social is governed by the dynamic self that mediates intrapersonal and interpersonal processes. A dynamic self, interprets and organises experiences, adjusting accordingly in response to the social environment. Thus, identity in this model is expanded to include roles and social status in addition to internal characteristics.

- Post-modern perspective. Self as a social construction (Burr, 2003).

Post-modernism places an emphasis on difference and fragmentation, the subject is decentralised and identity is no longer seen as stable but fragmented (Featherstone, 1995). Multiculturalism and the crossing of boundaries has led to the multiplicity of self, imbued by multiple voices. The availability of new technologies, such as social media, results in social saturation, whereby the post-modern self is pulled into different and sometimes contradictory directions (Gergen, 2001). The self is continuously adapting to current circumstances, with outside forces playing a crucial part in its construction. One of the greatest forces that exercises control over the construction of self is language (Hermans & Geiser, 2011). In addition, post-modernism allows for emancipation and the liberation of identities from traditional oppressive structures.

The current research advocates a ‘dialogical self’ that transgresses the boundaries and elaborates existing models. The dialogical self is agentic, because it can integrate diverse positions (modernist, postmodernist). The dialogic self is also able to reflect on powerful structures in society and respond to these from an original point of view (Hermans & Geiser, 2011). “Power relationships in society can be reflected in the self, but, at the same time, the self is able to construct counter-positions from an original point of view” (Hermans & Geiser, 2011, p.108). Following a description of different models of the self, the next section reviews prior studies that have attempted to study the experience of hearing voices, including studies where clinical samples are used with a diagnosis of schizophrenia or psychosis.

B.2.6.2 Review of empirical studies

There is an abundance of quantitative research investigating the processes involved in the experience of ‘hallucinations’, which includes the experience of hearing voices. A systematic review of cognitive studies by Bentall (1990) indicates that hallucinations result from the failure of metacognitive skills, preventing voice hearers from discriminating between self-generated and external sources. Recent neuro-imagining methods (PET, MRI) further confirm this finding by showing how voice hearing is accompanied by activation in the frontal brain regions (Jones & Fernyhough, 2007). These studies suggest that voices are caused by a misattribution of inner speech to external sources. Studies also examine the role of cognitive appraisals of voices on distress (Mawson, Cohen, & Berry, 2010), the interpersonal nature of the voice hearing experience (Paulik et al 2012; Sorrell et al., 2010), links to trauma (Longden et al., 2012), links to negative beliefs and self-esteem (Smith et al., 2006) and links with emotion (Close & Garety, 1998). The cognitive model of auditory hallucinations has been studied extensively (Mawson et al., 2010). Cognitive models place an emphasis on the role of cognitive appraisal in the experience of distress. Mawson et al. (2010) reviewed 26 studies investigating the relationship between cognitive voice appraisal and level of distress. Most studies are based on clinical groups that experience distress from verbal hallucinations, however it is acknowledged that not all individuals who hear voices experience distress. Factors implicated in the experience of distress in clinical groups include perceived voice malevolence or benevolence, voice supremacy, voice acquaintance, voice approval and acceptance (Mawson et al., 2010). Mawson et al. (2010) argue that a limitation of the studies reviewed is that voice content alone did not predict distress and researchers did not take into consideration social variables; social processes that guide interaction with voices. Paulik (2012) conducted a systematic review of the role of social schema in the experience of auditory hallucinations. The 13 studies reviewed highlight the interpersonal nature of the experience of hearing voices. Findings suggest that relating to voices from a position of closeness or dependency is associated with lower levels of distress and that voice hearers relate to voices in a similar way that they relate to others in their social environment (Hayward, 2003; Mawson et. al., 2010).

These studies provide useful insights into the variables that impact on the distress experienced from hearing voices informing interventions. However, they seldom take into consideration the personal accounts and subjective experiences of those who hear voices. An approach that does not include those who live with these experiences serves to maintain the status quo. People who hear voices are excluded from such discussions, and assumptions about what these experiences mean are not questioned. More recent movements also suggest that views may be changing. There has been an increasing number of self-help organisations emerging, offering support for people who hear voices that challenge traditional views of voice hearing (HVN Web; Intervoice Web). As a researcher, I was interested to know how people who hear voices talk about this experience and how they negotiate the identity of being a ‘voice hearer’ within this diverse and changing context. This is especially pertinent as a negative view of self has been linked with worsened outcomes (Yanos et al., 2010). Qualitative studies are better able to capture the subjective experience of hearing voices and it is to these studies that we turn to next.

B.2.6.3 Qualitative Research on voice hearing

More recently studies attempt to explore qualitatively the subjective experience of hearing voices using the personal accounts of voice-hearers (Jackson, Hayward, & Cooke, 2011; Goldsmith, 2012; McCarthy-Jones, Marriott, Knowles, Rowse, & Thompson, 2013). These studies provide an in-depth account of the experience of hearing voices. For example, in a grounded theory study, Jackson et al. (2011) found that participants who tried to develop a personally meaningful narrative of the experience of hearing voices developed a more positive relationship with these and narrative constructions lead to a more positive, integrated sense of self. In another grounded theory study, Fenekou & Georgaca (2010) also explored the subjective experience of hearing voices. The authors suggested that voice hearers use different explanations to understand their experiences, but they did not feel able to talk about these. Findings have implications in seeking support if voice hearers are not able to talk freely about their experiences. Furthermore, in a Foucauldian discourse analysis, Goldsmith (2012) investigated the implications that different constructions of voice hearing and positions in discourse have for subjectivity. A discursive approach was applied to narrative accounts of recovery from hearing voices and findings suggest that alternative discursive constructions to the biomedical model allow for a greater capacity for living with voices (Goldsmith, 2012).

In a meta-synthesis of peer reviewed qualitative research on the subjective experience of participants with a diagnosis of psychosis, an important theme found across many qualitative studies was the losses that participants faced, for example, loss of self, relationships, occupational activities, finances, and the basic human need of sleep and security (McCarthy-Jones et al., 2013). However, participants also attempted to seek support and re-establish a sense of self (self-esteem, self-identity) most importantly though family and peers. Central to this attempt was a need and hope to regain a normal life, but the authors pointed out that practical issues get in the way including the stigma that these individuals face (McCarthy-Jones et al., 2013). Although the quality and rigour between studies varied, the authors were satisfied that the themes extracted were grounded in the participants’ accounts. One of the greatest limitation of the meta-synthesis is that it excluded discourse analytic studies which may have produced interesting findings.

Studies have also investigated the impact of stigma on the experience of hearing voices. In an IPA (Interpretative Phenomenological Analysis), Knight et al. (2003) found that individuals face stigma from many sources leading to their identity being subsumed by the diagnosis. The negative judgement experienced by participants in all facets of their lives, from the public, health professionals, family and friends had an impact on self-concept. This resulted in avoidance, withdrawal and secrecy, which had negative effects. The authors concluded that participants need social support and understanding to retain a positive sense of self (Knight et al., 2003). In a phenomenological study, Bril-Barniv, Moran, Naaman, Roe, and Karnieli-Miller (2017) examined the dilemma that people with serious mental illness (including schizophrenia) face in disclosing their diagnosis. The analysis revealed that different factors influenced disclosure such as cultural influences, prior experiences of disclosure, and the personal meaning ascribed to diagnosis. Participants who ascribed negative meanings to their diagnosis often concealed their experiences to appear normal around others. On the contrary, sensitivity and acceptance encouraged disclosure and was experienced as an opportunity to strengthen one's sense of self through others (Bril-Barniv et al., 2017). Similarly, in a grounded theory study, Judge, Estroff, Perkins, and Penn (2008) found that participants engaged in withdrawal from others as they found it difficult to explain their experiences. They also identified stigma as a reason for not seeking help. A priority in rehabilitation was to find meaning in these experiences and develop an identity separate from illness (Judge et al., 2008).

A sense of belonging was also found to be an important factor in recovery (Barut, Dietrich, Zanoni, & Ridner, 2016; Mauritz & Berno van Meijer, 2009; Perry, Taylor, & Shaw, 2007). In a phenomenological study, Barut et al. (2016) found that the predominant experience for inpatient clients with a diagnosis of 'schizophrenia' was a lack of belonging, isolation and hopelessness. Sense of belonging involved being a part of something and connecting with others in the community and society. Participants expressed a wish to integrate back into society, but were not hopeful about regaining a connection with others and were resigned to being alone. The authors concluded that developing a sense of belonging may improve self-concept (Barut et al., 2016). Perry et al.'s (2007) study also highlighted that a sense of belonging and being part of the community through social groups and work increased feelings of hope. These findings suggest that social inclusion is crucial in recovery. In addition, in a grounded theory study, Mauritz and Berno van Meijel (2009) discovered a main theme of 'not belonging' due to the loss of social relationships. The authors suggest that people with a diagnosis of 'schizophrenia' need support from others to manage the grief associated with these losses. However, this support is not always available either in personal or professional circles. Such losses result in a change of identity and an inability to function as previously or in line with normative standards, leading to segregation from others (Mauritz & Berno van Meijel, 2009).

Many studies have focused on the importance of relationships and establishing a connection with others. For example, Redmond, Larkin, and Harrop (2010) conducted an IPA study to investigate the perceptions of young persons, with a diagnosis of psychosis, of romantic relationships. Findings show that participants associated romantic relationships with normality and recovery, however they considered these to be incompatible with 'psychosis'. They would try to negotiate these by not disclosing their diagnosis, presenting it as something else (for example depression) or by downplaying the impact these experiences have on their lives. Despite having a desire to have romantic relationships, participants felt that they lacked the experience and resources (confidence, finances, peer and social network) and faced difficulty negotiating the stigma associated with the diagnosis. All participants wanted potential partners to be understanding of their difficulties. Being in a relationship thus resulted in less identification with 'psychosis' and more with normality and a positive identity (Redmond et al., 2010).

In a grounded theory study, Schön, Denhov, and Topor (2009) analysed the recovery narratives of 58 participants with severe mental illness in Sweden (including a diagnosis of schizophrenia or psychosis). The three dimensions found included recovery in terms of re-defining a social self, recovery-facilitating social interventions and establishing a connection to others. The core category and key element that arose across the three dimensions identified the quality of social relationships as important in recovery. The study revealed recovery is a social process that is mediated by social relationships. What was highlighted in terms of social interventions was treating participants as persons and showing an interest in them. In addition, engaging in occupational activities allowed participants to build relationships of equality and reciprocity, enhance self-esteem and construct a positive identity counteracting stigma. All participants mentioned that either friendships or family aided them in the recovery process (Schön et al., 2009). The outcome of the study suggests that recovery takes place in a social context and relationships are a crucial part of this.

In another grounded theory study, Laithwaite & Gumley (2007) investigated how inpatients with a diagnosis of 'psychosis' in a high secure forensic setting experienced recovery. All participants mentioned that social support such as family, staff and developing relationships played an important role in their recovery. The two higher order concepts - relationships and a changing sense of self – were reciprocally related. Participants reflected on the impact of significant others on the sense of self. This reflection also included early adversity where participants talked about early rejection, bullying, being on the outside and not fitting in with others. Developing relationships with others in recovery allowed participants to explore their sense of self and repair relationships by developing trust, respect and feeling valued. The development of relationships was an important part in the recovery process. Nevertheless, participants with a lack of and/or a sudden break in trusting relationships in their early years, found it harder to form trusting relationships with others in the present, compromising their ability to recover and redefine their sense of self (Laithwaite & Gumley, 2007).

Ogden (2014) examined in a narrative thematic analysis the life narratives of seven older-adults with a diagnosis of 'schizophrenia' for patterns of relating to others. One of the most prevalent themes was interpersonal loss, with most participants experiencing considerable loss of contact with others over the course of the illness. Meaningful relationships were absent in participants' narratives. Socialising presented many challenges with participants choosing to withdraw into solitude despite longing for social contact. Adaptations to the relational voids included establishing new relationships with health professionals and peers with similar experiences. Peer relationships were found to be integral to a positive sense of self, however most were centred around treatment settings. Overall peer relationships were the most beneficial because they were characterised with true reciprocity and continuity over time. The lack of opportunity to develop meaningful relationships with individuals without mental illness was pervasive, suggesting there is a continuous need for social inclusion (Ogden, 2014).

In a phenomenological study, Nixon, Hagen, and Peters (2010) investigated the experiences of people with a diagnosis of psychosis that encountered a post-psychotic transformative growth. During the 'psychosis' phase, participants talked about a near death experience. The emotional turmoil they encountered, left them feeling that life had come to an end and that they had lost their self in this process. The transformative phase involved developing a distance from the psychotic experience and coming back to the present. This was achieved by 'embracing a spiritual pathway', which was preferable to understanding their experiences as opposed to relying on pathological explanations. Participants grew in response to their 'psychotic' experiences and tried to move towards a creative and preferred direction in life. The authors suggest there is potential for transformative growth from hearing voices (Nixon et al., 2010).

Connell, Schweitzer and King (2014) conducted an IPA study to investigate the early experiences of twenty young people with a diagnosis of 'psychosis'. The authors proposed that a dialogical approach (Lysaker & Lysaker, 2010 cited in Connell et al., 2014) allows meaningful social interactions with others to occur, leading to a renewal of social roles and to the enrichment of self. The two superordinate themes identified include self-estrangement (loss of self) and self-consolidation (building a strong sense of self through others). Loss of self, resulted from the loss of social roles that anchor the self, due to hospitalisation and the impositions of unwanted social roles (e.g., "psychotic", "sick"). The stigma attached to the diagnostic labels posed a threat to social and self-acceptance. On the other hand, resuming social roles and relationships helped normalise the experience of self (Connell et al., 2014). Participants accounts pointed towards the significance of restoring the sense of self in recovery and more research is needed to explore this process further. The dialogical model suggests that this is done through social and relational avenues, which may be usefully explored from a discursive approach.

From prior qualitative studies, it is evident that relationships, maintaining a connection with others and having a sense of belonging is important in developing a positive sense of self for people who hear voices. A social constructionist perspective suggests that this sense of self and the development of identity is a social process (Benwell & Stokoe, 2006). As an extension to these studies it would be of interest to see how participants negotiate identity through language and social interaction as it is suggested in previous studies that a social element is implicated in how people who hear voices view themselves and how they cope with their experiences. Relationships with others have been found to be crucial in recovery and hope from psychosis (Barut et al., 2016; Connell et al., 2014; Ogden, 2014; Schön et al., 2009; Mauritz & Berno van Meijel, 2009; Perry et al. 2007; Laitwaite & Gumley, 2007), but also in the development of a personal and social identity (Bril-Barniv et al., 2017; McCarthy-Jones et al., 2013; Redmond et al., 2010, Judge et al., 2008). If we take into consideration these findings and the importance of the social in recovering a sense of self, it would be useful to investigate how participants negotiate this identity within the current social-cultural context to inform interventions, particularly as a link has been found between low self-esteem and the diagnosis of psychosis (Freeman et al., 2006). A negative view of self has also been linked with negative outcomes (Yanos et al., 2010).

A useful way of uncovering the processes whereby this negotiation of identity occurs in the social, is by examining language and how it is used in local interaction to construct identity (Benwell & Stokoe, 2006). In Redmond's (2010) study participants tried to distance themselves from the identity of 'psychosis' that may inhibit the development and establishment of meaningful relationships with others. The authors also suggested that participants did not feel they had a strong enough identity to manage the demands and expectations of relationships and viewed these are potentially risky (Redmond et al., 2010). The authors conclude these beliefs may have an impact on an individual's ability to socially integrate leading to further isolation. Taking the findings of these studies in consideration it would be a useful to take a discursive lens on how participants might negotiate this identity in social interaction, with the purpose of uncovering what they are trying to accomplish in talk, how they position themselves within dominant discourses of hearing voices in society and with what consequence for their sense of self. Few qualitative studies have investigated the impact of the experience of hearing voices on identity and these shall be discussed next.

B.2.6.4 Review of literature on identity and voice hearing

In a grounded theory, Korman (2003) investigated the validity of claims for the lack of a sense of self in schizophrenia. The author found that participants had self-awareness. Some main features identified were lack of control and the presence of a social/public self, both of which were found to greatly affect participants' experiences. Of interest in this research was the finding that participants had a need to be in contact with others and attributed their isolation to the discrimination they faced in society. Another surprising finding was that participants preferred to talk about positive aspects of coping with their experiences, as opposed to contemplating the more negative aspects of this. Although participants said they were made accountable for their unusual experiences, no attempt was made to theorise the impact of this on identity, particularly as other ways of being for example not having a mental illness are not accountable (Reynolds & Wetherell, 2003). Furthermore, there were many instances where participants tried to construct themselves as atypical members of the category. However, because the researcher adopted a realist approach whereby what participants say was taken at face value, no further attempt was made to interpret why participants constructed themselves in this way. The researcher attributed participants' tendency to describe themselves as dissimilar to others with the same diagnosis to the heterogeneity present in schizophrenia. This may indicate that a realist approach may not be ideal in examining identity work, where people are trying to do things with the way they talk as they construct themselves in a certain light for others. Overall this research appears to focus more on identity as an essential feature of the person, neglecting the social context.

In addition, the sampling strategy of Korman's (2003) study consisted of outpatient clients with a diagnosis of schizophrenia, which does not allow us to relate findings to individuals that may not have a diagnosis and do not experience distress from hearing voices. A further exploration is needed on how the social or public impacts on the formation of this identity, as little was offered in terms of the process, despite the author suggesting that stigma, lack of social roles and exclusion from social groups leads to an inability to connect. The sampling strategy also presents with some limitations. Clinicians selected participants if they were deemed able to communicate in a coherent manner. It is difficult to evaluate the selection process because the authors did not clarify how they measured participants' ability to communicate coherently. In addition, some of the participants were already known to the researcher in a clinical capacity, whereby he was offering treatment as well as being a researcher. This presents dual role issues and no consideration was made about how this might have potentially impacted participants' accounts. However, the most problematic finding of this study was the suggestion that perhaps the new atypical antipsychotic medication allowed for more self-awareness during remission and an enhanced sense of self. It is questionable whether this assumption was reflected in the personal accounts of the participants. In my view, it is possible that individuals do retain a sense of self, which they are not able to talk about if they are feeling unwell and future research may explore this. That would be understandable for anyone under those circumstances. And how might we know for sure that this hypothesised loss of self is not related to external variables such as for example inhumane treatment in hospitals? Most importantly, the author observed a discrepancy between the ideal self and the actual self. For future research, it would be useful to investigate where this ideal self originates from, by perhaps taking a discursive approach.

Using an interpretative phenomenological approach, Mawson, Berry, Murray, and Hayward (2011) investigated the experience of hearing voices in a social context, by looking at how participants relate to the voices and others around them. The main finding of this research was that improving voice hearers' sense of self is a key factor in reducing distress. Of interest in this research was the finding that participants' sense of worth was affected both by outside forces, for example, external relationships and the stigma associated with their experiences, but also from the voices that they hear reinforcing self-defeating messages. Participants also discussed how friendships helped them to maintain a sense of normality, with those not having friendships having a negative view of self. Overall, the authors described how participants experienced a dilemma between on the one hand, having a need for social contact and obtaining a felt sense of normality, and on the other, experiencing social relationships as effortful and difficult. They suggest that interventions are needed that empower the social capabilities of voice hearers, to build assertiveness and confidence, and to develop more balanced interpersonal relationships using techniques such as the 'empty chair'[3]. In line with a social constructionist view, I believe the consequence of taking an individualistic approach to these problems without considering the cultural context leads to problematising voice hearers, further marginalising and excluding them from society. The authors suggest that further research is needed to investigate why participants hesitate to talk about their experiences and the implications for seeking support. It necessitates the need to take a macro approach to such constructions by looking at the broader forces that have an impact on participants' accounts.

In an IPA study, Howe et al. (2014) sought to explore the experience of service users following the diagnosis of schizophrenia, in terms of how the stigma attached to the label impacts on identity. The findings from seven participants included five superordinate themes: 1. Avoidance of diagnosis, 2. Stigma and diagnostic labels, 3. Lack of understanding of schizophrenia, 4. Managing stigma to maintain normality, 5. Being 'schizophrenic'. Although this research provides useful insights into how the language of diagnosis can affect service users' sense of self with suggestions for practice, it presents with some limitations. The main limitations include the narrow focus on experiences in terms of the diagnosis alone, which excludes other possibilities in participants' experiences in terms of identity construction, particularly more positive aspects of this experience. The methodological approach adopted has no interest in and potentially omits the process of categorisation that constructs in-group/out-group differences in terms of identity construction, which would have been useful when looking at issues of stigma. An added limitation suggested by the authors was the reliance on retrospective accounts and the variability in diagnostic processes at different time periods, that would render this experience contrastingly different for each participant making it difficult to draw conclusions. Therefore, this study may not accurately tell us a lot about the

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[3] The empty chair is a Gestalt therapy technique where the client imagines someone in the chair and tries to communicate with her/him or parts of the self.

impact of diagnosis on identity, without taking into consideration the diagnostic processes of the time.

Dinos et al. (2005) conducted a content analysis of temporal comparisons of the self (perception of self over time) in a group of participants with a diagnosis of schizophrenia. The authors wanted to investigate whether temporal comparisons of the self are associated with self-concept, particularly where there appears to be a threat to identity. The authors found that participants made a lot of comparisons with a past self, with the current self being constructed in a more positive light than a prior self particularly post-diagnosis. Thus, participants constructed the past in such a way that permitted them to view their present circumstances more positively. However, if we take the view that identity is fluid and constantly fluctuating depending on the context, then it is possible that the participants were orienting to the interview situation and were responding to demand characteristics in terms of what they thought the researcher wanted to know. In addition, the findings do not allow the authors to generalise that this type of temporal patterning would re-occur in any other context apart from this interview. It could be that participants are simply constructing positive versions of the self to portray themselves in a positive light, rather than telling us anything about how they manage identity in the social domain. The authors also suggest these findings could be due to the rehabilitation setting where participants expected to improve, thus offering more positive descriptions of the present self.

Dinos et al. (2005) noted that some of the findings contradicted expected patterns of a tendency to enhance one’s view of self over time, as some participants described the pre-illness period as better than the present. They theorise that this could be due to participants not placing a great importance on certain attributes. However, this is a simplistic explanation of a complex phenomenon that should also include the impact of society and others perceptions. It may be a limitation of content analysis as a theoretical approach, which takes a micro focus. This approach tends to be descriptive, as opposed to providing a rich account of the phenomena in question. Validity is thus low in terms of being able to provide any depth and detail about the behaviour. Ryff (cited in Dinos et al., 2005) suggests that there may be constraints on the temporal comparisons that some groups can make as opposed to others, because some ways of being are simply not available to some. This omission is a limitation of Dinos et al.’s (2005) study and can be addressed using a discursive approach to the data using positioning theory. Positioning theory may provide an insight into why participants are positioning themselves in a certain way, with what consequences, and sometimes to their own detriment (Davies & Harré, 1990). Finally, the authors suggest that a distinction needs to be made between events that are long term (schizophrenia) and those that are not (brief bereavement). I would argue that this distinction is not clear cut. People who hear voices may encounter periods of wellness and periods when they are unwell, and this may change how identity is constructed at any point in time depending on the occasion. In addition, the main finding of the authors was that temporal comparisons were characterised by great variability and flexibility, with participants offering both positive and negative descriptions of self for all time periods (past, present, future). There is thus scope for future research to investigate and further account for such variability in temporal constructions of self.

Shea (2010) attempted to theorise the process of identity construction in people with a diagnosis of ‘schizophrenia’ using a grounded theory approach. She conducted 15 semi-structured interviews and described a six-stage theory of identity reconstruction. She described a process of the recovery of self, between severe mental illness and an emerging new self. The author differentiated sense of self as something residing in the individual and identity as something residing in the social. The sampling strategy included individuals with a diagnosis of schizophrenia receiving ‘intensive’ treatment and included participants from three categories: those that adjust well, those experiencing minimal difficulties in adjustment and those that do not adjust well. This is potentially a problem for this research as difficulty and level of adjustment can have an impact on identity and therefore differences between these groups of individuals were lost. In addition, it was not clear how the 19 participants were chosen from a stratified sample of 150. Furthermore, the author indicates where theoretical reasons existed, carers and some health professionals (4/19) were also interviewed to clarify some concepts. However, it can be argued that this approach may disempower participants, by reinforcing the status quo in allowing others to define them.

The greatest limitation of this study in terms of the findings, is the view of identity as static at a specific point in time for example pre/post-illness, loss of old self/finding new self. Shea (2010) does acknowledge that identity construction is a dynamic process, which can involve movement back and forth between stages. Nevertheless, there is an assumption that identity resides in the individual and characterises the essence of a being. This view results in problematising the individual, as the solution given to reclaiming a lost identity, is for the client to progress through certain stages. One of these stages is developing self-awareness. This is especially problematic because only two out of fifteen participants, the author suggests, accomplished self-recovery. However, a social constructionist viewpoint proposes the process of identity construction is not clear-cut and straightforward, it varies between individuals, it resides in the social and is negotiated (Burr, 2003). Overall, the finding that the emergence of self-identity was dependent on others and finding a social fit, is of interest. The process of reconnection to a sense of self through others, nevertheless, was not made clear and the current research seeks to address this gap.

Corin (1998) explored the subjective experience of persons diagnosed with schizophrenia using a phenomenological/hermeneutic approach to look at the strategies that participants employed to construct a narrative identity. She developed a comparison between hospitalised and non-hospitalised clients in various elements of social interaction. She discovered that although hospitalised individuals have normative ideals of social integration, they often had a sense of being excluded and marginalised from society. On the other hand, non-hospitalised individuals adopted a position in the margins, by using the strategy of positive withdrawal. Withdrawal in this group was experienced as an intentional strategy, for example, participants explained their withdrawal from others as resulting from the need to find some peace and tranquillity. In addition, non-hospitalised individuals attempted to elaborate their self-worth by reshaping their experiences in terms of religious and spiritual beliefs, and described these experiences as existing within an interpersonal frame, even if this was imaginary. In comparison to hospitalised individuals they thus appeared to be detached as opposed to excluded. Corin (1998) described this intentionality as having the inner space to be able to withdraw from others, but not to feel trapped in it. It allows for more flexibility in identity construction.

This is an interesting study on many levels. It was the first of its kind in this period to take an interest in the subjective experience of participants with a diagnosis of schizophrenia. It takes a critical approach towards the normalising techniques adopted in Westernised society to manage those perceived to be different, that remain unseen, and marginalised from the rest of society. She describes:

> “…people who ‘do not fit’ and cannot be integrated in the dominant paradigm, tend to remain ‘unseen’, almost socially non-existent and are left to a parallel life which has few links to mainstream society…the general stigmatisation attached to psychiatric disorders converges with an economic marginality and pushes people who have been diagnosed as schizophrenic towards a space of alienation which hinders their restorative attempts” (p.145).

Corin’s (1998) research highlights the politicised nature of the diagnosis of schizophrenia or psychosis. Furthermore, it raises questions as to whether the same marginalisation and exclusion is also something that people who share the same experience of hearing voices, whether they have a diagnosis or not, or whether they have been hospitalised or not, also share, and with what implications on identity. Future research may investigate whether people who hear voices, even when they do not have a diagnosis, experience the same marginalisation and exclusion from society.

Schneider (2003) used an ethno-methodological approach to investigate how people with a diagnosis of schizophrenia construct identity through talk and belonging to social categories, such as schizophrenia. She described three strategies that participants used to perform identity work: 1. a tendency of distancing themselves from the diagnostic category, 2. rejecting schizophrenia as a motive for behaviour, and 3. mobilising descriptions of themselves as normal. This research is unique in terms of the approach it takes on identity and has produced findings of interest about identity construction in people with a diagnosis of schizophrenia, but presents with some limitations. First, the research question was specific in looking at how participants construct a positive identity, which assumes that participants will always construct themselves in a positive light, limiting possibilities. Second, there was no information given on methodology and the method used to carry out the analysis, which makes it hard to evaluate. In addition, the author mentioned that she was going to draw on the broader resources in society to explain the findings, but very little attempt was made to describe these discourses or the impact of participants being positioned within these. On the contrary, the researcher positioned participants within a medical discourse, by acknowledging that schizophrenia is an illness caused by a chemical imbalance in the brain, without reflecting on how drawing on a medical discourse may have impacted on the findings. Moreover, in mentioning discourses she does not consider the implications of power, the impact of institutions and practices on reinforcing these discourses and vice versa. It is therefore missing a critical element, particularly as she is discussing schizophrenia, which is a highly-politicised subject. However, the findings were of interest and there is scope for improvement particularly in the methodology employed. The sample could include people who hear voices that do not have a diagnosis, to see whether they use the same strategies in constructing identity. In addition, a critical discursive approach can be taken that includes a macro focus expanding the discussion on discourses, the power implications of these and how participants are positioned when doing identity work. The current research seeks to address some of the methodological limitations of Schneider’s (2003) research.

To conclude this section, the problem with prior studies concerned with the impact that the experience of hearing voices has on identity, is that they are essentialist in nature and problematise the individual, in suggesting ways that the self should be addressed in interventions. The consequence is that wider social problems requiring political action are ignored, including the way that we conceptualise and treat those experiences. Furthermore, simply arguing towards changing the name of experiences from schizophrenia to something less pathological and modern (George & Klijn, 2013) is not going to lead to a change in the status quo, if we do not change the institutions and practices that reinforce these discourses. Research should therefore place more emphasis on the personal accounts of people who hear voices. The critical discursive approach adopted in the current study aims to answer the following questions: how do voice hearers talk about their experiences, what resources do they draw upon and what is accomplished with this discursive management? It may thus highlight how participants negotiate the voice hearing identity through the strategies they employ in local interaction. It may reveal how participants position themselves in available discourses, including the power implications of these in terms of institutions and practices, offering something more than previous studies.

B.2.7 Research Approach and Rationale

The old paradigm of social psychology, privileged the cognitive and emotional states residing in the individual to understand patterns of social interaction (Harré, 2001). The experimental approach adopted, however, was heavily criticised for producing findings lacking in external validity and ignoring contextual surroundings (Harré, 2001). By contrast, the discursive turn in social psychology privileges language, the meaning that a subject ascribes to phenomena and the socio-cultural context surrounding this (Harré, 2001). A social constructionist viewpoint suggests reality and persons are socially constructed through language and the process of social interaction (Burr, 2003). Language, is not just a means of communicating information; it has a performative function. Language is where identity work occurs, where identity is negotiated and contested (McKinlay & McVittie, 2011). Language provides a rich resource, offering multiple ways of constructing talk, depending on the conversational context (Edley, 2001).

Traditional theories of identity are essentialist and simplistic in nature. They propose identity construction is an individualistic process progressing through stages. Erikson (1968) proposed a lifespan model of psychosocial stages of development, with identity progressing through five stages up to the age of 18, and three further stages into adulthood. The model suggests that problems encountered at one stage of development lead to an identity crisis. However, it contributes little towards an understanding of the process of identity construction and/or how an identity crisis is negotiated. Marcia (1980) attempted to elaborate Erikson's (1968) theory by proposing ways of dealing with an identity crisis. However, the theory focused primarily on adolescent development. Levinson's (1978) theory, described a stable period crucial for individuals in making choices and a transitional period whereby one stage ends and another one begins. He described six stages of identity construction in adulthood. The theory, nevertheless, is based on a traditional 'stable' family structure and does not account for the variation in current society's relationships and living arrangements. For example, it assumes that most people have children and settle down by the age of 40. In addition, it does not consider divorce or any other relationships other than heterosexual ones. Overall, traditional theories take a simplistic approach to identity construction, particularly as they were originally based on male populations and only take account of the social in a peripheral way. On the contrary, identity in social constructionist terms, is not achieved through a stage process. It is achieved through social interaction and is therefore fluid and fragmented. Davies & Harré (1990) argue that the production of selves and therefore identities, occurs by the positions being made available through talk and discourse. In this process of identity construction, individuals position and are positioned by others in discourse. This positioning reveals what the person can do from a subject position and what possibilities it offers (Davies & Harré, 1990).

Discourse analysis is a useful approach to examine language and how it is implicated in the process of identity construction (Potter & Wetherell, 1987). Discourses – shared and routine ways of formulating a topic - are resources that people draw upon in social interaction to do things (McVittie & McKinlay, 2011). The discursive approach taken in the current research thus aims to take into consideration, what people do with language in a specific interactional sequence and the discursive resources that they draw upon in the process of identity construction (Edley, 2001). In addition, a critical stance is adopted that looks at two specific features of talk; it's ideological nature due to the power implicated in the way that it is employed, and its rhetorical and dilemmatic nature that offers a rich resource for speakers to construct multiple versions of events (Potter & Wetherell, 1995). A critical approach seeks to examine how dominant discourses oppress less privileged groups in society, how they are reinforced by institutions and their practices in a two-way process, to uncover whose interests are being served by maintaining the status quo (Foucault 1972, 1978). This research thus seeks to address the limitations of traditional models of identity, by taking a critical discursive psychological approach, which attempts to look at how people who hear voices construct identity through language, by drawing on available discourses on voice hearing within our culture.

B.2.8 Summary of Introduction

The current research does not use traditional psychological models (Erikson, 1968; Levinson, 1978; Marcia 1980) to investigate how people who hear voices negotiate their identity. Such models are essentialist in nature and rely on a process of separation and individuation to describe identity. Such an approach to identity construction is reductionist, because it does not account for the socio-cultural context that an individual inhabits. The approach to identity construction taken in this research is based on the idea that identity is not fixed, it is fluid and negotiated through the process of social interaction (Benwell & Stokoe, 2006). Identity as this viewpoint suggests, is not an essentialist feature residing in the individual, but an activity that resides in the social accomplished through language in the process of social interaction. Identity construction is something that is continuously negotiated by drawing on the cultural norms and discourses available in the social domain and is made up of different positions within discourse (Davie & Harré, 1990). Positioning theory is thus used in the current research to understand how people position themselves and position others through talk (Davies & Harré, 1990).

Discourse analysis provides the means of being able to examine how individuals construct identity through language. In addition, having a critical awareness of discourse is essential for psychological theory and practice (Vingoe, 2007). The analytic approach adopted in the current research investigates the discursive practices that participants use to negotiate the voice hearing identity. As the previous literature review illustrates, the exploration of personal accounts of people who hear voices has been neglected and especially from within a discursive framework, which allows us to take into consideration shifting cultural ideals and resources. A discursive reading that goes beyond what is said in a purely descriptive account, offers a much richer account than prior studies, by revealing how individuals position themselves in social interaction and the consequences that this positioning has for identity. Not only do negative images in the media have an impact on people who hear voices, some argue that such negative images become internalised (Evan-Lasco, 2012; Corrigan et al., 2003; Link & Phelan, 2001; Wahl, 1995). This research aims to look at how people who hear voices negotiate this identity using a critical discursive approach that takes into consideration the micro-conversational (action-orientation of talk) and macro-discursive elements (broader discourses of voice hearing in society). The approach seeks to answer the following research questions: How do participants talk about their experience of hearing voices? What resources do they draw upon in the process of identity construction and with what consequence? A more detailed discussion of the methodological approach taken will be discussed in the following section.

B.3 METHODOLOGY

B.3.1 Methodological Approach

My interest in the experience of hearing voices was generated through years of working with people who hear voices in the NHS. I wanted to know how individuals who hear voices negotiate the identity of being a 'voice hearer' in the social, especially as in Western society, this experience has traditionally been linked to psychopathology (Longden et al., 2012a). There has been little investigation in how voice hearers respond to typical constructions of voice hearing in the social domain and how they negotiate this identity.

B.3.1.1 Research Questions

This research attempts to address this gap, by seeking to answer the following research questions:

- How do people who hear voices talk about their experiences?
- What resources do they draw upon in the social domain to construct their experiences?
- What are the consequences of these constructions for identity?

The methodological framework that informs the current research is social constructionist. Social constructionism proposes that individuals' realities do not reside within, but are constructed through the process of social interaction (Burr, 2003). Such a framework lends itself well to an analysis of discourse, by looking at how such realities are constructed through language. The critical discursive analytic approach adopted in this research takes a dual focus (Edley, 2001; Wetherell, 1998). A micro focus aims to look at what participants are trying to achieve through the local interaction with the researcher. A macro focus aims to look at the broader discourses that participants draw upon in society in talking about their experiences. However, there are power implications in how wider discourses are reinforced and maintained (Foucault, 1979). The current research “aims to examine not only how identities are produced on and for particular occasions, but also how history or culture both impinge upon and are transformed by those performances” (Edley, 2001, p.190). The dual lens adopted seeks to answer different research questions, as well as address the limitations of adopting a purely micro (conversation analysis/ethnomethodology) or macro (Foucauldian Discourse Analytic) approach. It has been argued that they complement each other, by addressing each other’s limitations (Wetherell, 1998). This chapter seeks to address methodological issues, in terms of the approach adopted in this study.

The critical discursive approach first takes a micro focus in looking at what individuals are trying to accomplish in interaction (a conversational sequence). An important assumption of this approach is that language has a performative action; it has an action orientation (Edley, 2001). People do not talk just to express what they think or feel. The language that they use has a purpose, it aims to achieve something. By looking at the action orientation of talk, we may identify what is at stake in conversation (Edley, 2001). This might tell us something about what individuals are trying to achieve through interaction. In addition to this analysis, the current research also attempts to look at the wider discourses available in the broader cultural context pertaining to the experience of hearing voices, and how participants position themselves within these. It is within this subject positioning where identity work is done (Benwell & Stokoe, 2006). Furthermore, the exercise of power is inextricably linked to the use of some discourses over others, particularly where certain dominant discourses become legitimised and seen as the ‘truth’ (Wetherell & Potter, 1992). Dominant discourses and their associated practices serve to ‘interpellate’, by hailing individuals into certain subject positions (Wetherell et al., 2001). This positioning has implications for subjectivity.

The following section attempts to present and describe the methodological decisions pertaining to this research, which is carried out within a critical/ideological paradigm (Ponterotto, 2005). A critical stance is taken towards mainstream accounts of what it means to hear voices, by identifying and exposing the power relations implicated in these constructions. The epistemology that informs the search for knowledge is social constructionist, which focuses on how meaning is constructed through language (Burr, 2003). An analysis of discourse is compatible with a social constructionist epistemology. The following section will further clarify the epistemological stance adopted, including the rationale for adopting a critical discursive analytic approach.

B.3.1.2 Epistemological Stance

B.3.1.2.1 Social Constructionism

The methodological framework adopted in this research, social constructionism, arose in response to rationalism and the search for knowledge based on the use of reason alone. Prior to the 20th century, scientific methods of investigation (positivism) and the idea of progress, gained an enormous amount of power, due to its effective application in industry and medicine. Postmodernism was a counter-response to rationalism. The turn to language rejects the theories and metanarratives generated by rationalism and denies modernist claims of truth, advocating a new method of enquiry (deconstruction) placing an emphasis on the power of language instead of the individual to construct knowledge (Harré, 2001). Meanings created through language are dynamic, transient and always open to question (Burr, 2003). "…with the poststructuralist view of language, we are drawn into a view of talk, writing and social encounters as sites of struggle and conflict, where power relations are acted out and contested" (Burr, 2003, p. 59)

Postmodernism, in contrast to positivism, espouses an epistemological relativism where knowledge produced is not judged to the extent that it corresponds to reality. Social constructionism, a strand of postmodernism, takes a critical stance towards objective ways of understanding the world. It advocates that meaning is historically and culturally dependent, constructed through social interaction (Elder-Vass, 2012). Shared forms of understanding are constructed through the performative role of language. Social constructionists would even go to the extent of viewing language and other symbolic systems as a pre-condition for thought (Burr, 2003). In addition, social constructionism advocates 'pluralism' – the notion that there are various and multiple ways of viewing the world, which are context dependent (Burr, 2003). There are thus many, different and equally valid forms of generating knowledge, with no direct route to reality by methods of observation and analysis. Access to reality is dependent on our representations of it and is difficult to verify (Burr, 2003).

Social constructionism also rejects mainstream psychology's notion of an intra-psychic agency that guides individual action. Meaning from this perspective is not an individual accomplishment, but is constructed in relation to others (Burr, 2003). Furthermore, power is implicated in the way that knowledge is produced and what is deemed acceptable. Meanings that are widely endorsed in society by various means create social inequalities (Burr, 2003).

Therefore, language is thought to have a performative role in shaping not only our experiences but also our identities (Burr, 2003). Identity construction is not a fixed process because of the versatility that the use of language allows to continuously re-define and re-shape identities. This ability to contest identities that may potentially lead to oppression, will depend, to some extent, on social structures and practices that act to legitimise some discourses over others (Benwell & Stokoe, 2006). An important limitation of adopting an extreme relativist position, where nothing exists outside of language, is that it does not consider the real effects that physical materiality has on discourse and individuals. If everything is relative, this poses questions as to whether anything at all can be claimed to be true on the knowledge that is produced. This is evident when we consider the actions and consequences of the words we use (Sims-Schouten et al., 2007). For example, being given a diagnosis of schizophrenia, may lead to someone being administered anti-psychotic medications without their consent or even incarcerated on a locked ward.

A limitation of social constructionism is the assumption that there is no essence inside people that makes them who they are (Burr, 2003). For social constructionism, placing individuals in such categories such as 'voice hearer' serves to pathologise and restrict available ways of being. On the other hand, to accept the notion that individuals are constructed through language, leaves little room for agency. To address the issue of agency, critical discursive psychology is chosen as an analytic method, because it allows for agency by looking at how individuals creatively use language to construct themselves and others. The dilemmatic nature of talk, is a resource that allows something to be said in different ways, offering many possibilities for action (Edley, 2001). Individuals are thus seen as strategic users of discourse and not totally determined by language (Willig, 2012).

The following section of the methodological chapter will discuss the analytic approach adopted. The decision to use critical discursive analysis to analyse the data, from the plethora of discursive analytic approaches available, was based upon the ability of the approach to combine a dual focus. It enables the researcher to focus both on what individuals achieve through interaction (the action orientation of talk), whilst at the same time takes a critical approach towards broader discourses that voice hearers draw upon to construct their identities (Edley, 2001). Fairclough's (1995) critical discourse analysis (CDA) takes a similar approach, however it has a less sophisticated theory of identity than discursive psychology. Language use for discursive psychology is a dynamic discursive practice enabled by interpretative repertoires, ideological dilemmas and available subject positions. In addition, Fairclough's (1995) CDA is also ambivalent toward Foucault's notion of power and the role of discursive practice in maintaining the social order, therefore, the current approach was deemed more appropriate. Discursive Psychology and Foucauldian Discourse Analysis are the most frequently used discourse analytic methods (Willig, 2013). Critical discursive psychology, attempts to address the limitations of using a standalone approach, by offering a more comprehensive analysis in combining these. Discursive psychology alone does not take into consideration the broader context in which an interaction occurs. Foucauldian discourse analysis does not take into consideration the action orientation of participants' talk. As well as looking at what action is achieved through a local exchange, the historical context in which interactional sequences are embedded can provide information on why participants chose certain interpretative repertoires over other available options, particularly where certain dominant ways of understanding the world become normalised and taken for granted (Edley, 2001). In other words, broader discourses have an impact on the local action orientation of talk, in the same way that these local exchanges have an impact on broader discourses in society. The critical approach also takes into consideration issues of power and how some taken for granted discourses serve to marginalise and exclude.

B.3.1.3 Analytic Approach

B.3.1.3.1 Discursive construction of identity

Identity, as defined in most dictionaries, is who someone is that makes them different from others. This implies an essentialist stable internal process that is a product of the self. Similarly, mainstream psychology has also taken an essentialist approach to the study of identity ever since the period of enlightenment. Nevertheless, despite people constructing consistent accounts of themselves, they also tend to vary these depending on the local interactional context (Benwell & Stokoe, 2006). Here a critical stance is taken to the idea of a unified stable identity, with identity being understood in postmodernist terms of who we are in relation to each other. The construction of identity is achieved through a two-way process: through an individual's own discursive activity in relation to others (agentic) and through taking up available subject positions within wider discourses (deterministic) (Benwell & Stokoe, 2006). Identities thus reside in the public as opposed to the private domain and are negotiated and validated through our interactions with others.

The current research examines how people who hear voices negotiate the identity of 'voice hearer', as well as the consequences that such constructions have on possibilities for action and subjectivity. Contrary to mainstream psychology's idea of the presence of an internal, fixed identity residing in the individual, identity in discourse is fluid and continuously changing through our interactions with others (Shotter & Gergen, 1989). This process can only occur through shared understanding of who we are to one another and to ourselves. This suggests that there is some negotiation involved in constructing identities. Burr suggests (2003, p. 144) "We are dependent for our identity upon the willingness of others to support us in our version of events". This process therefore involves not only constructing a meaningful identity for oneself, but also trying to publicly sanction this. However, a constructionist view does allow for some agency, in striving to construct credible accounts of the self.

Simply looking at the conversational context to understand how participants negotiate their identity is not sufficient. We need to take a broader view of discourses, ideology and power (Foucault, 1972). Discourses present in society, their availability to be taken up by an individual and the limitations that they place on ways of being, will all have an impact on identity construction (Burr, 2003). To be able to construct a comprehensive account of how participants negotiate their identity, it is important to look at the broader context and the available resources that they draw upon (Gergen, 2001). This process is neither fixed not linear in kind. A post-structuralist perspective suggests that the process of identity construction is flexible, whereby individuals draw from multiple discourses to preserve a positive self-image, particularly if they belong to a stigmatised group (Gueta & Addad, 2013).

B.3.1.3.2 Critical Discursive Psychology

As discussed previously in relation to the social constructionist framework adopted, language has the power to construct subjects and objects through social interaction (Burr, 2003). To access such meaning, we need to investigate language and discourse, as conversation is where meaning is created and contested (Willig, 2013). The term discourse has been used by both discursive psychology and Foucauldian discourse analysis to denote the same thing, however there are differences in how the term is used. Discourse at a micro level is understood in terms of interpretative repertoires – different ways of talking about something based on shared understanding and social consensus (Edley, 2001). The availability of linguistic resources to drawn upon, inevitably leads to the dilemmatic nature of talk. Thus, interpretative repertoires are smaller and more fragmented than discourses. They can be deployed flexibly in interaction. Sometimes conflicting interpretative repertoires can be adopted within the same conversation to achieve different aims. On the other hand, wider discourses produce, and are the product, of our practices and institutions (Edley, 2001). Power is implicated in these discourses and being positioned within these enables or limits possibilities.

Edley (2001) suggests that through talk and the availability of rich and varied interpretative repertoires we creatively navigate the ideological dilemmas presented by the complexity of language. The way that participants choose to position themselves in relation to these available resources, is where identity work occurs (Davies & Harré, 1990). By looking at the discursive strategies that participants employ and the rhetorical devices in support of these, we see what participants are trying to achieve through talk, and how they have come to adopt a certain position over other available options, in the process of negotiating identity. It is not sufficient to look at the interpretative repertoires employed in the local interaction, because this would be ignoring the discursive backdrop formed by the broader historically and culturally produced discourses (Wetherell, 1998). This analysis therefore attempts to uncover the discursive strategies employed in negotiating the voice hearing identity, by taking into consideration interpretative repertoires, ideological dilemmas, subject positions and the power implications of dominant discourses.

It has been argued that looking at the local context of the conversation, as well as the wider discourses and their power implications, may provide a more comprehensive analysis (Botella, 1995; Wetherell, 1998; Burr & Butt, 2000; Burr 2003; Willig, 2013). Furthermore, Wetherell (1998) suggests that a post-structuralist (macro) approach provides a more thorough answer to the question ‘Why this utterance here?’ than a micro approach can provide alone, because it also looks at the discursive history that makes the account possible. The next section focuses on what each method accomplishes in turn. “The movement of contextualisation and the troubling of positions gives some insight into the contradictory and inconsistent organisation of the broader interpretative resources the participants are actively working over” (Wetherell, 1998, p.404).

B.3.1.3.3 Discourse Analysis Micro Proximal Focus (Conversation Analysis/Ethnomethodology)

Discursive psychology (DP) originates from ethnomethodology and conversation analysis (Parker, 1992; Potter, 1997 cited in Willig 2013). It is primarily concerned with how individuals create meaning through interaction, the action orientation of talk and what is at stake in the conversation. In trying to understand what individuals are trying to accomplish in talk, we need to take into consideration the context in which the conversation takes place. The context surrounding the talk is crucial in understanding the action orientation of talk, that is, the interpersonal objectives that speakers want to achieve (e.g., disclaiming or footing), what they are trying to do (Willig, 2013). This is because depending on the context, individuals may deploy different discursive strategies to achieve their aim. Thus, discursive psychology views speech as social action, in terms of what it accomplishes in interaction. This part of the analysis aims to look at the discursive strategies that participants employ, as they try to negotiate the voice hearing identity and the consequences of these strategies (Willig, 2013). On the contrary, a postmodernist discourse analysis with a macro focus, considers the wider deployment of discourses in society, including issues of power and how this is implicated in the normalisation of discourses. The power of dominant discourses has an impact on selfhood and subjectivity.

B.3.1.3.4 Discourse Analysis Macro Distal Focus (Post-modernism)

To understand what speakers are trying to achieve in a local conversational exchange, the broader discursive resources that form the backcloth of language and which individuals are drawing upon to make sense of this encounter, need to be considered. Post-structuralism takes a broader view on discourse, as having a constitutive effect on a decentred subject (Wetherell, 1998). The experience of hearing voices is an extensively politicised subject, thus taking a post-modernist critical stance is a useful approach for capturing the interplay of power in discursive constructions, and the ways in which discourses arise and are reinforced by social structures and institutional practices (Foucault, 1972, 1978, 1979). Knowledge is power and those who have access to it by drawing on dominant discourses legitimise their actions in society. However, power does not necessarily reside in the hands of powerful individuals or groups, it is a product of discursive practices. Thus, forms of knowledge that are legitimised in society, tend to prevail over other less dominant discourses. This is not always intentional, as often certain enabling conditions need to be present in a culture, which favour some discourses over others (Burr, 2003). A historical approach to the backcloth of discursive patterning that participants draw upon in local exchanges, reveals the way in which discourses have emerged and their availability to be drawn upon as discursive resources. Making dominant discourses visible in this way, may enable individuals to question their legitimacy and ultimately resist them. By deconstructing language, we reveal the discursive practices and their role in constructing versions of truth, enabling us to challenge these (Burr, 2003).

Postmodernism's assumption that subject positions and thus identities are determined by discourse, takes into consideration how social institutions and practices shape such constructions, and how power is implicated in these (Wetherell, 1998). The exercise of power, which is inextricably linked to institutions and institutionalised practices, occurs in a two-way process whereby discourses affect how institutions practice, but practices also reinforce and legitimise the very discourses that shape them (Willig, 2013). Foucault (1978) believed that although discourses are often used in covert ways by those who have power to control others, language also allows us to resist such discourses. Therefore, discourses have both the ability to give and remove power. It is essential to look at the exercise of power through the legitimisation of discourses by social institutions and practices, especially in contexts were social inequalities may occur and particularly in areas linked to mental health. Mental health is an area where constructions are culturally and historically specific, with constructions changing over time. Burr (2003) argues

"…health, illness and disability are not only socially created; they are sustained by social practices that often serve the interests of dominant groups in society" (p.38).

Furthermore, the field of Counselling Psychology research places an emphasis on the use of alternative methods of investigation from a qualitative perspective, as well as, interest in areas where social inequalities occur around gender, race and ethnicity, disability and mental health, with the purpose of challenging such views and empowering individuals (Douglas et al., 2016). Traditionally the experience of hearing voices has been linked to mental health, such discourses will without a doubt have implications for subjectivity and possibilities for action. Being positioned as someone who hears voices, will pose limits on what she/he can do. The macro focus of the analysis aims to enrich understanding.

B.3.1.3.5 Critique of analytic approach

A frequent critique of discourse analysis is addressing issues of agency and the extent to which individuals are constructed through language (Burr, 2003). The approach adopted in this study attempts to address issues of agency by adopting a dual analytic focus. Within the local interaction of talk, interpretative repertoires are applied flexibly and creatively in interaction to suit the speaker's purpose, sometimes adopting different positions within these repertoires depending on what the speaker is trying to achieve (Edley, 2001). At the same time, we cannot neglect dominant discourses that have the power to allow or restrict possibilities for action. However, the dilemmatic nature of talk allows for agency, by enabling individuals to construct accounts through interaction to suit each occasion and for their own purposes (Burr, 2003). The essential difference between the two analytic methods, is the extent in which the individual is an agent who is in control of this construction process or the product of social forces. However, there are points of agreement between constructivism and social constructionism, and bringing them together in synthesis addresses the limitations of using either method alone (Botella, 1995; Potter & Wetherell 1995; Wetherell, 1998; Burr and Butt, 2000).

A main criticism of discursive approaches, is the lack of concern for the intra-psychic and the internal psychological world of the individual (Burr, 2003). They cannot explain why individuals choose to adopt certain subject positions over others sometimes to their own detriment. In the initial stages of conceptualisation of this research, a psychosocial approach was considered to address this limitation, in combining social and psychological methods of investigation (Hollway & Jefferson, 2013). However, using psychoanalytic theory, even one that is compatible with a social constructionist view of language (Lacanian discourse analysis; Parker, 2005) posed some ethical issues. It would be difficult to gain informed consent from participants that may have limited understanding of psychoanalytic theory or how it may be applied to interpret their accounts. Therefore, it did not seem ethical to apply psychoanalytic theory, originating from psychoanalytic practice, to interview data outside of the therapeutic context. Furthermore, in therapy such interpretations are offered tentatively to clients, allowing them to accept, reject or merely consider these. There is no option in research for participants to be able to contest or challenge, once such theoretical interpretations have been applied to the data. Furthermore, it is debatable whether application of psychoanalytic theory can offer anything more than a purely discursive approach (Davies & Harré, 1999). In summary, the dual analytic focus adopted offers a more comprehensive approach and addresses the limitations around issues of agency and subjectivity, inherent in adopting a purely micro or macro approach.

B.3.2 Methods

B.3.2.1 Sampling & Recruitment

The recruitment strategy involved approaching individuals with a lived experience of hearing voices, through the Hearing Voices Network (HVN). The following criteria were used to define voice hearing: having the experience of hearing voices when no one is present, perceived to be either internal or external in origin. Participants were recruited from the Hearing Voices Network (Corstens, 2014) as it encourages diverse views in understanding the phenomenon of hearing voices, which is useful in generating the rich and variable accounts suitable for a discourse analysis. An attempt was made to recruit participants from different geographical locations. Eight participants were recruited, which Georgaca & Avdi (2012) suggest is sufficient for a publishable discourse analysis. Due to the complexity of the discursive analytic approach adopted at a micro and macro level, it was deemed that eight interviews would generate sufficient data to conduct an in-depth analysis.

The sampling method was 'purposive' and participants were selected because of their lived experience of hearing voices and the expertise that they provided on the subject. Two of the participants were recruited through a 'snowballing' sampling method (Robson, 2002) whereby an existing participant recommended a friend from their HVN group, who also hears voices, to take part in the research. The inclusion criteria were participants who have a lived experience of hearing voices and who are adults over the age of 18 and therefore able to provide informed consent. Seven female and one male participant took part in the study from various ethnic, educational and socio-economic backgrounds, between the ages of 18 and 70. Participants' demographic data have intentionally been omitted from the research as discourse analysts are cautious in using categories to describe participants (Willig, 2013). For example, Beck (1992 cited in Benwell & Stokoe, 2006) argues that in response to a fragmented sense of self, individuals attempt to construct a coherent and unified self by affiliating themselves to the constructed certitudes and identities of modern institutions for example gender, ethnicity, religion. These essentialist notions of identity are ideological because they maintain social inequalities by serving the interests of some at the detriment of others (Benwell & Stokoe, 2006). The way that they become common and naturalised results in them not being questioned, maintaining inequalities and the status quo. Defining people as 'black', 'women', 'immigrants', limits possibilities for action. Categorisations also have an impact on identity construction and subjectivity. An attempt is made in this research to deconstruct such certitudes and therefore it did not seem appropriate to assign participants to prior categories depending on their demographic characteristics (e.g., age, sex, ethnicity, socioeconomic status, employment) that already serve to define them in predefined ways. Labels are indisputable collective identity formations that remain influential in academic, political and public domains. A collective view of identity theorised using singular labels in an essentialist way is in contrast with the methodological approach adopted in this research, where identity is understood as not residing in the individual but as residing in the social. “For social constructionists, the labels themselves are crude and monolithic, usually defined by biology (for example sex and age) and imposed by analysts rather than being provisional identities that people themselves negotiate in talk” (Benwell & Stokoe, 2006 p. 27). The purpose of this research was to look at how participants construct their identities through language and social interaction.

However, demographic characteristics may provide a richer account of the phenomenon of interest, as they capture variety in the subject matter by looking for example at how constructions of voice hearing differ between participants of different ages (Saldana, 2011). We know that there are differences in the utilisation of health services between different ethnic groups, gender and life course factors (e.g., low income) (Kronenfeld, 2010). How participants construct the experience of hearing voices may determine whether they will seek help or not. Furthermore, as was discussed in the introduction chapter culture plays an important role in how the experience of hearing voices is constructed; with various interpretations offered by different cultures ranging from ill to gifted (Larøi et al., 2014; López et al., 2004). If identity construction is something that is negotiated with others, then the cultural context plays a crucial part in this process and omitting to discuss ethnic and cultural differences is a limitation.

Previous studies have tried to generate rich understanding by mapping social identity (for example social class) with specific language use (Coates, 2004) and feminists espouse that all knowledge and experience is gendered (Linkova & Cervinkova, 2004). However, some argue that dividing the world into such finite categories serves to shape and mould the object of study and this is the reason why demographic information has been omitted in the current research (Benwell & Stokoe, 2006; Willig, 2013). In addition, many authors argue that contextual information (e.g., demographic variables: class, ethnicity, sex, gender) should only be used in the analysis if it is relevant to the participants (Schegloff, 1997 p. 195; Antaki, 1994; Potter 1998). The problem is how do we select those that are relevant to our participants? How do we know that a characteristic is relevant and not confounded by another? Such categories can be worked up in different ways in talk and they cannot be glossed over as gender or age in the analysis. Categories in discourse analysis should only exist if they are worked up by the participants in text (Wood et al., 2000).

Participants were only excluded, if they were currently experiencing distress to such an extent that taking part in the interview may serve to intensify this. Screening for levels of distress was difficult, as people who hear voices sometimes experience distress on a regular basis. The way that I chose to address this was to ask participants at the time of recruitment and then again at the day of the interview, whether they are currently experiencing any distress from hearing voices that they anticipate may be exacerbated by taking part in an interview or from having to talk about their experiences. Contrary to the common belief of the fragility associated with hearing voices due to the distress linked with the experience, no participants in the debrief said that they found the interview difficult or upsetting. Only one participant had to cancel his interview, because at the time he was experiencing distress and was receiving support from services. Measures were also taken to minimise any distress experienced by offering a handout post-interview to each participant with sources of support in their current area (Appendix B.10). These procedures will be discussed further in the ethics section.

The recruitment process involved approaching HVN groups in Central London, Hertfordshire, Bedfordshire and some groups in the North (Yorkshire). I contacted the group facilitators listed on the HVN website, with the aim of arranging a meeting with the group to present my research. I received a response from groups in London, Hertfordshire and Bedfordshire areas. No response was received from the groups in the North, following attempts of the researcher to contact the facilitators. Some group facilitators did not allow access to groups, particularly where these were run by organisations. Some of the participants were recruited from HVN groups that are run independently by people who hear voices and some were recruited from groups run by organisations. These are hard to reach groups and therefore initially group facilitators were approached via phone to see whether I would be able to attend the groups to talk about my research.

During these initial meetings with the groups, I introduced myself, my institution and my research. I explained that my main concern was how the experience of hearing voices is talked about within the current socio-cultural and political climate, and the impact that such views have for people who hear voices. I further clarified that my aim was not to elicit detailed and personal information on the content and nature of participants' voices (e.g., who they are, what they say) but how they construct meaning from their experiences. During the presentation, I allowed time for group members to ask questions about the research. It did not seem appropriate to ask participants to decide there and then, putting them under pressure. I therefore left my contact details and the participant information sheets with group members and facilitators to contact me if they wanted to take part, either directly or through the group facilitators if they so preferred. I explicitly stated that participants were not obliged in any way to take part in this research, and choosing not to take part would not affect their group membership.

B.3.2.2 Data Collection Procedures

B.3.2.2.1 Interview approach

The decision to conduct semi-structured interviews to collect data was based on the research questions, which aimed to answer how individuals who hear voices talk about their experiences. It did not aim to capture professionals' accounts on the subject or how the media represent these issues, although historical constructions of hearing voices have been included in the introduction chapter. The research looks at how people who hear voices construct meaning through their experiences, which can either be captured using interviews or focus groups. However, focus groups were not chosen as a data collection method, because it was felt that a group setting may have prevented some participants from talking openly about their experiences. In addition, there was also a consideration of other issues such as having to manage conflict, needing another observer to facilitate the running of the group and having less control over the construction of data (Robson, 2002). Focus groups, however, may have generated some interesting discussions in collaborative talk, which may not have been captured in a 1:1 setting, and may be a consideration for future research. Overall, an important limitation in using interviews, particularly in adopting a discursive analytic approach, is that participants are orienting to the interview situation, what they think is expected of them, and this will influence to a certain extent the data that is produced. Some could argue that interview data produced in such a context is not naturally occurring data. However, in discourse analytic research, the researcher co-constructs the findings by being an active participant in this process (Gubrium, 2012).

A social constructionist perspective proposes that meaning is constructed through social interaction and this also includes the interview situation (Holstein & Gubrium, 1995; Gubrium, 2012). The researcher is thus an active participant in constructions. An active participation however does not have to be challenging or confrontational, and the overall aim was to produce complex and diverse meaning. This was achieved by taking a curious stance, actively listening at participants' accounts and using follow up questions and prompts to explore areas of interest. By highlighting aspects of the account through further questioning and repetition, I tried to encourage reflection from participants, whilst always keeping in mind the research questions (Holstein & Guibrium, 1995). I attempted to achieve a balance between being active in producing diverse accounts by highlighting points of interest relating to the research questions, whilst also trying to take a step back from my own agenda to allow participants to generate their own accounts of their experience. This was reflected in the research questions asked, which were constructed in a way that would not lead participants. Participants were asked questions such as 'How do you make sense of your experience of hearing voices?' 'Tell me about your experience of hearing voices', 'Is voice hearing a term that you use or do you prefer another term to describe your experiences'? 'How would you talk to others about this experience'? Implications from the construction of the interview questions, is further discussed in the reflexivity section.

B.3.2.2.2 Interview Guide

An interview guide was prepared, which was used loosely and flexibly to help the researcher keep focus on the research questions (Appendix B.8). For most part participants' responses determined which direction the questioning would take (Hostein & Gubrium, 1995). Participants were also given the opportunity to give feedback on the questions asked and to talk about anything relating to their experiences, that wasn't on the agenda of the researcher. This acknowledges the active co-constructive element of the interview process and some of the interview questions were changed following this feedback.

With regards to describing the process whereby this knowledge was produced and particularly in response to the interview questions, I wanted to know how participants talk about the experience of hearing voices and with what effect. It did not matter so much what perspective the participants approached the subject from, because my interest was in how they constructed the account and for what purpose, as opposed to what they are saying (e.g., their subjective experience of hearing voices).

B.3.2.2.3 Pilot Phase

During the process of developing the interview guide, I completed two pilot interviews with people who hear voices from local community groups in Hertfordshire. These however were not full interviews per se and were not audio recorded. Pilot participants were asked their opinion with regards to the questions asked, requesting their feedback on how easy or difficult they found these questions and what they would have liked to have been asked. Following feedback from the pilot interviews, an interview guide was prepared (Appendix B.8). I followed the same process following the interviews with the participants and they were asked to provide feedback on the interview, the questions asked, and whether they wanted to make suggestions for improvement.

B.3.2.2.4 Procedures

Most interviews took place at the premises of City University of London, except for the interviews conducted in areas where participants, due to distance, would find it difficult to travel to London. For these interviews, the premises where HVN groups take place were used to conduct interviews and a risk assessment was undertaken to ensure the safety of participants and the researcher (Appendix B.11). Where it was not possible to utilise City University of London premises, arrangements were made for facilitators who run HVN groups to be available on site to offer support if an issue arose. Prior to the interview, participants were given the participant information sheet informing them of the aims of the research, confidentiality, and their right to withdraw from the research at any point (Appendix B.6). They were also asked to sign a consent form (Appendix B.7). In addition, participants were advised of the limits to confidentiality and that someone would have to be informed if something was disclosed to the researcher indicating that the participant is a risk to herself/himself or others.

I introduced the nature of the interview as an informal chat, as opposed to a formal meeting. The interview began by asking participants to tell the researcher a little bit about themselves, to break the ice, but also to see whether participants mention voice hearing as a distinct part of their identity. It was interesting to see whether participants mentioned voice hearing when describing themselves, but also whether they omitted this. The duration of the interviews ranged between 45-60 minutes and participants were given time afterwards for a debrief session, to discuss whether anything arose during the interview of a distressing or emotive nature (Appendix B.9). Furthermore, a debrief sheet was given to participants with sources of support to use if they experienced distress after taking part in the interview (Appendix B.10).

B.3.2.3 Transcription

I transcribed all the data generated from the interviews, to familiarise myself with the accounts produced and subsequently read and re-read in preparation for the analysis. As a guideline, Jefferson Lite (Parker 2005) was used to inform the transcription of the interview data (Appendix B.12). This included pauses, tone of voice, speed, interruptions and volume. The way something is said can affect its meaning and therefore it was important for me to pay attention to how things were being said, as well as what was being said when transcribing the data. In addition, written reflections were made upon completion of each interview, paying attention to specific aspects of the interview, such as facial expressions and movements that could not be captured on the audio-tape. Reflections were also noted with regards to the thoughts and feelings of the researcher from taking part in the interviews.

B.3.2.4 Analytic Procedure

The method selected to analyse the interview data was a critical discursive analytic approach (Edley, 2001; Wetherell, 1998; Willig, 2013). The analysis unfolds in layers, beginning with a micro focus of the local context of the interaction looking at the action orientation of talk. The selection of texts for this part of the analysis was based on the research question, how participants construct the experience of hearing voices. The analysis with a macro focus, based on the texts already selected for the discursive reading, identifies the discourses that form the backcloth of these conversational sequences. Others have previously attempted to investigate the construction of identities this way using a discursive approach (Horton-Salway, 2001).

The process of forming an identity is understood to be a product of discursive practices, as identities are taken up and negotiated through the process of social interaction. Edley (2001) suggests that such identities are fluid and dependent on the social setting in which they are negotiated. The analysis aims to reveal the discursive strategies that participants draw upon to negotiate identity. It seeks to answer the following questions: What identity are participants constructing for themselves? What is the discursive purpose of working up such an identity? For example, is it to blame, defend or justify? The selection of text for the critical discursive analysis with a micro focus was based on the research questions (Willig, 2013). Specifically, the texts selected for the discursive analysis, are sections where participants are clearly seen to be negotiating this identity, for example where they are trying to construct the voice hearing experience in a certain way. The extracts chosen to present in the final report were selected because of the clarity in which they display the discursive strategy and/or the affect evident in discourse (Wetherell, 2012).

Steps detailing the analytic procedure:

- Following the transcription of the interviews, the transcripts were initially read to become familiar with the data. A second reading was undertaken prior to the analysis to take a broader view of the discursive effects of the text (Willig, 2013).
- Subsequently each interview was read line by line to look for patterns in the conversation where participants are constructing the experience of hearing voices and negotiating the voice hearing identity.
- Material was subsequently selected for the discursive analysis based on the research questions. The texts selected for analysis were extracts where participants either implicitly or explicitly were seen to be constructing the 'voice hearing' identity, for example one participant constructed voice hearers as some of the kindest people she has ever met. This search was guided by shared meaning as opposed to just looking for keywords (Willig, 2013). The data selected were analysed in terms of the action orientation of talk and what participants are trying to achieve in conversation for example what discursive strategies they use, including the rhetorical devices that support these. The questions asked of these pieces of text were: What are participants trying to do in this discursive context and with what consequences? For example, are they disclaiming, persuading, pleading, rationalising, excusing and so forth. This was achieved by looking at the resources that participants were drawing upon (interpretative repertoires), how they deployed these in different contexts for different purposes (ideological dilemmas), and how they chose to position themselves in relations to these and with what consequences (Edley, 2001).
- The discursive strategies identified including the rhetorical devices that support these, were separated into unique files, with each file including all relevant sections of text where participants were seen to be utilising the discursive strategy in question (e.g., disclaiming). Where different participants used the same discursive strategies to achieve their purpose, these sections of text were included in the same file.
- The interview transcripts were read again to check whether the discursive strategies were valid and whether they clearly corresponded (were self-evident) to the selected extracts. The data was therefore frequently revisited to refine strategies (Willig, 2013).

The discursive strategies were also checked alongside each other to ensure that there was no overlap.

- The next step of the analysis attempts to locate the discursive constructions within wider discourses, without losing the action orientation of talk. This analysis seeks to address power implications and address questions such as what possibilities of action do the identified discourses enable? Whose interests are being served by the prevailing definitions of voice hearing? What is the relationship between discourse and practice? And how are these maintained, resisted or transformed? (Willig, 2013). However, this stage of analysis was not exhaustive and was not applied to the entire data corpus, but to the specific datasets selected in the initial stage of analysis. This part of the analysis is specifically used to better inform our understanding of the discursive strategies already employed by participants to negotiate their identity.
- The different levels of analysis were brought together to consider how they are all implicated in the way that voice hearers negotiate their identity, to gain meaningful insights from this.

B.3.3 Reflections on the methodological approach

My interest in the research subject originated from my work with individuals who hear voices in the capacity of support worker in NHS community services and as a trainee counselling psychologist on placement in an acute inpatient setting. From my own experience of working with people who hear voices, it seems that being a voice hearer involves a double jeopardy. Not only do voice hearers manage the distress that is sometimes associated with hearing voices, they also manage the stigma attached to mental health and specifically the negative connotations associated with the diagnosis of ‘schizophrenia’. I found that people who hear voices do not always feel able to talk freely about their experiences for these reasons. As a practising counselling psychologist, I was curious to know how people who hear voices negotiate this problematic identity to inform interventions for people who hear voices.

My background and experience in the subject matter proved to be an invaluable resource in engaging participants, gaining rapport, and knowing when to probe deeper during the interview to generate rich data. However, it may also have served as a disadvantage due to many reasons. Firstly, my work experience was mainly in the NHS and therefore this setting, in addition to my psychology background, may have shaped the interpretation. However, I tried to be aware of the discourses informing the construction of the research findings. Secondly, I am emotionally attached to the subject, because I have worked over the years to reduce the stigma attached to mental illness for people who hear voices. A primary concern throughout this process has been to consider how issues of power may be implicated in my own research. I did not want to disempower participants, by inadvertently highlighting or reinforcing discourses that may be damaging for their identity.

Furthermore, by adopting a social constructionist framework which claims that realities are socially constructed, it felt important to be aware of the problematic status of one's own knowledge claims, including the knowledge generated in this research (Burr, 2003). I thus tried to place an emphasis throughout the analytic process on participants' constructions and how they manage and work up the facticity of their accounts and manage stake in conversation, as opposed to working for my own agenda. One way this can be achieved by the researcher, is detaching oneself from her own understandings of the descriptions provided (Potter, 1996). This process was greatly aided through regular supervision and having someone else question the knowledge claims produced. An attempt was also made to take a critical stance towards the discourses used to construct meaning from the data. Potter (1996) suggests that we should equally be critical of the way that credibility is built up in our own accounts, as researchers using rhetorical devices. We need to be aware of how our descriptions are being produced, as external, and independent of the speaker, by drawing on empiricist discourses. Constructions produced are bound up with our own practices (Potter, 1996). An attempt was made to question the practices that were part of the constructions generated, including the research questions that could generate different outcomes.

The interview questions were neutral and non-directive, to prevent leading participants (Robson, 2002). Example questions included 'Tell me about your experience of hearing voices', 'How do you make sense of your experience?', 'What does it mean to you having the experience of hearing voices?' (Appendix B.8). However, prior to the interview, the way that the research was presented to participants, may have served to set the scene in advance of what was required of participants and they may have been orienting to this. For example, I informed participants that I was looking at how the experience of hearing voices is talked about within the current socio-cultural and political climate. Therefore, setting the scene involved participants having to consider the context within which they hear voices (e.g., the culture, media, institutions and practices). This introduction may have had an impact on the accounts generated.

B.3.4 Ethics

The current research has been approved by City University of London Psychology Department Research Ethics Committee, with some minor amendments requested on the participant information and participant invitation sheets (Appendix B.2, B.3, B.4). During the presentation of my proposal to fellow students and staff, concerns were raised about interviewing participants who may be experiencing distressing voices. Two measures were taken to prevent the risk of participants coming to any harm from taking part in the interview. Firstly, during the initial meeting to recruit participants and subsequently just prior the interview, participants were asked whether they were currently experiencing any distress and whether they felt that talking about their experience of hearing voices was likely to cause them any distress. If participants did not feel well enough to attend the interview, an opportunity was given to reschedule the interview. Secondly, because the experience of hearing voices is quite often linked to distress, there was the possibility that during the interview matters arose of a personal and emotive nature that may cause participants to become distressed. This was addressed in two ways. Prior to the interviews, I informed participants that they are not obliged to respond to any question that they may find difficult and with no consequence. The interview was immediately followed by a debrief session, where participants were given time to discuss how they felt post-interview and whether they had experienced any distress from taking part. Surprisingly, despite material of a personal and emotive content discussed in the interviews, none of the participants said that they experienced any distress. Most participants commented that they found it helpful to talk about their experiences. Finally, participants were given a sheet with detailed sources of support to be used in the eventually that any distress was experienced after the interview (Appendix B.10).

With regards to data protection and the management of recordings and transcriptions, adequate measures were taken to ensure that all data were backed up and stored on a password protected computer, which was kept in a locked secure location. Participants were advised that audio recordings would be destroyed upon completion of the research, but that transcriptions and other written documents would be held for up to 5 years. The data gathered from the interviews were anonymised, coded and stored by number in the order in which the interviews took place, so that the interviewer can easily identify the individual that the data belonged to. Only the researcher and research supervisor had access to the research data. During the write up of the report, every effort was made by the researcher to remove information in extracts that could potentially identify participants.

B.3.5 Summary of methodology

To recap, where discursive strategies are identified, including the rhetorical devices in support of these, the analysis is specifically looking at the action orientation of participants' talk. In addition to this, a further analysis looks at the wider discourses that participants draw upon to provide a more comprehensive approach to an analysis of discourse.

B.4 ANALYSIS AND DISCUSSION

B.4.1 Analysis

B.4.1.1 Introduction

The critical discursive analysis examined the action orientation of participants' talk, what they accomplish through language as opposed to describing their subjective experience of hearing voices. In short, not *what* was said but *how* it was said. The analysis revealed six discursive strategies that participants employed to do identity work: Blaming, Disclaiming, Justifying, Reframing, Normalising and Trivialising. To clarify, discursive strategy refers to the way that a discourse is deployed by an individual (Carabine, 2001). Each of these strategies is explained in detail here below, including the supporting extracts. The analysis revealed that these strategies can have different consequences and therefore have been separated into two patterns of doing identity work. The first set of strategies 'positioned as object' were adopted in response to participants being positioned by others as an object of danger and fear in dominant discourses of pathology. When positioned within discourses of pathology, the only option for participants was to disclaim, blame and justify. This is framed here as a negative identity practice that participants used to distance themselves from a rejected identity (Butzolch, 2009). It is a discursive practice that is used when members of a category experience a threat to their identity and aims to define what a voice hearer is not. They thus tend to be other-oriented. The second set of strategies were adopted in response to participants being 'positioned as subject' within less pathological discourses, under the proviso that they were enabled to do so, for example, there were available discourses to draw upon.

Participants used this strategy to construct a chosen identity, thus these strategies aim to define what voice hearers are like (Butzolch, 2009). They are thus self-oriented.

Construction of ‘otherness’ is an important aspect of defining a sense of self (Wetherell & Edley, 2009). In the first set of strategies (disclaiming, blaming, justifying) there is a struggle to control identity, whereas in the latter discursive strategies of normalisation, trivialisation and reframing, participants are trying to exert control through shared values (Butzolch, 2009). As discussed previously, control and agency have an impact on identity (Lovell, 1997). The pattern of identity work revealed by each grouping of discursive strategies differs and centres on the effect of the latter strategies (normalisation, trivialisation, reframing) to be more persuasive and less likely to be challenged because they are implicit, subtle and covert. For example, explicitly disclaiming the identity of dangerousness, where one acknowledges a stake or interest, is more likely to attract a counterclaim.

B.4.1.2 Positioned as object strategies

When individuals who hear voices, are positioned within the pathological discourses of ‘dangerous’, ‘crazy’, ‘weak’, they are constructed as fundamentally different from the normal population, thus becoming the object of others’ talk (Wetherell & Edley, 2009). In the absence of alternative, more benign constructions, participants chose the discursive strategies of blaming, disclaiming, and justifying, to negotiate an identity different to that on offer. Taking a discursive view on participants’ data, involves undertaking a suspicious reading of what participants say, by going beyond the semantic content to examine latent content (Willig, 2013). Throughout the analysis what is at stake is not what participants say at face value (semantic content) to illumine their subjective experiences, but what they are trying to achieve (to do) with talk.

B.4.1.2.1 Blaming – Us versus Them

Blaming others has the effect of reducing accountability and responsibility for one’s actions, particularly if what is accountable is thought to be problematic. Participants use ‘blaming’ as a discursive strategy to make others accountable for the problematic identity associated with being a voice hearer. In the extracts that follow individuals embrace the identity of voice hearer, but blame others for the fact that this identity is problematic, rejecting any truth in the claims made. Participants construct themselves as bystanders who are not accountable for their situation, absolving them of responsibility.

Extract 1 - Jack

606. J: So, they think put two and
607. two together (.) and come up with the answer, you must be (.) that label
608. that they've read about .hhh and they're so much (.) I~I think it's
609. ignorance come fe::ar. I know ignorance is a strong word
610. ~and it's probably not (.) being too fair (.), but:: (.) I think (.) fear is a
611. better word []. I think people (.) people who::: (.) I've experience it meself
612. R: [mm]
613. J: like I said when I, when I was first in a psychiatrist clinic and [] spoke to somebody
614. R: [mhm mhm]
615. J: who heard voices, .hhh I remember (.) being quite wary (.) .hhh and::: (.)
616. lo and behold (.) I'm now in a position where (h) I hear voices meself (h) and
617. so ↑I can understand, I can understand that↓ (.) initial (.) wariness and fear
618. of the label attached to (.) schizophrenia (.) of people who haven't (.)
619. had a great deal of experience in mental health issues, because I was
620. like it ◦meself so:::::◦, I can't really cast the first stone, because I was (.) I was (.)
621. very much in a – when I was younger I was very much in a similar (.)
622. .hhh ahm had that similar fear of of of~ mental illness.

Jack in this extract is apportioning blame, in a way that will not attract criticism. He uses rhetoric devices to do this, such as a disclaimer "it's probably not being too fair, but" (line 609), which is a disavowal of what he is about to subsequently claim. The stake inoculation and footing (Potter, 1996) "I've experienced it meself" (line 611), constructs himself as someone who was also originally wary of people with mental health issues, thus reducing his stake in the conversation by seeming to present a non-biased account. He illustrates this quite vividly through the idiom “I can’t really cast the first stone” (line 620), but the action orientation of talk indirectly apportions blame to others for not being informed about mental health issues. Thus, nobody can criticise him for being biased, because he constructs himself as someone who also used to be ignorant, who used to think this way.

This construction first serves to bridge the gap between Jack and the rest of the population, by saying that he used to be that way himself. In addition, the construction serves to elevate him to a position of someone who knows, in relation to the ‘other’ (the public), that doesn’t know. There is a reversal of power here. The use of “lo and behold” (line 616) indicates that he was surprised when he started hearing voices, further reducing his stake in the conversation. Here the participant is drawing on the interpretative repertoire of ‘fear of the unknown’ (Xenophobia) and choses to position himself within this, as he himself in the past was fearful of mental health issues until he experienced it first-hand. By doing so he makes the voice hearing identity less problematic because he claims it is based on others misconceptions and uses his own experience to back up the claims he is making.

Extract 2 - Zoe

580. Z: (.) I was talking to::: a friend yesterday (.) about (.) the:::: stigma (.)
581. around (.) HIV? From like the early 80s until now [] and
582. R: [mhm]
583. Z: how much it has massively improved. There’s still stigma
584. but its (.) completely different to how it was 30 years ago.
585. And schizophrenia has not moved (.) at all. It’s still (.)
586. at even with all of this (.) .hhh, you know, 1 in 4 people
587. have mental health problems::, lots of mental health
588. this, mental health that everywhere, it’s all about
589. every mental health problem other than psychosis?
590. There’s like nothing out there? Ahm I don’t understand

why kids aren’t being taught this (.) in schools? Ahm::: People think that psychosis is synonymous with psychopathy? .hhh so:: will actually think (.) that~ a psychotic per(son) – people use the term psychotic (.)~ as if they’re saying psychopath? (.), like you know, (.) and and I’m just this is just so:::: (.) such poo::::r kind of (.) public education (.) about something that is really common, and really normal, and really distressing for people who experience it, and (.) the whole thing would be so much less distressing if there was no shame about it? Because people wouldn’t bottle it up? They would be able to go and talk to someone. I would have probably gone - to get help (.) really soon (.) if it had felt like an ok thing to do, if if I could have just booked an appointment with my GP and said ◦‘I’ve started hearing voices’◦. .hhh And if there was like literature and leaflets and posters and stuff around, that kind of say, ‘Are you hearing voices?’ You know, ‘come to this group’ or:: ‘go see (.) your GP’, or d’ (.) you know, book an appointment with a counsellor (.) or:: just something that isn’t [] .hhh (.) yea just just

R: [mmm]

Z: terrifying and, you know, lots of people have their first experiences in their late teens and early 20s? (.) And:::: you know, w~ when people are really worried about self-image and being popular and what people think about them and (.) .hhh people are still kind of immature enough to be making jokes about

616. (.) all of those (.) you know, about being crazy and (.), ahm going schizo (.),
617. or:: .hhh and I just (.) it’s just so frustrating that (.) and that’s why
618. I kind of say, you know, I don’t blame people that are ignorant about it, because
619. it’s not their fault, there’s just not enough information out there unless
620. you go looking for it and of course, you know, .hhh most people aren’t
621. going to go looking for it, so::: because it’s just not (.) out there (.) ahm and I don’t
622. know how psychosis has so completely missed the band wagon (.) .hhh of
623. this new mental health ↑drive?

Zoe is drawing on a broader normalising discourse that suggests 1 in 4 individuals will experience mental ill health (WHO, 2016). This discourse constructs the experience of mental health problems as a widespread phenomenon in society, if not the leading cause of ill-health and disability. However, she finds herself in an ideological dilemma (Billig et al., 1988), as she is unable to position herself within this discourse. This is because she constructs psychosis as “completely missing the band wagon” (line 622) of this new mental health drive and compares this with other mental health diagnoses constructing an in-group/out-group divide (Edwards, 1998).

She thus manages this problematic position using rhetoric devices that apportion blame on others for the lack of awareness of hearing voices, and constructing an account that appears to be balanced and informed to persuade the audience. The purpose of the discursive analysis is not to illuminate the subjective experience of the participant, but what she is trying to accomplish with talk and with what consequence. For example, she uses a degree of exaggeration- extreme case formulation (Potter, 1996) “massively” “completely” (line 583-4) and active voicing to arouse emotion in the audience. She uses a persuasive 3-part list “something that is really common, really normal, and really distressing” (line 597) to create impact and construct an alternative account of voice hearing. The disclaimer “I don’t blame people that are ignorant about it” (line 618), is used to pre-empt a counter-claim due to the sensitivity of the topic. She constructs herself as not accountable for her difficulties and places the problem firmly on others “such poor kind of public education” (line 596). Others are constructed as being judgmental, uninformed and not willing to listen without prejudice. Here the participant says very little about voice hearers, however the consequence of constructing the ‘Other’ in this way “the whole thing would be so much less distressing if there was no shame about it” (line 559), implicitly constructs people who hear voices as moral agents.

Extract 3 - Zoe

671. Z: But actually more than psychiatry or pharmaceutical industry is
672. the media (.) ahm and you know (1) it’s the media for so many
673. things, but it is, you know, this kind of (.) need to print
674. shocking scary things, because that’s what people want to re:::ad (.).
675. R: mhm=
676. Z: =Ahm::: and then (.) print them in a really ill informed way and report
677. them in an ill informed way (.) like every time something awful happens, there’s
678. like a query about whether the person who did it, had mental health
679. problems [] (.) and if they (.) did (.) that’s just so. So I was really really sad
680. R: [mhm]
681. Z: about (.) the::: ahm the guy who crashed that plane on the Alps on purpose? []
682. R: [mhm]
683. Z: but I was like (.) 15 times sadder when I found out he had depression?
684. Cause I was like, you know, this is the kind of thing (.) that (.) hardly
685. ever happens (.) that could happen (.) and anyone (.) in a certain set of (.)
686. ::circumstances [] could be driven to do something like that (.), but now
687. R: [mhm]
688. Z: it’s a person with mental illness, and now they’re saying that everyone
689. has to be vetted before they can fly, but then it’s just kinda like,
690. another one of those (.) examples and Andres Breivik who shot
691. all the ahm:: students in (.) Norway? [] There was this big (.) to do about whether

692. R: [mhm]
693. Z: he had schizophrenia or not that went on for ages –
694. he was pleading (.) that he didn’t
695. have it. (.) And that he was acting rationally. And there was
696. psychiatrists arguing (.) that he (.) did have it and that he was (.)
697. acting (.) irrationally. .hhh and I was just like (.) ‘Ple::::ase let (.) him (.)
698. not be (.) labelled (h) with this because he’s just a (.) ba::d man?’ .hhh
699. And you know (.) I don’t care what drove him to do it (h), but I
700. really hope it wasn’t psychosis (h) cause (.) there’s also
701. lots of people .hhh who hear voices and (.) experience (.)
702. other unusual things (.) who (.) do:: amazing good things? and (.)
703. or just struggle (.) but never hurt anyone?

The discursive strategy adopted by Zoe in this extract serves to blame the media for printing articles in ill-informed ways to sell news, and constructs the ‘Other’ (media) as immoral agents. She uses the rhetoric devices of extreme case formulation “shocking scary things” (line 674) and generalisation “Like every time something awful happens” (line 677) to make these claims more believable. The frequent use of “you know” presents her view as common sense, self-evident and not requiring justification (Edwards, 1997). By constructing such acts of violence, as something that could potentially happen to anyone “this is the kind of thing that hardly ever happens, that could happen, and anyone in a certain set of circumstances, could be driven to do something like that” (line 684), she constructs people as either belonging in one of two categories good versus bad. She positions those who commit such acts of violence in a discourse of morality, therefore distancing herself from it. “He is just a bad man?” (line 698). Accountability shifts to those that perform such acts and not people who hear voices. Because of the sensitive nature of her claims, she presents this tentatively by ending the statement with a question mark. This serves to reduce her stake and therefore is less likely to attract criticism.

The construction of good versus bad people is strengthened by her claim “he was pleading that he didn’t have it and that he was acting rationally” (line 694), which further distances violent individuals from the mental health category. However, she is positioned in an ideological dilemma by a category entitlement, by expert “psychiatrists arguing that he did have it and he was acting irrationally” (line 696), leaving her in the problematic position of being somebody that could potentially become dangerous and act irrationally. She deals with this dilemma by placing accountability where it is due, in the hands of those that cause violence “I don’t care what drove him to do it” (line 699). On the other hand, people who hear voices are constructed as people who “do amazing good things or just struggle and never hurt anyone” (line 702). Footing is crucial here using consensus to validate claims “lots of people” (line 701), because presenting her account in the first person would have increased her stake in the conversation. A problematic identity is rejected in favour of portraying voice hearers as people who do amazing things, in contrast to those who do bad things. The consequence of this strategy is a more positive identity, because the alternative would be to be left with an identity of someone who is feared. By constructing binaries (good versus bad), she is constructing people who hear voices as distinctly different to violent people.

B.4.1.2.2 Disclaiming

Disclaiming is used by participants as a discursive strategy to outright reject the problematic identity associated with being someone who hears voices, which is reinforced by dominant discourses of dangerousness and madness (Darrell-Berry et al., 2016).

Extract 4 - Jack

501. J: .hhh the three areas that (.) they look upon (.) is,
502. one is just general prejudice you’re mad, you’re crazy, you’re bad (.),
503. the other area is::: (.) basically in some respects it’s your fault
504. (.) that you’ve suffered it, (.) and the other respect is (.) in
505. some, in some (.) warped sense you you must be weak in so:::me
506. respect or suffered a breakdown .hhh
507. R: mhm

508. J: And:::::: that's absolute rubbish on ◦all three fronts◦ (.).
509. I know a lot of the people that I associate with, wouldn't have
510. had the mental capacity or strength to do the job that I used to do
511. seven days a ◦week◦ .hhh and they just wouldn't have be able to ◦hack it◦ (.) So::::::
512. in terms of (.) in terms of weakness (.) No that is absolutely ◦wrong◦ (sad).
513. I was a very strong (.) strong person strong mentally (.) it was
514. just a:: (.) a build-up of factors (.)

Jack uses a persuasive three-part-list "you're mad, you're crazy, you're bad" (line 502) for impact and extreme formulation to rouse emotion (Potter, 1996). He constructs himself as someone who used to be very strong mentally, to disclaim the notion that mental illness is associated with weakness. He achieves this by drawing upon the interpretative repertoire of mental breakdown caused by stress "it was a build-up of factors" (line 514) and claiming that anyone under these circumstances would buckle under such pressure. He compares himself against others, in terms of the work that he used to do. Others are constructed as being weaker in disposition than himself "they just wouldn't have been able to hack it" (line 511). The sudden change in footing initially from a second person that reduces his stake in the conversation to the first person recounting his own experiences as evidence against these claims is interesting in terms of the action orientation of the talk. This strategy again, like the blaming strategy, reduces accountability on the participant's part by presenting events as being out of his control. Not adopting this strategy could result in him being considered at fault for his mental health difficulties, calling his character into question.

Extract 5 - Ros

586. Ros: =li:::ke (.) <I'm allo:::wed to feel the way I am now [] (.) and I'm not ashamed (.)[]
587. R: [mhm] [mhm]
588. Ros: of being a voice hearer. (.) ◦I am::::: (.)◦ - No I'm not ashamed. (.)> I think I was
589. to start of with, it was::like a huge taboo, you don't talk about it, that's
590. why .hhh I went for three years without getting any help at all, because

591. I was [] frightened that (.) they'd lock we me up. And of course as soon
592. R: [Ah::::: ok]
593. Ros: as they found out I got sectioned, so (.), you know, people::: (.)
594. even professionals, they can panic at bit and think 'Oh she needs to
595. be in the hospital'. And a lot of voice hearers, I think, do not
596. wanna go into hospital. It's a horrible place (.) but yea:::: voice hearers~.
597. I think some of the nicest people I've ever met (.) are:::: voice hearers.
598. Cause they're understanding, they're gentle, they're kind.
599. And they go through this ↑shitty illness [], (.) you know, and all the:::::
600. R: [mhm]
601. Ros: stereotypes people ha::::ve, (.) you kno:::::w, (.) gonna mu::rder
602. people and:: (.) all – even just (.) tut – or they, they're not worth anything.

Ros constructs the experience of hearing voices as a huge taboo. A prohibition by society of acting in a certain way. To position herself within the medical discourse (McCathy-Jones, 2012) can have severe consequences for her. She narrates a personal account of such an example, to provide first-hand experience of this "And of course as soon as they found out I got sectioned" (line 591). She uses consensus "a lot of voice hearers, I think, do not wanna go to hospital" (line 595) to strengthen her account. She directly refers to the extra-discursive (Sims-Schouten et al., 2007) for example being locked up "sectioned" (593), which has direct implications on materiality and her own embodiment, restricting her freedom and her human right to move around freely. Within a hospital setting, the medical model predominates and for Ros there is no option other than being locked up. Orienting to extra-discursive factors reveals why the participant chooses not to position herself within the medical discourse and instead builds up an alternative construction of voice hearers.

Voice hearers are constructed as some of the nicest people, as understanding, gentle, and kind (line 597). On the contrary, others (health professionals) and their actions are constructed as unkind, even irrational and impulsive in nature "they can panic and think oh she needs to be in hospital" (line 594). This account leads to a reversal of power and disclaims the stereotypes associated with people who hear voices as dangerous murderers “tut…they’re not worth anything” (line 602), showing her disapproval. It therefore becomes questionable, even immoral to lock up people of such a kind and gentle nature, constructing professionals as immoral and irrational. This strategy turns the tables around, because now it is not voice hearers who are associated with committing immoral acts, but those that section them.

Extract 6 - Neve

275. N: I’ve seen so many people (.) suffering
276. so badly with hearing voices (.) but it doesn’t seem to be really related
277. to violence. I mean some people are violent and they hear voices (.), but (.)
278. I think a lot of them would want to be violent, if they did hear voices
279. to be perfectly honest.

…

290. N: I wouldn’t put the stand to being (.) having a psychotic problem
291. or whatever you want to label it, or ahm being having other
292. grasp of reality, because (.) if somebody else (.) would have had the
293. same experience and I (.), god knows I feel people get angry in the street, (.)
294. I then keep my head down or I just (.) If I really was, I really wanted to say something
295. because I was really upset, I would say ‘Excuse me, ahm why
296. are you following me? Or I feel you are you following me?’ Or
297. something like that. I would put it politely. There is NO
298. need to shout abuse and be violent
299. You see? so I don’t
300. actually (.) accept that (.) ahm (.) it’s directly related to hearing
301. voices.

Neve speaks from a personal footing of her own experiences and uses consensus “so many people” (line 275) to corroborate her account and disclaim the discourse of dangerousness associated with voice hearing. “It doesn’t seem to be really related to violence” (line 276) is presented as a tentative remark because sometimes this experience is associated with violence and thus she is careful not to attract criticism. “To be perfectly honest” (line 279), is stated to imply that what she is about to say is the honest trust and therefore reliable. She constructs violence as an inherent human disposition, creating an in-group/out-group division. Either you are violent or you are not. Violence is constructed as being something inherently present in some people, but not others, despite that they may hear voices. “I mean some people are violent” (line 277) drawing on the interpretative repertoire of violence as an innate biological predisposition “I think a lot of them would want to be violent” (line 278). She constructs violent people as agents with choice and objectively positions them within this discourse, who are now constructed as the ‘Other’.

The account is made more persuasive, by giving an example of how she might respond to a situation herself (using personal footing), as evidence to show that not everybody who hears voices resorts to violence. This discursive strategy serves to distance herself from the problematic category of being someone who is violent. She also goes a step further to construct violence as wrong “there is no need to shout abuse or be violent” (line 297) and the result of rational choice, which further serves to distance herself from this category as she constructs herself to be a moral agent “I would put it politely” (line 297). People who are violent are constructed as having a choice whether to be violent or not. The consequence of disclaiming popular discourses and constructing a version of self that is moral, leads to a more positive sense of self than being associated with violence would allow for. The statement “You see?” (line 299) is delivered quite powerfully and said with emphasis (rising intonation) to make evidence speak for itself, to show that what she is saying is common sense and self-evident. This strategy serves to downplay her role in interpreting the evidence, to show that it is the evidence that makes the case, not her own subjective interpretation of it.

Extract 7 - Zoe

564. Z: (H) [] .hhh ahm yea, so like I suppose I sometimes

565. R: [h h h]

566. Z: do it in those kind of situations (.) ahm (.) or I’ll just (.) I will just sometimes (.)

567. lash out (.) if (.) somebody says (.) something (.) derogatory [] or
568. R: [mhm]
569. Z: inappropriate about [] people with (.) psychosis or schizophrenia or,
570. R: [mhm]
571. Z: you know, (.) but I will just say (1) I, you know, I've got schizophrenia,
572. or (.) I've got (.) schizoaffective disorder (.) or (.) I hear voices or some(thing),
573. you know, if it ~just comes up (.) .hhh just to make everyone go (.)↑'Oh' and then
574. I get a bit of air time to say ↑'We're not all dangerous and crazy::: (.) and
575. this (.) article that you're reading is completely written ↑wrong' (h).
576. Look at this (h) .hhh

Discourses of pathology, as portrayed in the media, position voice hearers as an object of fear. Zoe disclaims such claims and constructs voice hearers as "not all dangerous and crazy" (line 574). However, she does not claim that no voice hearers are dangerous and crazy. She chooses to position herself somewhere in between a hybrid of discourses between normal and abnormal, such as the new mental health drive (WHO, 2016). The participant positions herself within this discourse frequently during the interview. The 1 in 4 discourse describes mental health issues as widespread and a highly prevalent phenomenon in society (WHO, 2016). What this discourse allows is for people with mental health issues to be able to live a normal life despite their difficulties, where they are still able to pursue goals.

Zoe effectively delivers a persuasive three-part-list, which is an extreme case formulation with emphasis and rising intonation "We're not all dangerous and crazy, and this article you're reading is completely written wrong" (line 575). In addition, it is useful to interpret what is left out and not said by the participant. She does not acknowledge that this experience may be associated with distress, as this would problematise her position. She draws upon her own experiences to strengthen her position instead. She specifically uses a personal footing to disclaim a problematic identity by claiming "I hear voices" (line 572). She constructs others as surprised when they find out that she has a mental health diagnosis "just to make everyone go (.) Oh!" (line 573). Although she does not make this explicit in her construction that she is someone who has a job, socialises and leads a healthy life, nevertheless she constructs herself as someone who despite hearing voices is not what others expect. Her construction is also in accordance with the discourse of new understanding, new hope of mental health in striving against adversity (WHO, 2016). The credibility of this view depends on her establishing a level of proximity with the norm (Wetherell & Edley, 2009). On the other hand, she constructs the media as misinforming the public, and displays disapproval from her statement “Look at this” (line 576), which denotes disbelief, surprise and astonishment. The consequence of this strategy is to disclaim a problematic identity, which is subsequently displaced onto others for example the media and the public.

B.4.1.2.3 Justifying

Considered to be different from the norm makes one accountable to others. Reynolds and Wetherell (2003) showed how being single is made accountable in comparison to couples. Similarly, having an experience of hearing voices is an experience that is made accountable to others, for example, having to explain an inability to work, taking medications, needing support from others. Participants use this discursive strategy to justify their position and reduce accountability for their problems. It is not an outright disclaiming of the voice hearing identity but an attempt to negotiate this. It is also possible that participants may be orienting towards the interview, believing that they must justify their position to me. Justifying thus involves having to account for one’s difficulties and justifying themselves to others, to portray themselves in a preferred way.

Extract 8 - Jack

453. J: It hurts when you:::: (.) .hhh when people question:::: the fact that
454. ‘well:::::: if you were drinking at the ti::::::me then (.) you suffered a
455. psychosis and::: (.), if you hadn’t have been drinking to excess
456. you probably wouldn’t have suffered that psychosis’. It hurts because
457. I’ll say well:::::: (.) after all (.) the traumatic stress factors
458. that I’d been through (.) the drinking wasn’t (.) like
459. you go down the pub and have a drink (.) it’s involuntary

460. it was it was it was keeping me::: at the time (.) it was s~ it it was something

461. I did (.) basically just to get through 24 hours of the ◦day◦ (.) .hhh

462. and it it was addiction (.) and looking back on it's:: quite a

463. serious addiction (sad) .hhh <I don't feel (2) I had a choice in that (.)

464. I feel I was ill (.) a dual diag dually diagnosis ill, I was depressed,

465. I was an addict (.) and I was suffering from psychotic (.) symptoms> .hhh

466. And I don't think I had a choice in any of ◦that.

467. And when somebody comes across and says well::::: points the finger (.) and

468. it does hurt (.) I must admit, it does (.) it can be very hurtful◦ (1)

Jack is placed in a problematic position when others make him accountable for his problems "If you hadn't had been drinking to excess, you probably wouldn't have suffered that psychosis" (line 454). This construction poses a threat to identity, which he manages in two ways. First, he constructs his addiction to drink as an 'illness', a popular discourse in Alcoholics Anonymous (AA) (De Leon, 2000; Denzin, 1987). Choosing to position himself within this discourse constructs himself as not accountable for his problems, because it is something he has no control over "quite a serious addiction, I don't feel I had a choice in that" (line 463). We can see here why he positions himself in a discourse of 'illness', to the detriment of his own freedom and autonomy, because to do so is preferable than being constructed as someone to blame for his problems. This strategy is counter to popular discourses of a neo-liberal self that is responsible and self-contained (Rose, 1989).

Secondly, he constructs himself as a victim of circumstances and traumatic factors that lead to his breakdown (Gueta & Addad, 2013). This strategy reduces accountability for his actions, particularly as he also draws upon the discourse of trauma to justify why he resorted to drinking "after all the traumatic stress factors that I'd been through" (line 457). He also draws on an emotional discourse (Wetherell, 2012) "it does hurt" (line 468) which instead serves to make others accountable for being cruel and unfair "when people question the fact" (line 453) - "points the finger" (line 467), particularly if these events are constructed as being out of his control. The micro-discursive analysis does not take what Jack says at face value, it seeks to decipher the action orientation of talk; what the participant is trying to accomplish with this discursive strategy, how he is positioning himself in discourse and with what consequence. Jack is trying to justify his position with this account, by constructing himself as non-accountable for his problems and constructing these instead as external factors that are out of his control.

Extract 9 - Neve

N: But ahm (5) yea I mean ‘just be normal, you’ve got two
arms, too legs, too eyes, everything works (.) Just be normal’.
~I still haven’t quite (1) I still haven’t sussed the principle of
being normal, except now gradually I’m allowed to be myself.
And within (.) such limitations, I’ve also got some strengths .hhh. It’s
actually getting a lot better. And the () thing is,
the more I am comfortable with and understand, what’s going on for me
especially with the autism, I mean (.), yea I find it’s stigmatised, but
not (.) nothing like anything (.) else (.) I’ve ever been labelled with (.) so (.)
and I’m (.) If if you explain actually actually a lot of people who probably at
first don’t get it; but once you say they’re like ‘Oh ok’ and they just (.) get
used to it, so:: hhh, (2) it’s very good (.) that
it’s getting easier to (.) to be in society (.)
and also to understand that maybe not everybody is trying to
kill me (h), even if they look like it, but it’s just an autism thing ahm (.) and then
that of course has an impact on the
voices in a sense that it makes them (.) slightly less threatening, (.) because
then the demons and devil, isn’t just (.) ah it’s only (.) in my
head rather than actually physically seeing (.) them =
R: mhm=

362. N: =so that makes it less scary (.)

363. R: mhm

364. N: Ahm (3.0) and its actually official (.) I I~

365. I just want to (.) make sure because I always feel maybe

366. I'm just some silly fake and just snap out of it ahm

Through this discursive strategy, Neve is trying to justify why she isn't a "silly fake" (line 366) in response to others not taking her distress seriously "just be normal, you've got two arms two legs" (line 342). She is made to account for why she is not able to do things in the same way that others can. She draws on the discourse of autism and category entitlement sanctioned by professionals "it's actually official" (line 364) to corroborate this evidence (Autism Web 2016, Equality Act, 2010). Despite choosing to position herself within another diagnosis, that of autism, which is still detrimental to her because it separates her from the norm, this is still a better option than being constructed as someone with a mental illness that needs to "snap out of it" (line 366). This positioning in the autism discourse allows her to be herself. The discourse of autism constructs society as needing to adjust to the individual and not the other way around. This makes it a lot easier for her to be in society as less judgement is imparted on her. She is no longer accused for being a "silly fake" (line 366) and no longer accountable for her problems. She justifies not being 'fake' by choosing to position herself within the discourse of autism as a developmental disability. The struggle for authenticity in mental health has also been documented by McPherson and Armstrong (2009). This construction, not only makes it easier for her to be in society but has a direct impact on her own experiences and the voices "not everyone is trying to kill me, even if they look like it, but it's just an autism thing" (line 355).

Extract 10 - Zoe

421. Z: been what? 13 years, ahm::: (1) it doesn't affect me that

422. much anymore because I just (1), it does at ti:::mes:: (.) but there's

423. loads of other things to worry about (h) and (.) I have spent

424. so::: much (.), certainly in the first kind of 6 or 7 years since

I heard them (the voices), so much (.) mental (.) effort and energy trying to figure it out and understand it, and getting nowhere and just going round and round and round in circles, and ended up in hospital and kind of, you know, being unemployed and and things like that (.), but I just, at the moment I just think my life’s actually (.) pretty good? and if I just carry on doing the things that I do, that help me to (.) distract myself from the voices. (.) And::: if I get into one of those moods where I start (.) thinking and thinking and thinking about it, I just have to say::: (.) ◦‘Really stop doing this (.) because (.) It’s~ it’s not helpful’◦ You~you’re not gonna figure it out~(.) because (.) th~there’s not a magic answer. Or if there is a magic answer (.) .hhh it’s not gonna suddenly come to you::, and you’re just gonna get stressed out (.) thinking abour it - so::: (1) and no one else has the answer (.) either’. You know, I’ve given up asking people (H), you know, ◦‘Why is this happening to me?’◦ .hhh because (.) ◦and nobody really knows?◦ Mental health professionals don’t know. And the psychiatrists don’t know. (.) .hhh ahm:::: I don’t believe it’s brain chemicals (.) so:::: (.) whatever it is (1) ahm::: (1) I just have to live with not knowing it, but there’s loads of things I don’t know. (.) Like anything about quantum mechanics (H) [] I’m kind of like [] yea that’s

R: [m mee too (h)] [(h)]

Z: stuff that’s happening everywhere all the time, that (.) some people understand and I don’t. (.) I’m alright with that (h) (.) [] I

R: [mmm]

Z: can’t know everything .hhh.

Zoe encounters an ideological dilemma, as she draws on the plethora of discourses on voice hearing to understand her experience, but chooses not to position herself in any of these. For example, she chooses not to position herself within the medical discourse "I don't believe it's brain chemicals" (line 441). To position herself in this discourse closes possibilities, as the only option is to take medication to restore the balance of brain chemicals. Within the same interview, she also drew on a spiritual and religious discourse (line 347), a technological discourse (line 345), a psychic discourse (line 384). Not positioning herself in one way or another, has implications for identity construction, because positioning is where identity work occurs (Davies & Harré, 1990). She justifies not knowing, by drawing on the interpretative repertoire of limitations in information processing "can't know everything" (line 449). What this construction allows is that there is only so much she can possibly know therefore not knowing is justified. She is also drawing on a broader discourse of the age of neuro-centrism, where an attempt is made to explain behaviours and actions in terms of the brain (Singh, 2013). There is a plethora of psychological interventions (e.g., mindfulness) based on the premise of this discourse. Ironically this is the same discourse that psychiatry and neuroscience draw upon to medicalise distress.

Simultaneously others are also constructed as not knowing, not having the knowledge "no one else has the answer" (line 438), "nobody really knows" (line 440). By constructing others as not knowing adds consensus and gives more credibility to her claims. If knowledge is infinite and thus impossible to master due to the limited capacity of our brains, then she is no longer accountable to figure this out "there's loads of stuff I don't know" (line 443). She justifies this point further by providing an interesting comparison with quantum mechanics, a highly-specialised field as an example "I can't know everything" (line 447), which makes a rhetorically self-sufficient argument and is an extreme case formulation (Pomerantz, 1986). The consequence of this discursive strategy, serves to justify her position, as someone who doesn't know. Not choosing this position would place her in an ideological dilemma, because she would either need to position herself within the medical discourse constructing herself as ill, or risk seen as irrational if she chooses to position herself within any other available discourse, for example, a spiritual discourse where she believes she is communicating with a deity or a technological discourse where she believes someone is trying to communicate with her through advanced digital means. The way that voice hearing is constructed and reinforced by current institutions and their practices, does not allow for any other discourse to be viewed as rational other than the medical model. We can see here below how she negotiates her position within the available discourses on voice hearing.

365. Z: I have kind of (1) agonised over whether it (.) whether the
366. illness model (.) makes sense (2). And it doesn’t feel like it really
367. does? []. Ahm:::: (3) but then also::: anything else feels like it (.) it’s (.) it would
368. R: [mhm]
369. be seen as slightly irrational?

Taking into consideration the broader context of talk reveals why Zoe chooses not to position herself within the available discourses. If she chooses any discourse other than that of illness, and if we draw on the medical discourse that regulates mental health and the institutional practices that reinforce this, any other construction (e.g., spiritual or technological) may be viewed as irrational and used as evidence that she is unwell. This would place her in a problematic position. Therefore, she chooses to opt out of these explanations and constructs her experiences as something unknown. One of many other things that we are not able to know. In addition, the unknown can also be constructed as something that generates curiosity.

Extract 11 - Ang

209. A: Because I felt settled []. It was like (.) ok (.)
210. R: [mhm]
211. A: she’s describing my moo::ds, my symptoms [] and it was like (.)
212. R: [mhm mhm]
213. A: that’s a person:: who’s not well [] ahm::: and it made me fee::l -
214. R: [mhm mhm]
215. A: strangely it made me feel more human? [] It’s like ok that’s not me:::

216. R: [mhm mhm]

217. A: (.) but [] that’s when I’m unwell. That’s how I get, how (.) what can happen []

218. R: [mm] [mm mhm yea yea]

219. A: if you (know) what I mean

220. rather than thinking this is all part of me and this is how I always

221. experience things [] ahm because I think seeing sta:::rs and (.) getting

222. R: [mmm]

223. A: light from places can actually be a spiritual experience [],

224. R: [mhm]

225. A: but if it’s causing distress, then I would describe it as unwellness []

226. R: [mm mhm]

227. A: I wouldn’t say I was a - I don’t see myself as a crazy person []

228. R: [mhm mm]

229. A: but I see myself as somebody who gets unwell mentally.

Ang adopts this discursive strategy to justify her construction of being “human” (line 215) instead of a “crazy” person (line 227). She accomplishes this by constructing periods of being unwell as intermittent and temporary, allowing her to be normal the rest of the time “rather than thinking this is all part of me” (line 220). On the contrary, constructing herself as totally engulfed by the ‘illness’, would leave little room for a sense of normality. In hospital, the participant has no choice but to be positioned within a medical discourse by a health professional. She uses category entitlement “she’s describing my moods, my symptoms…that’s a person who’s not well” (line 211). Taking into consideration the extra-discursive and the materiality that she negotiates (Sims-Schouten et al., 2007), the participant is sectioned in a locked ward. In a psychiatric ward, the medical discourse predominates, illustrating how materiality may enable some discourses over others within this setting. Whilst in hospital, the participant has no option but to construct herself as someone who is unwell and in receipt of treatment in response to the psychiatrist describing her symptoms. When she is out of hospital, however, she chooses not to position herself within this discourse. On the contrary, she chooses to position herself within a spiritual discourse “I think seeing stars and getting light from places can actually be a spiritual experience” (line 221). This theme was prevalent throughout her interview and is characterised by periods of wellness (remission) and un-wellness (acute presentation), allowing her to maintain a sense of normality some of the time and some level of proximity with the rest of the population. She presents herself as a rational agent that has contemplated the possibilities and who is talking from an informed objective standpoint. Nevertheless, despite trying to justify her position amongst competing discourses, it continues to present an ideological dilemma. The use of medication during periods of wellness, threatens her dual construction of periods of wellness/un-wellness, which enables her to maintain a sense of normality. This dilemma illustrates the participant’s struggle to negotiate an identity in a way that is not problematic, in the absence of more benign understandings.

492. A: (.) Tends to be conversations with (.) most friends and family, tend
493. to be like (.) ‘Take your meds’ (.)
494. R: Mhm ok.
495. A: And no::w I’m not showing symptoms everyone’s relie::ved.
496. R: Mhm mhm.
497. A: So – I ~ I can imagine~, you know, those people that (.) don’t want to take
498. medication for whatever reason(.) [], you know, it’s much easier for society to go (.)
499. R: [mhm]
500. A: Meds, fix, done.
501. R: Mhm
502. A: Which has been (.) a bit my case in a way. That [] I haven’t had (.)
503. R: [mhm]
504. A: symptoms f:::or (1), maybe 3 or 4 months [] (.) ah:::: and
505. R: [mhm]
506. A: everyone’s relie:::ved (.), everyone can - breathe a sigh of relief

507. cause you've taken your meds and you're well [] and I feel for -

508. R: [mhm]

509. A: cause - for ages I didn't want to be putting all that (.) .hhh into my body []

510. R: [mhm]

511. A: and I wanted [] to be able to work with my reality as it was.

In the above extract, Ang experiences an ideological dilemma because the construction of self that brings her closer in line with the norm is threatened. Constructing herself as someone that is sometimes unwell but not others, is not congruent with permanently having to take "strong" medication during period of wellness. Others are constructed as being relieved that she is taking medication and looking for a quick fix to her problems. She uses a powerful 3-part-list rhetorical device to persuade and evoke emotion "Meds, fix, done" (line 500). The comment "everyone is relieved" (line 506) "it's much easier for society" (line 498) makes her accountable for not wanting to take medication. Contrary to the previous extract, in this context she resists being positioned in a medical discourse and justifies not wanting to take medication during periods of wellness, by claiming "I didn't want to be putting all that into my body, and I wanted to be able to work with my reality as it was" (line 509). It further clarifies why she chooses to reject being positioned in the medical discourse in this conversational sequence, because she is currently at home and well. She is drawing on the interpretative repertoire of taking drugs to escape reality, however, here she reverses this, claiming she does not want to take drugs so that she can work with her reality as it is. Constructing her account in this way enables her to attain closer proximity with the rest of the population, whereby if you are 'ill' you receive treatment. However, if you are no longer 'ill', there is no need to take medication. This strategy allows her to retain a level of normality by constructing a duality between periods of wellness and un-wellness. She also constructs herself as a moral agent that does not need drugs to escape reality.

B.4.1.3 Positioned as subject strategies

Participants use the discursive strategies of reframing, normalising and trivialising to position themselves within less pathological discourses for example trauma, stress and recovery. Using the ‘positioned as subject’ strategies, participants are actively trying to construct a chosen identity and to define what voice hearers are like (Butzolch, 2009).

B.4.1.3.1 Reframing

Wherever possible participants attempted to reframe their experiences in ways that allowed for a less problematic identity. The discursive strategy of reframing allowed them to distance themselves from a position that is potentially problematic and particularly one that does not enable possibilities for action. Watzlawick et al. (1974) describe this strategy as a new interpretation given to a problematic situation (cited in Rhodes, 2014). Reframing involves restating a situation so that it may be perceived in a new way. In the following three extracts participants construct themselves as atypical members of the category of hearing voices by reframing their experiences.

Extract 12 - Jack

J: .hhh Ah:::: it’s it’s interesting that ahm::(.) very little is known and there isn’t a:: (2.0)
a:::: cast iron test for voices []. I thought (.) as a layman, that you would
R: [mhm]
J: be able to pick that up on scans (.), on CT scans and
CAT scans and and MRI::s but you can’t do that. You basically (.)
the psychiatrist is is working with basically all - all his got to arm
himself is what you can tell him, cause there is no physical
test for them .hhh and::::: they have their::: certain scales and questionnaires (.)
R: mhm
J: and which I:::: obviously have have have have talked to the psychiatrists
with a::nd .hhh they said no you suffered a major psychotic episode
but you’re not schizophrenic - because you lack the paranoid
part that goes with schizophrenia.

Jack gradually builds up a case about the subjective nature of diagnosis and the inability to prove the existence of pathology through scientific means. He then draws on the power of psychiatry and the medical model to provide a diagnosis. He uses category entitlement to construct himself as outside of the pathological category of ‘schizophrenia’; an atypical member of this category (Snow & Anderson, 1987). Contrary to other participants, he draws on the medical discourse of diagnosis to make his account more credible and constructs psychiatrists as the ones who know, who have knowledge. The consequence of constructing himself in this way, as someone who does not fall into the typical category of ‘schizophrenia’, allows for a less problematic identity because as he also discusses below, the psychiatrist (category entitlement) confirmed he has neither the paranoia associated with schizophrenia, nor the distressing persecuting voices, ‘symptoms’ that the medical model suggests may be associated with risky behaviour – potentially causing harm to the self and/or others. This allows him to construct himself as an atypical member of the category by comparing himself to members of that group and one where risk and danger is minimised as shown in the extract below:

J: It’s it’s really quite strange. But my::: my own experience of voices hasn’t been
that (.) that ahm::::: distressing. My voices have actually been:::: ahm >compared
to s:::ome of the group that I associate with, some of the
voice hearing group that I associate with, .hhh they tend to have
voices that are more aggressive and mo::re demeaning and attacking<.
Mine have been mo::::::re compassionate and ahm:::: (.) reasoning and and::::
helpful, as such, on occasions .hhh but that (.) I tend to be:::: the exception
to the case there (.) whereas most of the group (.) their voices eh::::: can be at times
↓distressing dark aggressive (.) .hhh and cause them some (2.0) quite some distress.
R: mhm
J: But I I I tend to find that I have been very lucky in that ◦respect◦ (3.0).

“I tend to be the exception to the case there” (line 297) is provided as further evidence of not being a typical member. This strategy works to negotiate the desired identity, however, in contradiction, earlier in the interview the participant constructed a different account of the experience of hearing voices, illustrating the dilemmatic nature of talk (Edley, 2001). He claimed “I’m not working at the moment, because I find work very very difficult with the voices” (line 30). The dilemma presented here is how to construct oneself as an atypical member of the category, whilst at the same time also acknowledge the distress associated with these experiences.

Extract 13 - Neve

198. N: ‘Oh I just escaped the BPD label’, because she’s got some scars, - and I’m
199. ‘How did you do that?’ ‘Oh I got diagnosed with Aspergers’.
202. and then she said ‘You got it bad’ - ‘hmmm’. I~ thought it was
203. a bit offensive but, like just to be diagnosed over a cup of coffee .hhh ahm
204. by somebody (h) who is clearly not a medical profession, but I did
205. read up on it and I (.) it almost made my eyes pop out (.) ahm
206. so I pursued the whole thing, and I got a (.) diagnosis
207. of severe aspergers now from somebody (.) who really knows what they
208. are talking about and studied at Cambridge University ◦and stuff
209. like that◦.

In the extract presented above, Neve constructs herself as an atypical member of the category (Snow & Anderson, 1987). She constructs an account of her friend diagnosing her over coffee who comments “You’ve got it bad” (line 202) – an extreme case formulation adding consensus and credibility to the account. She suggests that her symptoms were so obvious that even an untrained individual would be able to identify these. She uses category entitlement “I got a diagnosis from somebody who really knows what they are talking about and studied at Cambridge University” (line 206), making the claim difficult to dispute because it is based on expert opinion. The use of metaphor “Almost made my eyes pop out” (line 205) and “I thought it was a bit offensive”, act as a stake inoculation (Potter, 1996), to show that this diagnosis came as a surprise to her, reducing her stake in the conversation. Nobody can thus argue that she has a vested interest in constructing herself in this way.

Interestingly, at the beginning of the interview when Neve was asked to talk a little bit about herself, she omitted to mention voice hearing in her description and introduced herself as autistic “I’m a person. I don’t know (h) ah::: I guess I’m autistic” (line 4). This again places Neve in an ideological dilemma, because later in the interview she says she does not want to be associated with labels, however at other times in the interview she chooses to position herself within the medical discourse and diagnostic categories (autism) to present herself as an atypical member of the category of ‘schizophrenia’ (Snow & Anderson, 1987). The consequence of this strategy is the construction of an identity that is less pathological “↑’So I’m NOT actually mad, there is NOTHING WRONG with me. It’s the autism” (line 240).

This discursive strategy reframes her experiences as ‘autistic’ instead of ‘schizophrenic’, which not only serves to distance her from the more pathological notions and labels of dangerousness, madness, but it also allows her to be herself. She chooses to position herself within the autism discourse (NHS Web, 2016), because it is broadly constructed as a developmental condition that is not associated with pathology or a mental health problem. Autism is constructed as a lifelong developmental disability. The implication for this is that now she is not held accountable for her problems and health professionals need to adapt to her just as she is, as seen in the following extract:

390. N: People listen to me now (.) and don’t keep
391. telling me◦ ↑‘You’re like this, you’re like that, therefore (.) do this,
392. that and the other, then you’ll be fi::ne↓ (.) and others
393. taken a step back and say ‘Oh, oh dear I didn’t know that, now
394. let’s see what can we do together’ so it’s much more
395. collaborative .hhh a:::nd hhh (.) also I (.) if - if somebody tries (.) to
396. get me to do stuff (.) I’m actually really crap at (.) ahm (.)
397. then (.) they’re more likely to say ‘Ok let’s try another way’ whereas
398. before it was ‘Just try harder, just try harder, you are not committed

399. enough' and (.) it doesn't matter how much I was trying, I was
400. trying so hard, I can't begin to tell you.

The consequence of the discursive strategy of reframing is a much less problematic identity, whereby Neve is accepted as herself, with less stigma and pathology attached to her experiences. The autism discourse, with reasonable adaptations to developmental disabilities, allows her to be included in society (Autism Web, 2016). The alternative would be to be considered an outcast of society.

Extract 14 - Flo

697. F: I'd say I have hallucinations:::: ahm::::
698. I hear voices::::, I experience psychosis::::, although the (.) as I (.) see:::: (.) the::::
699. hallucinations for what they are it's pseudo psychosis [] (.) ahm:::: (3.0)
700. R: [mhm]
701. F: I can't really think of how else::: I would describe it. Or::: how else it's been
702. described to me::: []. Not on the top of my head.
703. R: [A:::]
704. R: Mmm what did you mean pseudo psychosis?
705. F: (.) Well::: a psychiatrist explained to me::: years ago, that because
706. I could recognise my hallucinations as hallucinations [] (.) they weren't
707. R: [A::::::]
708. F: true psychosis. Now I get delusions, which are believe (h) are true, I
709. don't see them as delusions, so I (2.0) if somebody (.) psychiatrist wants
710. to argue they are delusions (.) I would (.) debate that with him or her. .hhh
711. So they could say I'm psychotic on that. .hhh ahm::: (.) but the hallucinations
712. I can see as hallucinations [] so they're:::: called a pseudo psychosis, not a

R: [mhm]

F: (.) a total psychosis [] (.). Because I can see them.

R: [mhm mhm]

F: (.) as (.) as [] not being (.) reality []. So being false [].

R: [mmm] [mhm] [mhm mhm]

R: So what? (.) What would be a total psychosis?

F: It’s if you experience something that wasn’t real and believed it was real.

R: Ok mhm mhm=

F: =So::: (.) for example, although I (.) not always but nearly always

believe this to be true. That I have certain people in my life, this is with ahm:::

paranoia now::: a delusion (.) that ahm:::: I (.) think certain people in my life

can read my mi::nd? [] (.) And (.) I really truly believe that. [] (.) And I feel

R: [mhm mhm mhm] [mhm]

F: I’ve got enough evidence for it, because I’ve tried and [] tested them

R: [mhm mhm]

F: so many times? [] (.) But (.) I occasionally have more rational moments

R: [mhm mhm]

F: when I (.) I’m like ◦‘That’s all coincidence’, ‘That’s all coincidence’◦. But

90% of the time I believe it.

R: Mhm

F: So if I am wrong::::, which I don’t believe I am wrong, but if I am wrong::::

you could argue that’s (.) is a full psychosis.

R: Mhm mhm

F: But with [] the hallucinations, I see them (.) as not being re::al.

R: [mhm mhm]

738. F: (.) So (.) they’re ◦pseudo (.) psychosis◦.
739. R: Mmm mhm mhm
740. F: That was how it was explained to be by (.) one of my (.) earlier (.)
741. psychiatrists.

Like previous extracts under the reframing category, Flo attempts to construct herself as an atypical member of the group, again drawing on the limitations of diagnostic criteria (Snow & Anderson, 1987). Due to the fallibility of a diagnosis based on symptoms alone, individuals do not always fit neatly in each category. What this allows is for Flo is to reframe her experiences, drawing on a category entitlement (psychiatrist) and a differential diagnosis that does not carry the same pathological notions of dangerousness that a diagnosis of ‘psychosis’ has.

She also makes a concession (line 709) to rebuff a potential counter-claim, by acknowledging that some psychiatrists could argue that she has psychosis. However, she chooses to position herself within the diagnosis of pseudo-psychosis, which the participant describes is not a full psychosis. She presents herself as balanced and informed, as having considered the possibilities and come to a robust conclusion, providing detailed examples to make her argument more credible. By constructing herself in this way, she distances herself from the more pathological notions associated with ‘schizophrenia’ and notions of dangerousness evident in the following extract. Flo clearly does not associate herself to members of this category, despite sharing some experiences with them, as seen in the two extracts below:

293. F: (.) I::: (.) think some people::: (.) erroneously sometimes::: are quite often,
294. I mean I don’t have schizophrenia, but (.) can believe if you hear voices you’re got
295. schizophrenia (.) []. Now:::: a lot of people would hear the word schizophrenia
296. R: [mhm]
297. and say ‘Oh my God::::::!’, which (.) [] hhh. It is a very serious illness.

…

I (3) wonder whether:::
R: [mhm] [mhm mhm]
F: if I told certain people I heard hear voices (.) whether they would be
scared I was going to get schizophrenic [] and what their perception of
R: [mhm mhm]
F: that (.) may be:::

Constructing herself as someone who has pseudo-psychosis, instead of schizophrenia, allows for a less problematic identity and one that is not associated with the pathological labels often linked with the diagnosis of schizophrenia or psychosis. For example, in pseudo-psychosis there is no perceived loss of contact with reality, which has been associated with violence in schizophrenia (Silverstein et al., 2015).

Extract 15 - Zoe

The following participant reframes her experiences from pathology and disorder to an interesting phenomenon such as synaesthesia:

Z: some people, you know, people talk about having – what do they call that
when you::: ahm::: (.) tut (.) .hhh associate (.) colours with sounds or smells;
synaesthesia or something (.) [] and they're always doing like (.) research
R: [mmm think so (.) (h)]
Z: on it and people say 'Oh I~ I have this synaesthesia' and it's kinda like
'Oh:::wow that's really interesting what's that like?' (excited) cause I
just can't imagine it (.)[] I'm like, I can't imagine being able to associate
R: [m]
Z: you know, so I think that that's like an interesting [] (.) .hhh mental event

257. R: [mmm]

258. Z: that I haven’t experienced, so I’m~ I’d like it to be a bit like that

259. to just be like ‘I’m a voice hearer’ and people to be like

260. ‘Oh really? So what? Do you::? (.) You know, what (.) what’s that like?

In the above extract, Zoe uses the discursive strategy of reframing to construct her experiences as something of interest to others. However, she accomplishes this in an implicit way, reducing her stake in the conversation, as she doesn’t explicitly claim that voice hearing is an interesting phenomenon. She uses comparison to get her point across, by likening this experience to synaesthesia. The rhetoric devices that support this strategy are active voicing, using direct quotes to make claims more vivid and persuasive (Potter, 1996). She also uses “you know” which suggests that what she is saying is self-evident, common sense and not requiring clarification. There is also an interesting change in footing, where Zoe initially describes this as an idea originating from others, to reduce her stake in the conversation “some people, you know, people talk about having” (line 248), then changing to a personal footing “that’s like an interesting mental event that I haven’t experienced” (line 256).

Through this discursive strategy, Zoe constructs the experience of hearing voices as something unique, interesting and exciting. Others are constructed as wanting to know about this experience and having a keen interest. It allows for a less problematic identity, less stigma and less shame. Zoe draws upon recent developments to the understanding of hearing voices in less pathological ways (HVN Web, 2016). However, she does not discuss the more negative aspects of this experience, which she mentions in other parts of the interview. This omission is significant because the discursive strategy of reframing adopted here results in a more positive identity. By constructing voice hearing in this way, she does not acknowledge the distress and suffering that some people experience in relation to voices. To do so would have put her in a problematic position. Similarly, in the following extract Lea also reframes her experience as an interesting phenomenon.

Extract 16 - Lea

190. L: worked with a group of teenagers who’re doing a citizen’s (.) award sche (.)

191. award scheme. Ahm:: (.).hhh and:::: a (.) these large groups that we get, we have

192. them come in the summer (.) and we talk about our group and our experiences
193. of hearing voices (.) and they're just so open and receptive, and they ask like -
194. thousands of questions, they're so (.) interested in the experience.

These constructions allow for a positive identity, whereby people who hear voices have something to offer to society, due to possessing a special gift, a quality, something that is of interest to others. This is observed in the way that participants navigate the ideological dilemmas present in competing interpretative repertoires (Edley, 2001). The discursive strategy of reframing constructs the voice hearing experience as an interesting phenomenon, in contrast to more pathological understandings of this experience. It enables voice hearers to contribute something to society, instead of being constructed as a burden (e.g., putting a strain on support services or draining money from the state by claiming benefits). The construction of teenagers as open and receptive, also serves to implicitly construct those and especially adults who are prejudiced about this experience, in a negative light.

B.4.1.3.2 Normalising

Normalising is a discursive strategy that attempts to construct the experience of hearing voices as a normal, ordinary and common everyday phenomenon. The consequence of this strategy is to reduce the perception of difference and otherness, by establishing a level of proximity with the rest of the population (Wetherell & Edley, 2009).

Extract 17 - Jack

150. J: A::::::: (.) basically I've often wondered about (.) and I've often theorized
151. about (.) where voices and why do I hear voices where .hhh~ the majority
152. of the population don't. And I:::::::'ve come to a conclusion that it's
153. dormant in all of us like (.) like a cancer, like other illnesses []
154. R: [mhm mhm]
155. J: .hhh and (2.0) where people take::::: for instance (hallucinelic)

156. eh hallucinating drugs [] like LCD [] there’s certain channels (.) in the

157. R: [mhm] [mhm]

158. J: human mi:nd and in the brain [] that remain dormant

159. R: [mhm]

160. J: throughout people’s lives [] (.) and::: hallucinogenic drugs

161. R: [mhm]

162. J: release those channels (.)

163. R: mhm=

164. J: =And I think (.) people who hear voices those channels are (.)

165. actually:: .hhh eh become active ↑naturally.

166. R: mhm mhm

167. J: Is is is

168. R: ↑mhm↓

169. J: is is how I I personally:: is it’s a personal view of mine .hhh [] and (1)

170. R: [mm↓]

171. J: So it’s a perfectly natural process (.) ahm:::: somebody (who) takes

172. a trip on LSD will see things, they’ll hear things, they’ll see

173. hallucinations. So it’s in all of us.

174. R: mhm mhm=

175. J: =But in in the vast majority of the population that remains dormant

176. throughout their lives, but with voice hearers that (.) is actually naturally

177. become active.

…

309. J: I:::: (1) (we) are in a small percentage of the population that

310. have an illness where (.) dormant channels in the mind have become

311. active and:: basically the meaning I attach to it is that I'm no
312. different to anybody else, I am a perfectly normal person.
313. <I just have (.) an illness.

An attempt is made using this discursive strategy to construct the experience of hearing voices as something which is inherent in all of us, an underlying disposition that could surface under the right conditions. Jack presents himself as someone who has carefully reflected on the available evidence, constructing his account as objective and non-biased "I've often wondered and I've often theorized about…and I've come to the conclusion…" (line 150). He chooses to position himself within the medical model of illness (Deacon, 2013) and compares the experience of hearing voices with other illnesses like cancer "It's dormant in all of us" (line 153). Thus no one is exempt, anyone could potentially 'contract' the illness. The consequence of this strategy is to establishing a level of proximity with the public.

Jack further compares the process of activation to that occurring during drug use, but with voice hearing this process is constructed as a 'natural' process. The consequence of this strategy is to normalise the experience and remove accountability, because if this process is triggered naturally, then it is outside of the control of people who hear voices. Furthermore, he presents this as "a personal view" (line 169), which makes it harder for someone to dispute. Rhetoric devices are used support this construction. He uses repetition, extreme case formulation "perfectly natural process" (line 171), "perfectly normal person" (line 312) and generalisation "so it's in all of us" (line 173) to persuade and evoke emotion. However, this normalising strategy contradicts Jack's earlier account about his 'psychosis' being triggered by alcohol. There he employed a justifying strategy to reduce accountability, revealing again the dilemmatic nature of talk and the different positions occupied in discourse to suit a purpose for each separate occasion. This observation also provides evidence that identity is not fixed, but fluid and constantly reconstituted (Benwell & Stokoe, 2006).

Extract 18 - Zoe

283. Z: so I think there is that kind of (.) .hhh ahm::: (1.0) that kind of (.)
284. belief out there. Either it's (.) scary cause you might be
285. dangerous or it's scary cause it's completely weird [] and

R: [m]
Z: people just can’t understand what I’d be like so they just
kinda like (.) ph:::: ‘I can’t relate the inside of my head to
the inside of your head’, which is really bizarre, cause the inside
of my head works in (.) a similar way to (.) well (.) everyone (.)
the inside of everyone’s head is pretty weird. And whenever you find
out something about somebody’s ways of thinking or::: (.) .hhh
beliefs and things, you’re like ↑‘What?’ (H) It doesn’t make any sense! (h).
So everyone’s different and weird and I don’t think it (.), you know, I
relate it quite often to (.) .hhh to my voices, are quite often troublesome
to me (.) in the night? That, you know, If I’m stressed [] (.) they’ll wake me up at
R: [mhm]
Z: like 3 in the morning, and kind of make lots of no::ise, but I know from
(.) other people that don’t hear voices, that when they’re stressed they
wake up at 3 o’clock in the morning with
their thoughts racing round in their heads. [] And that’s
R: [mhm]
Z: completely no::rmal. And I’m like ‘Well it’s not so:::: different from
that!’. It’s just like (.) my bod~ body and my brain reacting to the fact that
I’m stressed (.) and (.) disrupting my sleep. And (.) for you it’s your thoughts,
for me it’s the voices. (.) But that triggers off the thoughts anyway.
And it’s all~, you know~, (.) and the consequence - you’ve had a crap
night’s sleep and you wake up grumpy and tired the next day and we’re all
in the same boat (h). [] .hhh so ◦I don’t know◦.
R: [mhm]

311. And I get scared by the voices at night.

312. Z: More scared at night than I do at day? But then (.) other people

313. get scared in the night? (.) You know, cause it's da::rk and you're

314. awake, and it's lonely and the house makes weird noises (.)~or

315. you know,~ it's not~ – it's not massively different? .hhh (.)

Zoe is drawing on the discourse of madness (Foucault, 2006) "Either it's (.) scary cause you might be dangerous or it's scary cause it's completely weird" (line 284). However, she chooses not to position herself within this discourse. Using rhetorical devices (active voicing, analogy, generalisation), she constructs the experience of hearing voices as akin to common daily experiences "the inside of my head works in a similar way to (.) well (.) everyone" (line 289). She works to establish a degree of proximity to the rest of the population through generalisation "everyone's different and weird" (line 294). Frequent pauses are suggestive that the speaker is carefully deliberating the account and hesitation may indicate that she is taking care in doing identity work (Wetherell & Edley, 2009). She compares the experience of hearing voices with that of having thoughts, which is something that everyone can relate to, thus appealing directly to the audience "For you it's the thoughts, for me it's the voices" (line 305).

What Zoe omits to say however is also of interest, as the analysis attempts to make a suspicious reading of participants' accounts by looking at what is achieved by the discursive management as opposed to what the participant is saying. The omission of how this experience may be different for people who hear voices, may serve to normalise the account bringing it more in line with the experience of the general population. On the contrary to highlight difference would serve a different purpose and reinforce negative views of voice hearing. The use of social comparison also serves to mitigate the account by constructing a naturalised version of the self (Wetherell & Potter, 1989). If an account is constructed as natural or normal, then the speaker cannot be judged or criticised. Most importantly, she constructs herself as someone who doesn't know (line 309) by appearing to be objective and non-biased to prevent a counter-claim. By doing this she also reduces her own stake in the conversation rendering the account more believable. This construction allows her to maintain a sense of normality and inclusiveness "we're all in the same boat" (line 308), "it's not massively different" (line 315).

Extract 19 - Anna

38. R: So, what was the message that you (.) you wanted to (.) get across to people?

39. A: That (.) it could be anybody with a mental illness.

40. R: Mhm=

41. A: =You could be sitting next to ‘em and not know. [] (.) You could be sitting

42. R: [mhm]

43. A: opposite them (.) .hhh, you know, opposite a manic depressive:::, you

44. could be sitting (.) .hhh next to somebody who’s:: suffering from anxi::ety:: (1), it’s

45. all walks of life. [] (.) Mental health (.) health (.) ill (.) ill health has got no boundaries, []

46. R: [mhm mhm] [mhm]

47. A: It’s (.) it could be anybody, [] It c c could be you tomorrow. [] (.) And that was the

48. R: [mhm] [mhm mhm]

49. message. (1) [] But we thought we’d ahm (.) use:::: schizophrenia as a (.) .hhh

50. R: [mmmm]

51. A: quite a:::: (.) a severe (.) mental illness.

52. R: Mhm

53. A: And ah::::: (.) show people that (.) we’re not people that walk around with .hhh (1.0)

54. knives and guns and (.) go shooting people and (.) stabbing people and (.) .hhhh

55. things like that. [] (.). That we’re we’re ordinary people.

56. R: [mmm]

Anna uses rhetorical devices to construct voice hearing as a regular and common phenomenon. Through the footing she adopts, by addressing the audience in the second person, constructs a persuasive argument “it could be anybody, it c~c could be <u>you</u> tomorrow” (line 47). By saying “mental health (.) health (.) ill (.) ill health has got no boundaries” (line 45), suggests that anyone may be a potential category member, bridging the gap between those that have a mental illness and those that do not. This strategy blurs the boundaries between the in-group and the out-group (Edwards, 1998). The consequence of this discursive strategy allows for the construction of voice hearing as a regular phenomenon and not something out of the ordinary. It serves to universalise the issue (Wetherell & Potter, 1989). She also constructs people who hear voices as moral agents "We're not people that walk around with knives and guns and go shooting people and stabbing people" (line 53). This is also exemplified with the following comment "We're ordinary people" (line 55). This statement serves to distance the experience of hearing voices from more pathological understandings, drawing on the 'new age, new understandings' discourse in mental health (HVN Web, 2016).

This construction contrasts with another part of the interview, where Anna said "I have been known to carry a knife" (line 123) where in that specific context she attempts to justify carrying a knife because she is afraid of others, instead of others needing to be afraid of her. This reveals the dilemmatic nature of talk and how within this context she resists being positioned as an object of fear, whereas in another part of the interview she is trying to achieve something different with that talk. The mitigating component here consists of a naturalised version of the self, thus what is perceived to be normal is not subjected to the evaluative moral order (Wetherell & Potter, 1989). She therefore becomes no longer accountable about having to explain her behaviour or diagnosis, because this could potentially happen to any of us.

B.4.1.3.3 Trivialising

Participants used this discursive strategy to trivialise their experiences, in a way that is less worrying and problematic, with the purpose of saving face and not raising concern in others. Humour was often used to help manage difficult situations (Gelkopf,2011). The alternative to not adopting this strategy, would leave participants in a position that they would have to acknowledge the sometimes distressing and severe consequences that the experience of hearing voices has for themselves and others. Minimisation is a common strategy adopted to manage guilt and has been the subject of prior research (Henning & Holdford, 2005; Rogers & Dickey, 1991; Scott, 2007).

Extract 20 - Zoe

470. Z: <But::: I am able to kind of (.) communicate (.)

471. the fact that (1) I hear voices~> I also think it’s really
472. reassuring to people .hhh (.) ahm::: if I present it in a way that
473. you know, ‘I’ve been hearing these voices, for such a long
474. time [] (.) and::: (1), you know, but I’m ok? (.) My life’s alright?
475. R: [mhm]
476. Z: You know:: (.), I get on with it, I go to work, I~:: I do the things
477. that I’m doi::ng and:::: I have these (.) these (.) experiences
478. but (.) I’m used to it so:::::

In the above extract, Zoe minimises the difficulties associated with her experience of hearing voices to reassure others. What is omitted here is the impact that this experience has on her life, instead the emphasis is placed on how this experience affects others. Others are thus constructed as the ones in need of help and reassurance, instead of herself. This strategy allows for a certain element of control over her experiences, constructing her as morally accountable and conscientious. Feeling out of control and unable to manage, would have a negative impact on identity (Lovell, 1997). Furthermore, Zoe constructs people who hear voices as getting on with their lives, even in adversity “My life’s alright” (line 474). By doing this she constructs voice hearers as strong individuals, even heroic in nature. She uses personal footing and draws from her own experiences to make the account more believable. She often uses “you know” (line 374, 474, 476) to suggest that what she is saying is common sense, self-evident and therefore not questionable. The use of “kind of” (line 470) and the ending of this extract with a question mark (line 474) “I’m ok? (.) My life’s alright?” suggest that the account is delivered in a tentative way, as this may not be everyone’s experience, pre-empting a potential counter-claim.

Nevertheless, in constructing her account Zoe omits to present the more negative aspects of the experience. Throughout the interview, she negotiates ideological dilemmas. On the one hand constructing voice hearing as something to be ashamed of due to the notions of craziness or dangerousness associated with this, and on the other constructing voice hearing as a ‘perfectly normal’, even gifted experience. The discursive management adopted and specifically trivialisation, suggest that she is choosing to position herself within the more positive interpretative repertoire of continuing to strive in adversity, as opposed to positioning herself in a declining narrative of illness, limiting possibilities. She chooses to overcome her struggles by trivialising these, enabling her to get on with her life as an ordinary person. The downplaying of events is as an effective way of preserving one's self-esteem and has been investigated before (Smith & Mackie, 2007). This strategy thus allows for a preservation of one's sense of self in adversity.

Extract 21 - Flo

607. F: Ahm:::: (2) it helps me::: by not (1.0) taking - things too seriously
608. at least in the moment of time that I'm (1.0) using humour.
609. R: Mhm
610. F: <It also:::: helps me help others. By (.) letting them kno::::w that I'm
611. ok>.
612. R: Mhm
613. F: (9.0) (Becomes tearful).
614. R: Are you ok?
615. F: (1.0) Just that I know that (.) one friend in particular
616. worries a lot about me [], (.) cause I'm most honest with he:::r, so
617. R: [mhm]
618. F: if I take the piss out of myself (.) .hhh it means she doesn't have to
619. worry as much.
620. R: Mhm
621. F: .hhh so::::: (1.0) ahm:::: .hhh (1.0) yea I mean I wanna take the
622. piss out of myself because (.) it's sad.
623. (R: Hand out handkerchief)
624. F: Thank you. (5.0) It just (.) It makes it e:::asier:::. It's so::: hard and dark
625. so much of the ti:::me. .hhh You know, (.) you've (.) got to have a bit of light relie::f.

Flo uses humour, first to trivialise her problems and make light of the situation so as not to worry others, and second to help her cope with her distressing experiences “I wanna take the piss out of myself because its (.) sad…it’s so hard and dark so much of the time” (line 624). Flo negotiates an ideological dilemma between on the one hand seeking support from others in distress (a common interpretative repertoire) and on the other trying not to become a burden to others by worrying them, particularly if the content shared is distressing and/or frightening. She therefore chooses to trivialise these experiences, reducing the guilt associated with having a negative impact on others. This enables Flo to construct herself as someone who can laugh in the face of adversity, enabling her to maintain dignity and control, instead of being thought of as a burden to others for making them worry. Stern (1989) suggests control and agency are important components in building a sense of self. At the same time, she constructs herself as a moral agent; someone who does not like to burden others “it means she doesn’t have to worry as much” (line 618). She is therefore able to construct herself in a way that allows her to talk about what is troubling her in seeking support, whilst at the same time saving face and maintaining her self-respect, by being able to laugh about these issues and minimising the impact it has on others.

Extract 22 - Zoe

515. Z: Ahm::: one of my ways of kinda coping with things
516. that have happened that have been really difficult (.) and this
517. is my family’s way of coping with everything is with humour (.) .hhh [] so:::
518. R: [mhm]
519. Z: I’ve got like (.) a collection of kind of hilarious stories about things
520. that have happened when I’ve been (.) in hospital (.) ahm [] because
521. R: [mhm]
522. Z: hospital’s been horrendously traumatic (.) [] and
523. R: [mhm]
524. Z: but usually (.) a few things happened that are quite funny,

525. and they’re particularly funny if it’s something silly that I’ve done, cause
526. I like (.) making fun of myself (.) .hhh so::: I’ll maybe say to somebody::
527. ‘Oh (.) like that time when I was in hospital (.) and dadadadada happened
528. and then they’ll laugh and::: someone might be like ‘Oh!:: what hospital were
529. you in?’ or something, [] and then - I’ll like (.) make →light of it (.) and kind of say
530. R: [mmm]
531. Z: ‘Yea and’, you know, most of my friends that are close can kind of make fun
532. of me (.) about it as well, ◦would be like ‘Yea::: .hhh, you know, it’s cause you’re
533. crazy’ (.)

Zoe uses two rhetoric devices to trivialise her experiences. She uses consensus in saying “and this is my family’s way of coping” (line 517) implying she is socialised into using humour to cope with difficult situations. She also makes a concession “I like making fun of myself” (line 526). It is thus impossible to dispute this, if it is constructed as her personal preference and serves to reduce her stake in the conversation. This discursive strategy has two consequences. Firstly, it enables Zoe to build a progressive narrative of adversity against all odds. She constructs herself as someone who doesn’t give in to her problems and choosing to laugh about them. Secondly, the strategy also helps her to establish a sense of control. This is crucial for one’s sense of self and it leads to personal empowerment (Lovell, 1997). Here humour is not used as denial. The participant fully acknowledges the difficulties associated with her experiences ‘hospital’s been horrendously traumatic’ line 522.

The consequence of this discursive strategy is a more positive identity than the alternative, which would be to be constructed as someone who is unwell and unable to cope. Zoe is drawing on the common interpretative repertoire of using humour to manage distress and laughing in the face of adversity, which helps us understand better why she chooses to position herself in this way. Using humour to cope is a social response, because it is not something that is usually done alone, but always in the company of others. It allows for hope, strength and self-respect in adversity (Martin, 2010). On the contrary, if Zoe does not trivialise her experiences in this way, she could potentially shock and worry others, which would leave her identity in a problematic position.

B.4.1.4 Summary of analysis

The critical discursive analysis revealed six discursive strategies in which participants attempt to negotiate the identity of being a voice hearer. The ‘positioned as object’ strategies of disclaiming, blaming and justifying and the ‘positioned as subject’ categories of reframing, normalising and trivialising. The former strategies are used as a last report to reject negative constructions of voice hearing in the social domain. The latter strategies are used to construct a preferred identity by normalising experiences, bringing voice hearers closer in line with the rest of the population. As will be discussed in the following chapter there are implications for identity in having to negotiate both positive and negative constructions of self.

B.4.2 Discussion

B.4.2.1 Overview of findings

As was discussed previously, identity construction is not a private process residing in the individual, but a social process residing in the public arena where it is negotiated. This is thought to be achieved by a two-way process: through societal discourses and through our own discursive activity (Potter & Wetherell, 1987). Who we are is dependent on available positions through talk. “Local identities, and the linguistic practices that produce them, become visible to sociolinguistic analysis as the purposeful choice of agentive individuals, operating within (and alongside and outside) the constraints of the social structure” (Butcholtz, 2009, p.227). The discursive strategies identified through this analysis reveal great variation in how the identity of ‘voice hearer’ is negotiated. The strategies employed by participants are complex and contradictory. What they share, however, is the construction of an identity that is positive. It is not uncommon for individuals to invest a lot of effort to preserve a positive self-image, particularly when they belong to a stigmatised group (Goffman, 1959). We have seen how participants use rhetorical devices to strengthen their accounts, making them more reliable and persuasive. The dominant discourses in society on voice hearing, pose a threat to participants’ moral identity, which they work hard to repair. It has also been indicated that when individuals become disconnected from their preferred identities, they lose hope and lack a sense of purpose (Brown & Augusta-Scott, 2007).

An important finding of this analysis is how the discursive strategies relate to each other. Three of these discursive strategies: disclaiming, blaming and justifying, appear to be strategies that we would expect from individuals who belong to a stigmatised group, in trying to negotiate (repair) their identity. In this category of discursive strategies, which has been termed ‘positioned as object’, participants are positioned in pathological discourses as an object of fear. Nevertheless, they are seen to be actively trying to resist this positioning and the identity imposed on them through negative discursive practices (Bucholtz, 2009). These strategies place an emphasis on identity constructed as an intergroup phenomenon, by attending to insider-outsider issues (Bucholtz, 2009). This was seen in the extracts, as participants tried to construct an identity by comparing themselves to others.

On the other hand, the three strategies which I have termed ‘positioned as subject’ strategies of reframing, normalising and trivialising, were surprising in a sense that they are not necessarily what we would normally expect from participants trying to negotiate a problematic identity. The use of positive discursive practices seen in these strategies, focus on identity as an intragroup phenomenon, meaning that participants tried to define the identity of voice hearers based on the similarity of characteristics between group members, in constructing what voice hearers are like (Bucholtz, 2009). These strategies are very effective, perhaps even more so than the former strategies, because they are covert and implicit reducing participants’ stake in the conversation and thus are less likely to attract criticism.

Whereas disclaiming, blaming and justifying may not be as effective in counteracting some of the most dominant discourses of dangerousness and madness that serve to create an in-group/out-group divide, it seems that the more implicit strategies of reframing, normalising and trivialising allow for a less problematic identity. The latter are based on establishing a level of proximity with the rest of the population allowing voice hearers to integrate with society. Such strategies are used as acts of mitigation, that is, they construct the nature of voice hearers in a way that supports the mitigating impact of their accounts. As discussed previously the aim of the discursive analysis is to reveal the action orientation of participants talk and the discursive strategies that they use to negotiate identity, as opposed to trying to illuminate their subjective experience of hearing voices. An example of this is Zoe’s extract illustrated above where she constructs voices as akin to thoughts, and since we all have thoughts, the experience is constructed as not all that different from the norm, resulting in sameness (Zoe, line 305-9). It serves to universalise the issue and construct a normalised version of the self (Wetherell & Potter, 1989). However, as will be discussed further on, a negative consequence of these positive discursive practices is that something gets lost; the distress and suffering that people who hear voices experience.

The question is why would participants attempt to normalise or minimise these experiences? And for what purpose? First and foremost, these strategies serve to build accounts as routine, ordinary and familiar. Such strategies have been shown to be very effective in constructing factual accounts (Potter, 1996) and justifying aberrant behaviour of a group of people (Wetherell & Potter, 1989). Participants, through the normalising, trivialising and reframing strategies, are attempting to maximise sameness, because to acknowledge difference may lead to them being undermined further, their problems amplified, and made accountable for their problems. This helps us understand why the strategies of blaming, disclaiming and justifying, may not be as effective as they focus on intergroup differences. In addition, the strategies of normalising, trivialising and reframing appear to reduce the gap between insider-outsider categories (voice hearers versus the public). Edwards (1998) describes how such insider-outsider issues are negotiated in talk and suggests that categorisation is crucial in forming an identity, as participants actively try to negotiate in-group and out-group memberships.

By looking at the strategies employed, we can see what participants are trying to achieve by drawing upon the category of voice hearer and how it is used. Particularly the three strategies of reframing, normalising and trivialising, serve to bring this out-group closer to the rest of the population and further away from the pathological notions associated with the experience of hearing voices. The emphasis in these accounts is on assimilation and blending into the mainstream. One way of achieving this is through the discursive strategy of reframing, where participants attempt to reframe their problems in less problematic ways. Hall (2001) terms this strategy ‘transcoding’ whereby notions of the object of construction are recovered from one chain of signification and subsequently embedded into another, radically changing their meaning. Three participants (Jack, Neve, and Flo) attempted to construct themselves as atypical members of the category (Snow & Anderson, 1987) first by distancing themselves from the more pathological diagnosis associated with hearing voices (schizophrenia or psychosis) and reframing these experiences in different terms (autistic, pseudo-psychosis, breakdown). Not all participants chose to construct themselves as atypical members and this was dependent on there being alternative discourses available to draw upon. Reframing also involved constructing voice hearing as a gift, a special ability that not everyone shares and something to be proud of (Jack, Zoe, Ang, Lea). Goffman (1976) similarly observed this response as a common strategy used by individuals considered to have a ‘spoiled identity’ imbued with stigma.

Of note is the observation that participants who were not able to draw on discourses that could reframe their experiences, chose as a last resort other discursive strategies to negotiate their identities, notably the ‘positioned as object’ discursive strategies of blaming, justifying and disclaiming. This pattern was observed, whilst trying to take into consideration the context for each discursive strategy, to understand further what it aims to achieve. For instance, reframing is used where participants draw upon another explanation for their experience that allows for a more positive identity. One participant for example, reframed her difficulties in terms of the less pathological discourse of autism. Autism, in the social domain, is constructed as a developmental disability and not a mental illness. The implications for this are evident in institutional practices, whereby no efforts are made to ‘cure’ people with autism, but rather to make reasonable adjustments (Autism Web, 2016). The discourse of autism suggests society needs to adapt to accommodate such individuals, which may explain why one of the participants chooses to position herself within this discourse. On the other hand, the discursive strategies of disclaiming, blaming and justifying were used a lot in situations where participants were not able to draw on more benign social resources to construct their experiences, leaving them with the only option of either disclaiming such notions, justifying their position, or blaming others. The ‘positioned as object’ strategies serve to reduce accountability for participants’ actions, for example Jack constructs his drinking as involuntary, as an addiction caused by a build-up of factors. Lea justifies carrying knifes because she is afraid of others. However, these strategies are not as effective in counteracting the dominant discourses of danger, disorder and madness, without acknowledging participants’ stake in the accounts produced. Someone could easily make a counter-claim that there is a vested interested in the ‘positioned as object’ strategies. Further implications for the use of the two sets of strategies to negotiate identity, are illustrated in the section discussing the application of these findings.

B.4.2.2 Relating to existing knowledge

This research took a critical discursive analytic approach in response to limitations of prior research studies that take an essentialist approach to identity construction. The following section attempts to evaluate the current findings in relation to similar studies looking at the identity of people who hear voices. Participants in the current research acknowledge on the one hand the distress associated with the experience of hearing voices, but also engage in discursive strategies that attempt to normalise experiences by talking about career, relationships and future goals. As was discussed above this allows for a less troubled identity and a progressive narrative. This finding is in support of Dinos et al.'s (2005) study where participants showed a tendency to produce both positive and negative comparisons of self over time. The authors also suggested that positive representations of the self, did not necessarily involve the denial of negative representations of the self.

The findings of this research are also in support of Howe et al.'s (2014) interpretative phenomenological analysis of participants' experience of the diagnosis of schizophrenia and related impact of stigma on identity. Howe et al.'s (2014) superordinate theme 'avoidance of diagnosis' suggests that participants hesitate to talk openly about their experiences, yet show a desire to talk about it in the safe (non-judgemental) context of the interview setting. Furthermore, the authors found that reluctance to talk about experiences resulted in negative outcomes and a lack of support in terms of treatment. The same desire to talk about the experience of hearing voices was also observed in the current research. Similarly, to Howe et al. (2014) participants in the current research minimised the distress experienced, potentially compromising their ability to seek support to save face and build a more positive self-image, with negative consequences for their wellbeing. Another commonality between Howe et al. (2014) and the current study, was observed to the superordinate theme of 'managing the stigma to maintain normality'. Howe et al. (2014) found that being 'schizophrenic' involved accepting the label to get help, whilst also rejecting the negative connotations associated with it. Participants managed stigma through normalising and resisting unfavourable positions. This bears some similarity to the discursive strategies of normalising, trivialising and reframing in the current research. The authors explain their findings may be a differential response to self-stigma, perhaps because some people are more resilient than others. However, I argue that this strategy is an effective response in escaping a troubled identity, allowing for a more positive construction of self. The authors also identified a dilemma and a struggle with identity and similarly suggest a contextualised approach to therapy and the development of a compromised identity, based on establishing a level of proximity with normality. However, there are implications in placing an emphasis in interventions on establishing a degree of proximity with normality, which will be discussed later in the chapter.

The consequence of the discursive strategy of trivialisation in the current research, serves to minimise the distress that voice hearers experience using humour, for the benefit of others. For example, they attempt to talk about their experience to others in seeking support or validation, whilst at the same time use humour to save face, reducing the guilt of burdening others. Similarly, Mawson et al. (2010) found that participants felt like a burden to family or friends and wanted to be seen to cope. Moreover, participants in the current research adopted the discursive strategy of reframing to construct themselves as atypical members of the category, a strategy that Snow and Anderson (1987) describe as ‘distancing’, to construct themselves as different somehow from those in pathological categories (the exception to the rule) and more in line with the public. This finding is in support of Mawson et al.’s (2010) observation that when participants viewed the voice hearing experience as ‘abnormal’, they tried to distance themselves from pathology by separating the experience of hearing voices from their social relationships. In addition, an exploration of the discursive strategies adopted by participants in the current research, serves to provide a more detailed qualitative exploration of how identity is negotiated, which Mawson et al. (2010) suggested was needed as an improvement to their research.

As discussed previously, the discursive strategies of normalising, trivialising and reframing aim to achieve proximity with the public. In Shea’s (2010) grounded theory study, she illustrates how participants displayed similar strategies in ‘finding a social fit’. Participants sought roles that gave them a sense of value, purpose in the community and a sense of belonging. The success on being able to negotiate this identity in a positive manner, was dependent on the availability of caring and supportive others. The author suggests that participants who were not able to negotiate this identity in relation to others (perhaps because this was not sanctioned by others or was not enabled by dominant discourses) became stuck and continued to struggle for control. Furthermore, she claimed that those participants who were trying to construct a ‘new’ identity, went on to attempt to negotiate this with others by checking this out and making comparisons. This comparing was particularly evident in the current research in the ‘positioned as object strategies’ of blaming, disclaiming and justifying, where participants tried to negotiate a preferred identity by comparison to others and emphasising in-group/out-group differences. Furthermore, in Shea’s (2010) study participants that saw themselves as disconnected from their preferred (desired) selves faced a continuing battle in negotiating this identity, like the dilemmas encountered by participants in the current research in navigating the complex discursive terrain of voice hearing in the social domain.

The final stage of Shea’s (2010) theory was ‘coming back normal’. She proposes that a point is reached where identity is restored. The findings of the current research contradict the author’s speculation of a fixed identity. A social constructionist viewpoint suggests that identity is continuously negotiated with no endpoint. The findings of the current research suggest that this identity is continuously negotiated with and through others. ‘Coming back normal' may not necessarily be a restoration of identity per se, but a continuous attempt to integrate and connect with the rest of the population. However, a point of similarity with the current study is Shea's (2010) description of participants' tendency after 'recovering' their identity to be able to normalise their experiences, which is observed in the normalisation strategy found amongst the participants in this research. In her study this was achieved through engaging in activities that brought them in line with the rest of the population for example work, marriage, and education. These findings may even suggest that the participants in the current research may be further along the process of 'recovery' because they adopt this strategy of normalisation, possibly through their association with the hearing voices network and this could be explored further in future research.

Estroff (1989) similarly found in her study that many clients she interviewed made normalising statements "…to stress and reassert their similarities with others and to retain claim to their persisting, unrecognized, not-disordered selves" (p.119). Estroff (1989) was also interested on the impact that pathologising the experience of hearing voices has on identity. She argued that maintaining a view of self that is not compatible with that held by others results in an incomprehensible self. The discursive strategies identified in the current research are also attempts to survive personhood. However, they suggest that there is some agency in this process as participants manage the ideological dilemmas encountered in trying to negotiate the varied and contradictory constructions of voice hearing in the social domain. Being positioned within the dominant discourses of pathology does not necessarily lead to a total obliteration of the self. On the contrary, the complexity of the strategies adopted in the current research suggest that participants are creative agents in the process of identity construction. One of the participants in the current research specifically referred to this (Ang, line 240). She argued that being unwell does not mean that you lose yourself. It is others that choose to perceive you in a different light.

Estroff (1989) described that her participants encountered a dilemma (what she termed a double discrepancy), between allowing oneself to become helpless is seeking public validation for distress, whilst at the same time using all one's strength to fight the 'illness'. She presents two choices of either allowing the experience to totally engulf one's identity or try and fight it. The author deliberated over the question of whether it would be better to separate the self from the 'illness' and preserve who one was, or whether to embrace voice hearing into one's identity. There is no easy answer to this question, but it is clear from the findings of this research and the personal accounts of participants who hear voices, that they would like to retain a sense of 'normality' despite their difficulties. This mirrors Estroff's (1989) conclusions “the loss and disorder of person so characteristic of our conceptions of schizophrenia may be at least partly our own invention, and one of many ways in which we desert the person” (p. 194).

Korman’s (2003) grounded theory also shares findings with the current study, despite placing lesser emphasis on external forces in identity construction. Korman (2003) observed that participants attempted to construct a new sense of self to the one on offer, specifically a self that is not engulfed by illness. He described how participants accomplished this by being able to construct a self that is separate from the illness. The author could not explain with certainty how this was accomplished. However, I would argue in relation to the findings of the current research that constructing themselves as ‘normal’ prevents participants from becoming totally engulfed by their experiences and allows them to retain other aspects of their personhood. This will not occur however if they lose such possibilities through the loss of social roles (e.g., employee, husband, friend). To further clarify, in adopting the identity of ‘schizophrenic’ an assumption is made that this is all one can be. By changing language in a way that someone ‘has’ schizophrenia, as opposed to being a ‘schizophrenic’ can have a huge impact on identity and hopefully allow people who hear voices to construct an identity that is facilitated and valued by others. Limiting possibilities for action by forcing people who hear voices to take on our theoretical models and paradigms, will only lead to the engulfment of self and being overcome by definitions of illness (Barham & Hayward, 1998).

This is a point of agreement between Korman’s (2003) study and the current research, as is the assumption that identity construction for people who hear voices is difficult due to a lack of positive resources on voice hearing to draw upon in society. In addition, Korman (2003) found a tendency of participants to reframe their experiences as something less pathological and stigmatising for example PTSD instead of schizophrenia. Nevertheless, no attempt was made to explain why participants attempted to do this. Reframing was also a strategy that participants adopted in the current research. However, I suggested this is a strategy that participants use to construct themselves as atypical category members to distance themselves from pathological labels. Other studies also reveal similar strategies of reframing problems in less pathological terms to preserve identity (Deegan, 1993; Barnham & Hayward, 1998; Williams & Collins, 1999; Schneider, 2003). In this way, the findings of the current research enrich Korman’s by identifying the discursive strategies that participants employ to negotiate identity, to better understand what these accomplish in turn. It goes beyond description by also taking a macro approach that looks at the context in which these accounts are produced.

Corin’s (1998) strategies of identity formation attempted to show how people with a diagnosis of schizophrenia “rearticulate” their relationship with the outside world (p.145). Findings suggests that hospitalised individuals experience a tension between developing a normative definition of personhood, whilst simultaneously having a sense of inadequacy and failure. Corin (1998) describes this is as a deep desire to conform to a normal way of life and expected social roles, yet this ideal being beyond their grasp. The same ideological dilemma was experienced by participants in the current research, between trying to maintain a level of proximity to others, whilst at the same time struggling with an experience that is marginalised and excluded. However, Corin (1998) suggests that individuals that haven’t been hospitalised showed more confidence in being able to neutralise demeaning and degrading comments. They reframed a problematic character to a positive dimension in life, for example, an easily triggered anxiety was appraised as helping one evolve as a person or keeping distance was appraised as helping one recuperate. Corin (1998) stated this strategy of positive withdrawal was infused with intentionality. Similarly, a participant in the current research (Flo) constructed an olfactory hallucination (ability to smell roses when they are not present) as a way of saving a lot of money on air freshener. The intentionality present in constructing identity using the discursive strategies adopted in the current research, particularly the ‘positioned as subject’ strategies of normalising, trivialising and reframing, reveal that participants are rejecting the identity on offer and attempt to construct a preferred identity. Intentionality allows more freedom to be able to construct the self, which is not necessarily seen in the ‘positioned as object’ strategies of disclaiming, blaming and justifying that participants use when there is no other option. Akin to Corin’s (1998) strategies, the discursive strategies adopted in the current research have a protective value.

Finally, Schneider (2003) identified strategies that people with schizophrenia use to construct their identity in a positive manner. Despite the differences in sampling between Schneider’s (2003) and the present study and the lack of information on her analytic approach, there is surprising similarity in the strategies that participants adopted. Schneider’s distancing strategy is alike the reframing strategy adopted in the current research, where participants are trying to distance themselves from pathological categories and has previously been documented elsewhere (Snow & Anderson, 1987). Although her second strategy ‘rejecting schizophrenia as a motive for every behaviour’ was not a common strategy in the current research, one participant (Ang) said that she did not allow her experiences to define her entire personhood. In Schneider’s (2003) final strategy participants mobilise descriptions of themselves as normal, which is alike the normalising strategy that participants employ in the present study. This suggests that Schneider's (2003) findings are in support of two of the six discursive strategies identified in the current research. Her finding that the normalising strategy was more effective than the other two strategies in changing the status quo, was also a similar conclusion drawn in the current research. By adopting a critical discursive analysis an attempt was made to offer a more in-depth understanding of strategies, by expanding the methodology adopted by Schneider (2003) to include a dual micro and macro approach, following her suggestion that further research was needed on these discursive strategies. This was achieved in the current research by offering a more detailed understanding of the broader discourses that participants negotiate to construct their identity. It is to some of these issues that we now turn to.

B.4.2.3 Research implications

The analysis revealed that participants negotiate a dilemma between struggling with distressing experiences whilst at the same time trying to normalise these to integrate with society, which has implications not only for identity but also on whether people who hear voices can talk about the distress they experience, without being treated as the 'Other'. The consequence of this for people who hear voices is suffering in silence and not getting the support that they need. It reveals the impact that wider discourses have on people who hear voices and whose rights are served by continuing to reinforce the status quo (Foucault, 1978). The tension evident in constructing the experience of hearing voices in conflicting ways, reveals the dilemma that participants face in negotiating the voice hearing identity. There are two main opposing interpretative repertoires involved in this dilemma (Wetherell & Potter, 1988). One is denigrating and the other is idealised:

- Voice hearing is constructed as a very distressing and damaging experience. Participants attempt with this construction to maximise difference by highlighting the distress, inequality and oppression they endure.

- Voice hearing is constructed as a common, regular, and ordinary experience. Participants attempt with this construction to minimise difference through normalising, universalising and trivialising the voice hearing experience.

Navigating this dilemma has proven to be very difficult for participants because they are damned if they do and damned if they don't. Maximising difference and the inequalities or oppression that they face, may further serve to marginalise and exclude them from society. On the other hand, normalising and minimising their experiences allows voice hearers to integrate with society. However, the cost of trivialising these experiences is high, leading to people who hear voices not being understood and not getting the support that they need. For example, the use of humour in the trivialising discursive strategy, demonstrates the dilemma of constructing experiences that have traditionally been linked to severe distress as humorous. Participants used this discursive strategy to minimise the less acceptable, more painful, and difficult aspects of their experiences. This indicates that in adopting the 'positioned as subject' discursive strategies and drawing on normalising discourses participants are doing themselves a disservice, because the distress associated with these experience is missed. There is a price to pay in negotiating a more positive identity for voice hearers, in trying to bring themselves closer in line with the rest of the population.

Furthermore, an ideological dilemma also presents itself in belonging in the category of being a voice hearer, without being stigmatised. Bakhtin (1981) suggests that authoritative discourse, the type of discourse associated with the power of institutions, is less difficult to modify and is binding. Usually in our day to day interactions we encounter ideological dilemmas, however due to the richness and complexity of language, there are many possibilities for action. Bakhtin (1981) argues that authoritative discourses such as the texts and practices of our institutions, are less flexible. He describes that the only options are to either totally affirm such discourses or totally reject them. There is certainly a tension between the authoritative univocality of powerful discourses and our internal persuasive discourse, which is part ours and part of someone else (otherwise known as interpretative repertoires) (Wertsch, 2001). Authoritative discourses discourage inter-animation and voices coming into contact infiltrating each other, whereas internally persuasive discourses, encourage it (Wertsch, 2001). In this research, participants show an ability through the discursive strategies employed to negotiate identity in a preferred way. However, it is acknowledged that the miscommunication and mystification that occurs through dominant discourses can lead to a failure of people who hear voices to develop an authentic self, if a discrepancy exists between self-image and social-image.

Bakhtin and Laing (cited in Burkitt & Sullivan, 2009) argue that a discrepancy between the relationship with the self and the relationship with others can lead to an identity crisis. They suggest that, if there is no opportunity to establish communication with an authoritative discourse, this struggle can only be engaged with indirectly using such strategies as humour. Similarly, the participants of the current research employ the discursive strategy of trivialisation and use humour to negotiate the discrepancy between a ‘false’ and ‘true’ self. The struggle in trying to negotiate an authentic identity, is not something that an individual can tackle alone. Positions are negotiated with others in terms of their power implications. This inability to establish communication with an authoritative discourse, has implications for those who may not be able to negotiate this discrepancy in self-image. Burkitt & Sullivan (2009) suggest this leads to the death of self, because there is no longer a dialogue.

The way that participants manage the more denigrating subject positions available in dominant discourses using these discursive strategies, reveals the discursive terrain that they negotiate to construct a more positive identity. The complexity and variability of these strategies suggests that being able to inhabit a positive identity is not an easy task for people who hear voices. This is particularly evident in the ‘positioned as object’ strategies, where participants in the absence of benign discourses to draw upon, construct a new in-group/out-group category - good versus bad people. They construct this disposition as irrelevant to whether someone hears voices or not (Neve, line 277). In this strategy, violence is constructed as an innate disposition present in some individuals, but not others. The consequence of this strategy is to reduces perceived differences between voice hearers and the rest of the population, because violence is no longer associated with people who hear voices (Snow & Anderson, 1987). This tendency to formulate the world through binaries for example good vs bad, are discursive techniques that intensify notions of otherness (Wetherell et al., 2001). Therefore, bad people are now constructed as the ‘Other’. Difference is crucial in identity work, because we only know who we are if we can define what we are not. Furthermore, trying to construct an identity that is positive, in the absence of more benign constructions of voice hearing in the social arena, is done in subtle ways so as not to acknowledge one’s stake and interest. Which is why the ‘positioned as subject’ strategies, are more effective in creating alternative constructions of voice hearing, but whether these are successful in changing the status quo is questionable.

It is not easy for people who hear voices to simply define themselves in terms of the more positive interpretative repertoires of ‘normal’, ‘gifted’ or ‘good’. This is because the dominant discourses are so prominent and powerful that to alter them requires a lot of discursive work. This is evident in how participants employ the discursive strategies to do identity work. Dominant discourses serve to marginalise by constructing people who hear voices as the ‘Other’ (Reynolds & Wetherell, 2003). Some ways of being are therefore taken for granted, whereas others, such as being someone who hears voices, become accountable (Corstens et al., 2014; Schulze & Angermeyer, 2003). As discussed in the introduction, the most prominent discourses on voice hearing are associated with pathology, illness, madness, and dangerousness. These discourses are socially constructed and vary across different historical periods and cultural contexts. In Western societies voice hearing is associated with pathology, but this is not always how it is conceptualised in other cultures. In some cultures, voice hearing is considered a gift, as opposed to a disorder (McCarthy-Jones, 2012). Such categorisations, however, have an impact on and are affected by our institutions and practices. It is imperative to consider what the institutional consequences are in practice, of drawing on discourses of pathology (Silton at al., 2011; Cromby et al., 2013; Coombes, 2006).

The emergence and dominance of the medical model (Sacks, 2012) in treating the experience of hearing voices as a disorder, limits possibilities for action. Most participants experience an ideological dilemma, as in some cases they choose to position themselves within a medical discourse to understand their experience and seek help for their distress. At the same time, they are constrained by the few possibilities for action that the medical model allows, which is most often to take medication. This is because despite the abundance of research on available interventions for people who hear voices (Chadwick, 2006; Garety et al., 2001; Jakes & Rhodes, 2009) such interventions are not widely available and in practice do not always materialise due to competing demands for resources. Furthermore, if we consider the wider discourses particularly in the West of the nuclear family based on marriage, success, autonomy and independence (financial, emotional, physical), we can see how people who hear voices may be excluded from such possibilities if they are not able to attain the norm. They are thus deprived of being able to construct themselves with a normative identity.

In addition, the narratives that participants construct through these discursive strategies, give us an insight into the identities being constructed and negotiated. This negotiation is always in relation to the social, because part of the process of constructing an identity involves a recounting of existing social identities made available in our culture (Murray, 2008). Popular and scientific discourses affect the structure of such narratives and by looking at the structure of an account we can see how identity is constructed (Lieblich et al., 1998). The discursive strategies adopted in this research construct a certain type of narrative and by looking at this, more is revealed about how participants construct the voice hearing identity. How such accounts are constructed has been of interest to researchers looking to better understand health and illness (Castonquay et al., 2016; Murray, 2008; Hurwitz et el., 2004).

Gergen & Gergen (1986) propose that three types of narrative govern discourses: progressive narratives are characterised by a progress towards an achievement or desired goal, regressive narratives show a decline where progress is impeded, and stability narratives are characterised by a lack of change and a continuation of things as they are. Narratives are affected by discourse and specifically regressive (inhibiting) accounts are often reflected by dominant discourses in society (Murray, 2008). In addition, as narratives are culturally dependent, the social context can limit available repertoires and possibilities (Gergen, 2001). For example, the biomedical model offers a regressive narrative of illness. It describes a progressive decline as the illness advances and an inability to strive towards goals. Regressive accounts and a subsequent loss of self, are common in chronic illness (Gergen & Gergen, 1986). Furthermore, shared narratives within a culture, pose constraints as to what can be taken up by participants and what subject positions are on offer (Gergen, 2001).

The discourses pertaining to voice hearing available in the social domain, discussed in the introduction chapter, do not allow for a positive construction of the self. Most of the available narratives that participants draw upon to fashion their identities, are regressive or stability narratives, whereby there is little opportunity for change (Gergen, 2001). For example, once you have a diagnosis, you always have a diagnosis. There is only one trajectory on offer. The real consequences of having an experiences of hearing voices, such as not being able to get a job, not being able to get adequate health care, health insurance and so forth, has implications for the future (Corrigan, 2004). There is little room to change this trajectory, where the norm is for voice hearers to have to continuously negotiate their position against the norms placed by dominant discourses (Carabine, 2001). In addition to the experience of hearing voices being associated with mental ill health, is the construction of people with mental health issues as a social problem (Carabine, 2001). Popular discourses construct the mentally ill as a drain on the state with access to benefits becoming increasingly harder. The ‘mentally ill’ are assigned to work programmes run by Jobcentre Plus, initiatives aimed at reducing unemployment (Ingeus web, 2016). If individuals are not assessed to have a limited capacity for work-related activity, they receive a lower level of benefit and adhere to strict work-related conditions (attending a series of work-focused interviews or undertaking work-related activities) to continue to receive their benefits in full (Disability Rights Web, 2012). It is argued that such initiatives run counter to more ‘recovery’ based initiatives in mental health.

What has been of great interest in this research, is how participants attempt through the discursive strategies to change stability or regressive narratives into progressive narratives that allow for progress and winning over adversity. Ang constructs herself as a confident and eloquent person, with a good social life and goals for the future (line 346). On the other hand, not constructing accounts in this way, only allows for stability or even progressively regressive narratives, which take a gradual regressive course over time offering little optimism and hope for the future. An example of this is the discourse of the downward drift effect, which links mental health with a decline in socioeconomic status (Hudson, 2005). Such discourses have a negative impact on identity and voice hearers' sense of self, which has also been observed in the therapeutic setting (Chadwick, 2006).

All participants in the current research drew on dominant pathological discourses to talk about their experiences and sometimes chose not to position themselves in these. Instead they constructed progressive and/or 'heroic' narratives with progressive-regressive phases (Gergen, 2001). Within these narratives participants strive to live their lives as normally as possible, despite the distress and stigma associated with their experiences. Such constructions involve a downward spiral of illness and stigma, but which participants compensate for by a sustained and invigorated capacity, for reaching personal goals and growth. Such progressive narratives, have been found to be linked to a more positive sense of self, allowing participants to gain control over and master the difficulties associated with their experiences (Robinson, 1990; Lovell, 1997, Murray 2008). It is possible that participants were orienting to the interview situation, perhaps trying to convey a message of hope to others with similar experiences. Their accounts are constructed to reduce fear, minimise the impact of distressing experiences through various strategies such as humour, to enrich their lives. It is an ongoing interchange and we have seen this through the emergence of new understandings of the experience of hearing voices in more recent years (HVN Web, 2016). Such attempts to negotiate identity occur through dialogue and it is hoped that this research has provided a forum for participants to be able to negotiate this, by identifying and promoting strategies of resistance. Perhaps providing a trusting environment free of prejudice liberates people who hear voices, to talk openly about their experiences.

As discussed above, there are two implications resulting from the findings of this research. Firstly, the voice hearing identity, and particularly within the dominant medical model, is described using a stability or regressive narrative, which doesn't change over time. If this experience is constructed as an illness that cannot be cured, there are implications for what one can do. One participant said she would like the label to go, especially if someone is in 'remission' and no longer experiencing distress (Zoe, line 216). Secondly, by using the discursive strategies of normalising, trivialising, and reframing to develop a more positive identity, on the one hand it allows participants to save face and integrate into mainstream society. On the other hand, voice hearers risk not being taken seriously for their experiences, especially when these are linked to severe distress, resulting in them not getting the support that they need. This can have real consequences for people who hear voices, as Lea described in her interview, she has lost many friends to suicide (line 433). Thus, the way in which these experiences are talked about, can have severe implications for people who hear voices.

The discursive strategies identified have further implications for practice and the therapeutic interventions that we deliver to people who hear voices. How can we encourage people who hear voices to talk more openly about their experiences without fear and help them develop progressive narratives that allow for a more positive sense of self, without minimising or trivialising their distress? The concluding section delineates how these findings may be applied to inform interventions and to help develop new politics of voice hearing.

B.5 CONCLUSIONS

B.5.1 Reflexivity

There is an assumption in critical discursive analysis that discourse is constructed through social interaction and so the findings of this research are co-constructed with participants by the researcher (Potter & Wetherell, 1995). There are factors that may have had an impact on these constructions, including my background and experiences. My experience with people who hear voices has been in the capacity of an NHS worker in a support role. Undoubtedly, these experiences have shaped my views of what it is like to hear voices. However, it is acknowledged that my experience has only been with individuals that experience distress from hearing voices and not with individuals who hear voices that have not been in contact with mental health services. Therefore, I was aware not to inadvertently make prior assumptions about what this experience may be like for all people who hear voices, by attempting to bracket my own personal experiences.

There is however a perception that this population is fragile and vulnerable, and to discuss their experience of hearing voices may either exacerbate the problem or be pointless because it does not resemble any sense of reality (Korman, 2003). The perceived fragility of this population has been the focus of many studies (Weinberg, 2012; Lysaker & Lysaker, 2001; Shahar & Davidson, 2003). I also encountered a similar reaction by fellow students and academics when I presented my proposal. They questioned whether participants would experience distress from talking about their experience and what risk this might pose to them.

These concerns were addressed during the application for ethics approval. The participants in this research were keen to talk to me about their experiences and none of them experienced any distress from taking part in the interview.

My prior experience of working with people who hear voices and the longstanding interest that I have in the subject matter, added pressure to do justice to participants' accounts. Especially because I felt they entrusted me with this task. Taking a critical discursive approach helped me to distance myself from my own personal feelings about what participants were saying and focusing on what they doing with language. The analytic approach does not attempt to describe reality from the participants' point of view or to uncover the true nature of phenomena, such as a phenomenological approach might seek to take. It does not attempt to tell us something about participants' thoughts and feelings, and this is one of the main limitations of adopting a discursive approach (Willig, 2013). The decision to adopt a discursive approach is based on the ability of language to construct, rather than describe reality (Burr, 2003). The same events can be described in different ways, depending on the context and what the speaker aims to achieve. Language cannot simply be an expression of experience and discursive psychology is concerned with how psychological concepts and processes are constructed and negotiated, rather than with its referents (thoughts and emotions) (Willig, 2013). This is acknowledged to be a limitation of the current research, as emotions, due to the adoption of a discursive approach are not theorised, leading to an 'empty' person.

Hammersley (2014) suggests that in discourse analytic studies a level of deceit is implicated when the researcher undertakes a suspicious reading of what participants say, if participants perceive the interview to be a forum where they can tell their story and describe their experiences. This is especially so if the questions are posed to participants in a naturalistic manner as when for example participants are asked to describe their experiences, rather than being told the researcher is looking at discursive management. Hammersley (2014) comments that participants are not fully consenting if they are not able to understand how the data they provide is going to be used. And that even if the researcher attempts to debrief the process, this might serve to confuse or anger participants if they are told that the analysis may make negative evaluations of what they say. However, the purpose of this research is emancipatory and it does not aim to portray voice hearers in a negative light. On the contrary, it aims to reveal the discourses in society that maintain the status quo and the subsequent impact these have on the identity of people who hear voices.

Taylor (2014) argues that the gap between participants' expectations and what is produced following theoretical interpretation of the data, presents a challenge to most approaches to qualitative research and does not simply apply to discourse analysis. In addition, she suggests that most often participants are presented with the aims of the research and opacity is not a problem as even if participants are not given full coverage of the analytic process, including technical terms, this is sufficient in terms of gaining consent (Taylor, 2014). When I introduced the research to the participants, I explained to them that I am looking to investigate how they talk about their experience, including popular views on the subject matter in the current cultural and socio-political climate, as opposed to describing what that experience is about (e.g., what voices they hear, what they say, why they are present). Therefore, participants were aware that I wasn't seeking to investigate what this experience is like, but how it is talked about and this also had an impact on their constructions. I agree with Taylor (2014), that describing experiences in a naturalistic way is not the only ethical way to interview, because most often participants are asked to talk from a vantage point (as a category member for example mother, wife, friend) potentially leading to generalisations. Furthermore, discourse analysis acknowledges and celebrates the complexity and multiplicity of constructions. Viewing the participant as a resource to be accessed for knowledge by taking what they say at face value, is problematic, especially if claims of truth are made without acknowledging the context in which the constructions emerged.

Furthermore, if language is characterised by so much contradiction and variability, can anything meaningful be gleaned from these findings? These constructions are situated because they are dependent on the interview setting in which they took place. This is how participants chose to construct their identity in this context. As will be discussed further in evaluating this research, an attempt was made to be transparent in the construction of these findings, potentially allowing the audience to make their own conclusions with regards to the transferability of findings (Tracy, 2013). Yet amidst this multi-vocality, it was evident that participants employ common strategies in which to construct identity, not only between participants in the current study, but also with strategies identified in prior research (Schneider, 2003).

The danger of working with in-depth accounts is the difficulty of being able to step outside of the data once you are immersed in it. I sought to address this using a reflective diary at each step of the process. It was evident when strategies began to emerge that they all attempt to construct a positive identity, even though the discursive strategies of disclaiming, blaming and justifying are not as effective and serve to maintain the status quo. A consideration was made as to whether it was my wish to portray people who hear voices in a positive light that generated this outcome. This was particularly important, because I have a close relationship with the subject matter, having worked with people who hear voices in the NHS for many years. An attempt was made to take a critical stance to these constructions. This involved adopting an iterative process whereby I went back and forth between the data and the analysis many times, and explored whether the data supported alternative interpretations to the ones already made (Willig, 2013). Supervision was also crucial at this stage, to keep a critical stance to the data produced. Moreover, in addition to looking at common strategies in participants' talk, an attempt was made to consider what didn't fit within the discursive strategies identified or what was inconsistent between accounts, including what was not said or could have been said differently by participants. (Wetherell et al., 2001; Tracy, 2013).

B.5.2 Evaluating qualitative research

In evaluating qualitative research, the question always arises as to whether the meanings derived are credible and believable. I refer to the criterion of transdisciplinary convergence in evaluating discourse analytic data. Jaipal-Jamani (2014) suggests that when more than one method or analytic tool is used that goes beyond one discipline, not only does this add methodological significance to the study, it also enhances the validity of discourse analysis. The current research combines validation from semiotics (use of established signs and social codes or conventions present in our society), validation from linguistics (looking at the function of language using rhetorical devices) and validation from critical theory (takes a broader social and critical perspective by questioning dominant discourses and highlighting social issues). When findings converge at multiple levels, resulting in an analysis that is transdisciplinary (linguistic, situational and social level) this enhances the findings of a discursive analytic approach (Jaipal-Jamani, 2014). The combination of the different approaches (micro, macro) converged naturally, offering a richer account than would have been possible with one analytic focus. They build a more complex picture of participants' accounts (Tracy, 2013). Furthermore, looking at the ideological dilemmas participants negotiated in these constructions, reveals the dilemmatic nature of talk and the multiple ways in which accounts can be constructed for a purpose, thus producing interesting findings and providing richness in accounts, increasing the validity of the findings (Tracy, 2013).

In hindsight, there were aspects of the methodological approach that worked well. During the interviews, I allowed myself to be vulnerable and open to participants' accounts. I felt connected with the participants which achieved a level of comfort that helped them to share their experiences. In addition, my longstanding experience in the field of hearing voices, meant that I accessed tacit knowledge, knowing where to probe and question absences. This contributed to generating thick description and rich accounts. The inclusion of the surrounding text in the extracts, was intentional to allow the audience to resonate with the data. Qualitative findings can only be made transferrable if findings are transparent allowing the audience to intuitively apply these to other situations. These aspects add to the validity of qualitative research (Tracy, 2013). On the other hand, there were aspects of the research that could be improved. The limitations of the research will be discussed in the following section.

B.5.3 Limitations of research

Conducting the interviews at centres where the hearing voices groups take place, posed the problem of occasional interruptions and disruptions, which were not observed at City University of London premises. Some participants chose to take time out of the group to take part in the interview, which may have impacted on their ability to concentrate on the task at hand. I felt that this could have served to distract the participants and I felt that I generated richer accounts when there weren't such disruptions. Furthermore, little attention was paid to demographic data. The decision not to present these was intentional so as not to pre-impose categories on participants and some may perceive this as a limitation.

A discursive analysis should ideally be conducted with naturally occurring data, because it looks at how participants make themselves accountable and manage their stake in interaction (Willig, 2013). Both practical and ethical issues made it difficult to gather naturally occurring data. The disadvantage of using semi-structured interviews, involves participants orienting to the interview situation and the accounts they generated reveal how they manage stake in the interview situation, rather than reveal the discursive strategies that they would use in their daily lives. It is acknowledged that the way I carried out the interviews, by constructing the research questions and setting the scene of the interview, is not as ideal as working with naturally occurring data. However, adopting an active interview approach produced variability in the accounts suitable for a discourse analysis. A different approach may have produced different findings. Furthermore, I chose to structure the writing of the report around discursive strategies in how participants negotiate their identity, but I could have chosen to structure it on interpretative repertoires instead (Willig, 2013). Looking at discursive strategies, in my opinion, better reveals how people do things with talk, especially if we are looking at how they negotiate identity.

Another limitation concerns the selection of material for analysis, which is based on the research questions (Willig, 2013). The research questions identify only an aspect of discourse that I decided to explore. Due to this, there was a plethora of rich data that was thus not subjected to analysis and it is acknowledged that this is a limitation of taking a discursive approach to the data, as it is not possible to interpret all the data gathered (Taylor, 2001). In addition, part of the analysis involved applying a macro lens to the texts already selected for the discursive psychological analysis with a micro focus and this may not have been as effective, because it was already applied to the data that was selected for the discursive part of the analysis, as opposed to the entire data corpus. Being selective in the texts used for analysis, means that there was data that could have been useful, but were not utilised for the purposes of this research. Nevertheless, the material collected can be analysed again to produce further insights.

Finally, the way that the research was presented to participants, including participants' experience of taking part in hearing voices groups where there is more opportunity for them to conceptualise their experience in many different and less problematic ways, may have had an impact on the findings of this research. This is not to say that these findings are not valuable. As a counselling psychology project, it is of interest to see how these discursive strategies, particularly the normalising and reframing strategies can be transferred to other settings. For example, in mental health settings to see whether adopting such strategies could have a positive impact on others who may not have the resources available to be able to negotiate their identity in less problematic ways. From the findings of this research and the situated nature of the accounts constructed, it would be useful to apply a discursive approach to identity construction in other settings outside of the Hearing Voices Network, to see whether the discursive strategies employed in constructing identities are the same or different in other contexts, and if so in what way, to better inform interventions. And considering that such constructions are historically and culturally dependent, it would be useful to investigate constructions in different cultural contexts and how individuals from different societies negotiate the voice hearing identity.

B.5.4 Applicability of findings

Prior research has established a link between low self-esteem and individuals who hear voices that have a diagnosis of 'psychosis' (Freeman et al., 2006). Therapies also emphasise the importance of working with a sense of self in this client group (Chadwick, 2006; Rhodes & Jakes, 2009; Garety et al., 2001). However, psychological interventions predominantly take an individualistic (constructivist as opposed to a constructionist) approach to clients' problems and draw on a 'deficit' discourse to understand these experiences (Gergen, 1994). There is a need to take a broader social constructionist approach to understanding the experience of hearing voices, which is what this research seeks to accomplish. The findings of this research suggest that participants try to normalise and minimise the distress they experience to fit in with the rest of the population and manage the stigma attached to hearing voices, because this experience is not considered to be the 'norm'. The evidence was present in the ideological dilemma of constructing voice hearing as a difficult, distressing experience, whilst simultaneously trying to normalise the experience to attain a closer proximity with the population. This strategy has implications for the support that we provide to people who hear voices, if they do not feel able to talk freely about these experiences for fear of the stigma attached to these. Interventions should address such issues in therapy, by considering the impact of the social, including the stigma attached to these experiences and working with clients to develop a preferred sense of self. Such issues are already being addressed and are a crucial element of interventions with LGBT (lesbian gay bi-sexual and trans-sexual) and minority groups (Kelleher, 2008; LaSala, 2006; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2008; White Hughto, Reisner, & Pachankis, 2015). However, a systematic review of prevalence rates, impact and interventions for stigma in 'schizophrenia spectrum disorders', revealed only two specific intervention studies that addressed stigma (Gerlinger et al., 2013) suggesting there is a gap in developing interventions for people who hear voices that specifically address stigma and identity issues.

Furthermore, the findings of this research may be disseminated to journals that appeal to broad based health professional groups from different disciplines that work with people who hear voices in different support settings (NHS, private, charity) for example 'Health' Journal (Sage Publications) to highlight and challenge dominant discourses of pathology and the subsequent impact on identity. These findings may also be disseminated via the hearing voices network, which is where the participants have been recruited from, to reach people who hear voices that may or may not be receiving support from mental health services, with a view to challenge dominant discourses of voice hearing and empower them to strive to develop a preferred identity. Highlighting such issues, may allow people who hear voices to reappraise their experiences in less harmful and pathological ways and help develop broader (community) representations of the experience of hearing voices (Murray, 2008). Part of the application of discourse analysis is to offer alternative accounts of voice hearing and to give a voice to hard-to-reach groups that have not previously been heard. It can provide a critique of established and mainstream views of voice hearing, with a view to empower marginalised groups in society. Gergen (2001) suggests “constructions of the self, require a supporting cast” (p. 258). If others do not affirm such constructions, then the construction of such narratives will not be validated. The current research highlights the importance of endorsing alternative discourses on voice hearing that may help voice hearers to construct a preferred identity, which need to be supported by health professionals and the public alike if these are to prevail and gain momentum.

Problems arise from restrictive and incoherent narratives. The purpose of therapy would therefore be to challenge dominant discourses of voice hearing that problematise the experience of hearing voices, and help individuals construct alternative, less pathological, emancipatory accounts of their experiences (White & Epston, 1990). Guildfoyle (2014) suggests that people do sometimes experience aspects of their lives that they are unable to control, however this does not depict the entire person. The individual is constituted, but not totally determined by the social and therefore has the capacity to resist dominant discourses on voice hearing and developing alternative constructions (Guildfoyle, 2014). Narrative is a powerful method to enable possibilities and help people who hear voices reconnect to a sense of being that is congruent with their view of self. Furthermore, to be able to facilitate new ways of conceptualising such experiences, as therapists we need to let go of what we already know and be open to new ways of knowing. Interventions should thus attempt to acknowledge the suffering, whilst simultaneously strive to work towards preferred identities (Duvall & Béres, 2007).

The findings suggest that participants use normalising as a discursive strategy to negotiate identity, but to the detriment of receiving adequate support. Guildfoyle (2014) advocates that resistance does not entail normalisation, on the contrary it may mean having to give up and stepping back from those idealised requirements. This has implications for interventions for people who hear voices that aim to normalise these experiences. Professionals should not prescribe what is the right way to be or live. That should be up to people who hear voices. All therapists may do is to facilitate the dialogical and provide escape routes (Guildfoyle, 2014). Professionals should also lobby for social change, by helping people who hear voices undermine dominant discourses through political action. We need to join them in challenging the status quo, the dominant discourses and the institutional practices that reinforce these. The aim therefore would be to increase awareness of subversive discourses and stop inadvertently reinforcing dominant ones. This is something that the current research tries to accomplish.

B.5.5 Final comments

The analysis produced interesting findings on how participants negotiate the 'voice hearing' identity, particularly where this identity has traditionally been constructed in the West as problematic. One way of challenging discourses, which is congruent with a Counselling Psychology research ethos, is to encourage individuals to construct different stories about themselves to the dominant oppressive ones. Identities however are negotiated and are therefore inextricably linked to power; certain privileges are afforded to some roles but not others (Edley, 2001). The purpose of this research was to create new possibilities for people who hear voices that allow for new positions and a preferred identity, whilst at the same time acknowledging the constant and continuous struggles that this group faces. This is possible through discourse because identities are not constant, they are fluid, constantly shifting over time and open to negotiation (Wetherell & Edley, 2009).

In summary, participants drew on six discursive strategies to negotiate the voice hearing identity. These strategies allow for a more positive identity. Positioned as object strategies (blaming, disclaiming, justifying) tend to be overt, reactive in nature and less effective. Positioned as subject strategies (reframing, normalising, trivialising) allow people who hear voice to assimilate in mainstream society. The strategies suggest that the dominant discursive positions available for people who hear voices do not allow for the negotiation of a satisfactory identity (Burr, 2003). However, despite strategies allowing for a more positive identity, I would argue that they serve to maintain the status quo. Participants experience an ideological dilemma between trying to reconcile living with distressing experiences, whilst at the same time constructing such experiences as the norm, to fit in with society. However, by trivialising these experiences they are minimising the distress they experience at their own expense. They are not able to express themselves without judgement.

Kitzinger (1989) points out that identities are profoundly political, they serve the interests of the dominant social order. She suggests that we need to be aware of more recent liberal identities that continue to reinforce the status quo. For example, the discourse of ‘recovery’ that serves to still locate problems within the person and not where problems lie, such as the ills of society. Despite offering positive messages or images, these discourses are accommodative in nature and do not allow voice hearers to resist the identities on offer (Kitzinger, 1989). This is evident is some of the language used on accessible recovery websites for people with mental health problems “staying in control of their life”, “building the resilience of people with mental health problems”, “a voyage of self-discovery and personal growth” (MHF-Mental Health Foundation Web, 2016). In addition, research suggests that stigma has an impact on an individual’s ability to recover (Buck et al., 2013; Corrigan, 2004; Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012). However, little attention is given by the MHF to the link between recovery and social inclusion, the discussion of which was condensed to a mere six lines and offered little advice on how people may integrate with a society that is marginalising and excluding (MHF Web, 2016). The discourse of ‘recovery’ becomes problematic if material conditions for example unemployment, financial difficulties due to reliance on benefits, and isolation in terms of social support prevents persons from recovering. ‘Recovery’ is thus something the individual cannot attain alone and involves various factors that sometimes may be out of peoples’ reach. Which suggests that although recovery is possible, that it is not an option that is within everyone’s reach and sometimes can even cause fear and uncertainty in some chronically ill clients (Corrigan, 2004). In addition, the recovery discourse has been used to serve the purposes of those in power, by removing much wanted services from vulnerable individuals (Slade et al., 2014).

Kitzinger (1989) argues against a liberal humanist ideology, which places a greater value on personal happiness and fulfilment than political action, because doing so reaffirms the dominant social order. We need to question the role of the ‘inner world’ and ‘subjectivity’ in psychological research (Kitzinger, 1989). We need to deconstruct our everyday understanding of the experience of hearing voices. We also should not fall into the trap of immersing ourselves in dominant therapeutic discourses that construct people who hear voices as victims of trauma (HVN Web, 2016). These discourses are also problematic because they inadvertently reinforce the status quo. They are not emancipating in nature and do not allow people who hear voices to construct themselves in positive ways, without the negative consequences of minimising their distress and suffering in silence. Moreover, discourses that attempt to construct these experiences as a normal and natural lifestyle, do a disservice to voice hearers, because they construct this as an individual and apolitical lifestyle choice (Kitzinger, 1989). An alternative would be to strive for political action to reduce the problems in society that lead to such ills, which renders some of the discursive strategies that participants adopt to construct their identity in the context of the current research problematic, particularly the normalising ones. These strategies serve to reinforce the power of normalisation (Foucault, 1978). Discourses that attempt to normalise experiences serve to maintain the status quo of living in a culture where individuality, autonomy and agency are valued foremost and those who are unable to achieve these values are excluded. On the other hand, more radical discourses such as anti-psychiatry that threaten the status quo are discredited and suppressed (Kitzinger, 1989). Moving forward, in accordance with the view that identity is a social construction, we therefore need to challenge the very validity of these concepts and the psy-complex (Parker, 1994) as opposed to trying to redefine them (as recovery or trauma). These are necessary measures if people who hear voices are going to be able to construct identities that do not reaffirm the dominant moral order, leading to further oppression. Furthermore, we need to offer interventions that do not inadvertently pathologise, encourage people who hear voices to discuss openly their experiences, work collaboratively, and provide support to those in distress that might enable them to live a more fulfilling and less stigmatising existence.

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CHAPTER 4 – Publishable Article

“We’re not all dangerous and crazy”. Negotiating the voice hearing identity: A critical discursive approach.

D.1 Abstract

Few studies and interventions address the impact of the experience of hearing voices on identity. Identity issues are particularly salient due to the discrimination and stigma that these individuals face. The current study draws on a critical discursive approach to identify discursive strategies that participants use to negotiate the voice hearing identity. Semi-structured interviews were conducted with eight participants recruited from the Hearing Voices Network. Analysis took a micro-focus looking at interpretative repertoires, ideological dilemmas and subject positions, as well as a macro-focus looking at the broader discourses of voice hearing present in society. Two contrasting interpretative repertoires were identified. On the one hand voice hearing was constructed as a distressing and difficult experience. On the other it was constructed as a normal, ordinary experience. Normalising the experience of hearing voices in the interest of establishing a closer proximity with the rest of the population results in the distress that voice hearers experience being missed. In addition, participants used six discursive strategies to negotiate identity. The ‘positioned as object’ strategies of blaming, disclaiming and justifying are overt and reject the social identity on offer, increasing the gap between voice hearers and non-voice hearers. The ‘positioned as subject’ strategies of normalisation, trivialisation and reframing are covert and construct a preferable identity that helps people who hear voices integrate with society. The findings suggest that these discursive strategies have implications in delivering interventions and point towards the need to take an outside-in approach by addressing identity issues in therapy.

Keywords: identity; voice hearing; schizophrenia; psychosis; critical discursive psychology

Health Journal Sage Publications. For submission guidelines (Appendix D.1)

D.2 Introduction

The experience of hearing voices can be traced back to ancient Mesopotamia around 3000 BC (McCarthy-Jones, 2012). Despite the various ways in which this experience has been understood during different historical periods and times, normative descriptions of hearing voices are consistently pathological in nature. Hearing voices has been constructed to be a sign of madness, an incurable illness, a disorder, a risk to others. These constructions also permeate our institutions and practices. The 'symptom' of hearing voices, is lawfully treated without the consent of individuals under the Mental Health Care Act 1983 (amended in 2007) (Legislation.Gov Web, 2007). Being a 'voice hearer' is an identity that is made accountable (Reynolds & Wetherell, 2003). For example, people who hear voices are accountable to health professionals as to whether these experiences pose a threat to themselves or others. They are also made accountable as to why they may not able to achieve the normative ideals of a Westernised culture for example getting married, having children, having a job, being autonomous and independent, having a social life.

Since the 'Age of Reason' (1600-1800) and the privileging of methods of science as the primary mode of producing knowledge, the experience of hearing voices has, and is still, predominantly understood to be a symptom of illness (Cromby et al. 2013). Those who are not able to contribute to the work force in a capitalist economy, particularly if the cause is thought to be mental illness (of an emotional as opposed to a physical illness), are perceived to be deviant and are associated with negative connotations (McCarthy-Jones, 2012). Thus, traditionally in the West, particularly when linked to distress, this experience is primarily associated with illness and pathology and is regulated through the Psy-complex (Parker, 1994). Furthermore, the frequent association of hearing voices in the media with violence (Coombes, 2006) distorts public images of this experience, despite evidence to suggest that people who have a mental illness are more likely to be harmed by others (Stuart, 2003). In addition, the construction of this experience as an illness, conceptualizes the phenomenon as a social problem in need of control, reinforcing current practices.

Despite an abundance of research on hearing voices, few research studies explore the impact that the experience of hearing voices has on identity. The link between the experience of hearing voices and a negative sense of self, has already been documented (Chadwick, 2006; Garety et al., 2001). Traditional identity theories are essentialist in nature because they focus on identity construction as an individualistic accomplishment downplaying the social. They do not consider the impact that constructions of voice hearing in the social domain have on an individual's sense of self. A distinction is made here of the sense of self being the capacity of an agentic individual to reflect on the self, whereas identity resides in the social (Shea, 2010). It is of interest therefore to investigate how people who hear voices negotiate this identity in the social, especially if we take a view that identity is a social construction, which is accomplished in interaction with others.

D.3 Review of literature on identity

The studies that investigate the impact that the experience of hearing voices has on identity are mostly carried out on clinical samples. Howe et al. (2014) investigated, in an interpretative phenomenological analysis, the effect that the diagnosis of schizophrenia has on identity. The findings suggest that people labelled with schizophrenia tend to avoid the diagnostic label due to the stigma associated with it. In addition, participants had little understanding of the diagnostic labels given to them and attempted to manage the stigma to enable them to retain a sense of normality. Dinos et al. (2005) conducted a content analysis of temporal comparisons of the self over time following the diagnosis of schizophrenia. Surprisingly, participants constructed themselves in a positive light post-diagnosis. However, the authors suggest that participants may have been orienting to the rehabilitation setting where interviews took place. An interesting finding of this study was that there appeared to be great variability and flexibility in descriptions of the self over time, for all time periods measured. A discursive approach may be suitable for an analysis of the variability with which participants construct accounts and for different purposes (Willig, 2013).

Shea (2010) investigated the process of identity construction in people with a diagnosis of schizophrenia using a grounded theory approach. She theorised distinct stages in the process of identity reconstruction following diagnosis. However, only two out of fifteen participants attained the suggested recovery of identity and re-emergence of a new self. The problem posed with describing identity construction as a stage model, is the lack of information offered on the underlying processes. In another study, Corin (1998) adopted a discursive approach to investigate the strategies that participants use to construct the identity of being 'schizophrenic'. She made a distinction between people that have been hospitalised and those who were not, and found a difference between the flexibility of identity construction between the two samples. Non-hospitalised individuals appeared to intentionally construct a detached identity that still enabled them to maintain a connection, whereas participants who were hospitalised felt excluded and outcast from society. This research raises questions as to whether people who hear voices that do not have a mental health diagnosis, may also experience the same level of stigma and impact on identity as that experienced by clinical groups.

Finally, Schneider (2003) using an ethno-methodological approach, looked at the strategies employed by people with a diagnosis of schizophrenia to construct their identity. Three strategies were identified: a tendency to distance themselves from diagnostic categories, rejecting schizophrenia as a motive for behaviour, and mobilising descriptions of themselves as normal. Although the researcher highlighted the existence of wider discourses that people draw upon to do identity work, no attempt was made to describe these or the impact that discourses have on institutions and practices. In addition, the author does not consider the power implication of how discourses are maintained and reinforced. A suggested improvement to this study, would be to adopt a critical approach to such issues, which is more suitable to the highly-politicised subject of hearing voices.

Overall, the above studies take an essentialist and individualistic approach to identity construction, akin to traditional psychological theories of identity (Erikson 1968, Levinson, 1978). Such approaches are simplistic in nature. They are not able to offer a rich account of how individuals negotiate their identity in the social domain. Furthermore, suggesting identity construction is something that resides in the individual and is accomplished through a stage process, results in problematising the individual if she/he is unable to progress through these stages. However, the turn to language challenges the assumptions of cognitivism and the search for an objective truth that lies within the individual. It views identity as the product of language (Willig, 2013). A social constructionist approach to identity construction proposes that identity is fluid, it resides in the social and is continuously negotiated through others and through the process of social interaction (Benwell & Stokoe, 2005; Burr, 2003). Positioning operates on the assumption that when someone draws upon a discourse, they chose a subject position and simultaneously position others accordingly to negotiate identity (Willig & Stainton Rogers, 2008).

D.4 The discursive construction of hearing voices

The methodological approach adopted in this study is a critical discursive psychological approach, with a dual focus combining conversation analysis and poststructuralism (Wetherell, 1998; Edley, 2001). The micro focus examines the local conversational sequence of an interaction and looks at the rhetorical devices that participants employ to do things with language; the action orientation of talk. In addition, a macro focus examines the broader discourses available in society relating to voice hearing. It critically examines the power implications of discursive constructions and how these are reinforced by institutions and their practices (Foucault, 2006).

Constructing categories enables us to better understand the world around us. One way of defining oneself, is through defining what one is not, in contrast to another (Burr, 2003). It involves highlighting and delineating in-group and out-group differences in the process of identity construction (Wetherell & Edley, 2009). Furthermore, discourses available in the social domain have an impact on identity construction. It is this positioning within available discourses where identity work occurs (Davies & Harré, 1990). At different historical periods and contexts, the experience of hearing voices has been constructed as a sign of madness, a supernatural encounter, a spiritual experience, a response to trauma or an illness that requires treatment (McCarthy-Jones, 2012). Thus, the voice hearing Identity is negotiated in a complex ideological field. A social constructionist view argues that identity is multifaceted and fragmented, constantly constituted and re-constituted in social interaction (Benwell & Stokoe, 2006). The complexity and diversity of such constructions is embraced in the current research, because it reveals something about the terrain that voice hearers negotiate in constructing their identity.

D.5 Method

Participants were recruited from the Hearing Voices Network (HVN) in greater London, Hertfordshire and Bedfordshire areas. The HVN was chosen because it encourages diverse and varied understandings of voice hearing, generating the variability needed for discourse analysis. In addition, the recruiting strategy was a response to limitations of prior studies, deriving findings based solely on clinical samples with a diagnosis of schizophrenia or psychosis. They omit 'normalised' accounts of voice hearing and it is of interest to see how people who hear voices that may not have these diagnoses, negotiate identity. Eight participants were recruited. The sample included 7 females and 1 male participant from a mixture of ethnic, occupational, educational, class and socioeconomic backgrounds ranging between the age of 18-70. The research was introduced in person to group members and an opportunity was provided to ask questions. Both HVN premises and City University of London premises were utilised to conduct the interviews. Inclusion criteria consisted of persons over the age of 18 with a lived experience of hearing voices. The only exclusion criteria were persons who were currently experiencing distress from hearing voices, who would find attending an interview or talking about their experience of hearing voices distressing. Participants were given the opportunity to withdraw at any time during the process without consequence. Post-interview, a debrief session was carried out to ensure participants did not experience any distress and sources of support were provided, should participants require any further help.

The duration of interviews ranged between 45-60 minutes. Participants were asked to talk about their experience of hearing voices, specifically in relation to the current socio-cultural and political climate. Sample questions included: “Tell me about your experience of hearing voices”, “How do you share this experience with others?”, “How do you prefer to describe your experiences?” “What does this experience mean to you?” The interviews were informal and aimed to place participants at ease. In addition, an active non-confrontational stance was taken in conducting the interview, by probing areas of interest. Data was transcribed by the researcher and anonymised, taking care to remove any potentially identifiable information. All data was stored and backed up in a secure location and was only accessed by the researcher. An interview guide was prepared consisting of three sections, but was used loosely to keep focus on the research questions. The first section aimed at querying participants about their experiences of hearing voices. The second section looked at how participants talk about this experience to others (how others perceive them) and the third section focused on participants’ feelings about their experiences. The research sought to address the following research questions:

How do people who hear voices talk about their experiences?

What resources in the social domain do participants draw upon to negotiate this identity?

What are the consequences for the way in which this identity is negotiated?

D.6 Analytic Procedure

A critical discursive analytic approach was adopted to analyse the data (Edley, 2001). The first step involved selecting sections of text from the data corpus based on the research questions (Willig, 2013). This included parts of the text where participants attempted to construct or negotiate the experience of hearing voices. As previously mentioned, the methodology employed converges on two levels micro and macro. A micro level analysis of the action orientation of participants' talk, looks at what participants are trying to accomplish in interaction for example disclaiming, blaming, persuading. At this stage of the analysis an attempt is made to identify the rhetorical devices that support the discursive strategies, interpretative repertoires (common ways of talking about things, formed by shared social consensus), ideological dilemmas (deliberations, contradictions and inconsistencies in talk) and subject positions (Edley, 2001). Ideological dilemmas result from the dilemmatic nature of language, observed in the multiple and varied ways that speech can be composed, depending on the occasion (Edley, 2001). The macro level analysis was carried out on the texts already selected for the discursive analysis with a micro focus. This level of analysis looks at the broader discourses that participants draw upon to construct the experience of voice hearing. Positioning theory was also used to identify how participants position themselves within available discourses and with what consequence (Davies & Harré, 1990).

Discursive strategy refers to how someone positions themselves in a discourse and with what effect. Who we can be is therefore dependent on available positions in talk (Davie & Harré, 1990). This is a two-way process because discourses have an impact on individuals, however our practices and the way that participants position themselves, serves to reinforce or undermine discourses (Sims-Schouten et al., 2007). A critical approach attends to the power implications of these (Foucault, 1978). Due to the limitation of being able to present detailed findings in this paper, only three out of the six discursive strategies, employed by participants to do identity work, are presented here.

D.7 Analysis and Discussion

D.7.1 Findings

Participants used two main interpretative repertoires to construct their experience of hearing voices:

- Voice hearing was constructed as a difficult and distressing experience.
- Voice hearing was constructed as a normal and ordinary phenomenon.

The first repertoire is adopted by participants to construct the experience of hearing voices as a very distressing experience, which is often not understood by others. By drawing on this interpretative repertoire, participants are creating a division between themselves and others, through maximising difference in terms of their distressing experiences. In the second repertoire, participants use rhetoric devices to normalise the experience of hearing voices, to attain closer proximity with the rest of the population. By drawing on this interpretative repertoire, participants attempt to minimise difference by constructing their experiences as ordinary. These repertoires are contradictory and as we shall see further on, pose problems for the way that participants construct their identity.

In doing identity work, participants employed the six discursive strategies of blaming, disclaiming, justifying, reframing, normalising and trivialising. These strategies reveal how participants position themselves within available discourses to negotiate identity. Strategies have been divided into two groups as they have different consequences for identity construction. The ‘positioned as object’ strategies of blaming, disclaiming and justifying were employed by participants in response to being positioned within the dominant discourses of madness, violence and illness (Coombes, 2006). These strategies exemplify a negative identity practice, because in adopting these, participants are trying to distance themselves from a problematic identity. They are other-oriented and result in intensifying in-group/out-group differences (Wetherell & Edley, 2009). This construction of ‘otherness’ is an important aspect of doing identity work (Wetherell & Edley, 2009). On the contrary, the ‘positioned as subject’ discursive strategies of reframing, normalising and trivialising, attempt to construct a chosen identity by seeking to define what voice hearers are like. They are thus self-oriented.

In this paper, due to space limitations only the discursive strategies of reframing, normalising and trivialising will be illustrated using extracts from participants’ accounts. These strategies are covert in nature, are less easily challenged and are therefore more effective in negotiating a desired identity.

D.7.1.1 The discursive strategy of reframing

When participants’ identity is under threat, they employ the strategy of reframing, whereby a new interpretation is given to a problematic situation. It is not an outright disclaiming of the voice hearing identity, but an attempt to reframe it in less pathological terms. In the following extracts participants attempt to construct themselves as atypical category members, bringing themselves in closer proximity with the rest of the population:

Extract 1: Jack

Mine have been mo::::::re compassionate and ahm:::: (.) reasoning and and::::
helpful, as such, on occasions .hhh but that (.) I tend to be:::: the exception
to the case there (.) whereas most of the group (.) their voices eh::::: can be at times
↓distressing dark aggressive (.) .hhh and cause them some (2.0) quite some distress.

Extract 2: Flo

F: I hear voices::::, I experience psychosis::::, although the (.) as I (.) see:::: (.) the::::
hallucinations for what they are its pseudo psychosis [] (.) ahm:::: (3.0)
R: [mhm]
F: I can't really think of how else::: I would describe it. Or::: how else it's been
described to me::: []. Not on the top of my head.
R: [A:::]
R: Mmm what did you mean pseudo psychosis?
F: (.) Well::: a psychiatrist explained to me::: years ago, that because
I could recognise my hallucinations as hallucinations [] (.) they weren't
R: [A::::::]
F: true psychosis. Now I get delusions, which I believe (h) are true, I
don't see them as delusions, so I (2.0) if somebody (.) psychiatrist wants
to argue they are delusions (.) I would (.) debate that with him or her. .hhh
So they could say I'm psychotic on that. .hhh ahm::: (.) but the hallucinations
I can see as hallucinations [] so they're:::: called a pseudo psychosis, not a
R: [mhm]
F: (.) a total psychosis [] (.). Because I can see them (.) as (.) as not being (.) reality.
R: [mhm mhm]
F: So being false.

Both participants in the above extracts construct themselves as atypical category members (Snow & Anderson, 1987). This strategy allows for a less problematic identity, because participants do not position themselves within the negative discourses of fear, danger and pathology associated with schizophrenia and psychosis (Darrell-Berrill et al., 2013). In addition, Flo specifically draws upon a category entitlement, the expert opinion of the psychiatrist, to corroborate and strengthen her account. She also makes a concession by acknowledging that some psychiatrists may argue this is psychosis, pre-empting a potential counterclaim which renders her account more persuasive. Most participants used this discursive strategy to construct themselves in a positive way, by reframing their experiences in less pathological terms, for example, synaesthesia, a gift or autism.

D.7.1.2 The discursive strategy of normalising

Normalising is a discursive strategy that attempts to construct the experience of hearing voices as a normal, ordinary and common everyday phenomenon. The consequence of this strategy is to reduce the perception of difference and otherness, by establishing a level of proximity with the rest of the population (Wetherell & Edley, 2009).

Extract 3: Zoe

Z: people just can’t understand what it’d be like so they just
kinda like (.) ph:::: ‘I can’t relate the inside of my head to
the inside of your head’, which is really bizarre, cause the inside
of my head works in (.) a similar way to (.) well (.) everyone (.)
the inside of everyone’s head is pretty weird. And whenever you find
out something about somebody’s ways of thinking or::: (.) .hhh
beliefs and things, you’re like ↑‘What?’ (H) It doesn’t make any sense! (h).
So everyone’s different and weird and I don’t think it (.), you know, I
relate it quite often to (.) .hhh to my voices, are quite often troublesome
to me (.) in the night? That, you know, If I’m stressed [] (.) they’ll wake me up at
R: [mhm]
Z: like 3 in the morning, and kind of make lots of no::ise, but I know from
(.) other people that don’t hear voices, that when they’re stressed they
wake up at 3 o’clock in the morning with
their thoughts racing round in their heads. [] And that’s
R: [mhm]
Z: completely no::rmal. And I’m like ‘Well it’s not so:::: different from
that!’. It’s just like (.) my bod~ body and my brain reacting to the fact that
I’m stressed (.) and (.) disrupting my sleep. And (.) for you it’s your thoughts,

for me it’s the voices. (.) But that triggers off the thoughts anyway.
And it’s all~, you know~, (.) and the consequence - you’ve had a crap
night’s sleep and you wake up grumpy and tired the next day and we’re all
in the same boat (h). .hhh so ◦I don’t know◦.

Zoe works to establish a level proximity with the rest of the population using generalisation “everyone’s different and weird”. The frequent pauses and hesitation in this extract suggest that she is deliberating how to construct her account in doing identity work (Wetherell & Edley, 2009). She carefully chooses the footing and addresses the audience directly by saying “For you it’s the thoughts, for me it’s the voices”. The significant omission by Zoe, that voices can lead to considerable distress, indicates that she is making some deliberate omissions in constructing the account and the comparison between thoughts and voices serves to produce a naturalised version of self (Wetherell & Potter, 1989) rendering the account less susceptible to criticism. The concession she makes “I don’t know”, results in constructing an account that appears to be objective and free of bias, reducing her own stake in the conversation and is thus more believable.

Extract 4: Anna

A: That (.) it could be anybody with a mental illness.
R: Mhm=
A: =You could be sitting next to ‘em and not know. [] (.) You could be sitting
R: [mhm]
A: opposite them (.) .hhh, you know, opposite a manic depressive:::, you
could be sitting (.) .hhh next to somebody who’s:: suffering from anxi::ety:: (1), it’s
all walks of life. [] (.) Mental health (.) health (.) ill (.) ill health has got no boundaries, []
R: [mhm mhm] [mhm]
A: It’s (.) it could be anybody, [] It c c could be you tomorrow. [] (.) And that was the
R: [mhm] [mhm mhm]
A: message. (1) [] But we thought we’d ahm (.) use:::: schizophrenia as a (.) .hhh
R: [mmmm]
A: quite a:::: (.) a severe (.) mental illness.
R: Mhm

A: And ah::::: (.) show people that (.) we're not people that walk around with .hhh (1.0)
knives and guns and (.) go shooting people and (.) stabbing people and (.) .hhhh
things like that. (.). That we're we're ordinary people.

The footing that Anna adopts addresses the audience directly. It serves to evoke emotion and make the account more believable. By saying "it could be you tomorrow" creates more of an impact than just saying "it could be anybody". By saying that "mental ill health has got no boundaries", the boundaries between the in-group (those who hear voices) and out-group (those that do not) are blurred (Wetherell & Edley, 2009). This account constructs all as potential category members, bridging the gap between those that have a mental illness and those that do not. This discursive strategy serves to universalise the issue (Wetherell & Potter, 1989). In addition, Anna constructs people who hear voices as moral agents, rejecting dominant discourses of violence (Coombes, 2006) "we're not people that walk around with knives and guns". This construction of a naturalised version of the self, is no longer accountable and is no longer subjected to an evaluative social order (Wetherell & Potter, 1989).

D.7.1.3 The discursive strategy of trivialising

By trivialising their experiences, participants use this discursive strategy to construct their experiences in a way that is less worrying and problematic, with the purpose of saving face and reducing concern in others. Humour is often used to help manage difficult situations in this way and was also used by many participants in the current research (Gelkopf & Hasharon, 2009).

Extract 5: Zoe

Z: <But::: I am able to kind of (.) communicate (.)
the fact that (1) I hear voices~> I also think it's really
reassuring to people .hhh (.) ahm::: if I present it in a way that
you know, 'I've been hearing these voices, for such a long
time [] (.) and::: (1), you know, but I'm ok? (.) My life's alright?
R: [mhm]

Z: You know:: (.), I get on with it, I go to work, I~:: I do the things
that I'm doi::ng and:::: I have these (.) these (.) experiences
but (.) I'm used to it so:::::

Zoe in the above extract is detracting attention from her own experiences and diverting this to a concern about others. Others are constructed as the ones that need reassurance, instead of her, which enables her to retain a sense of control over her experiences. In addition, she constructs herself as a moral and conscientious agent, that seeks to protect others who may become concerned about her. This downplaying of events, by minimising the distressing experiences that she sometimes endures, is an effective way of protecting self-esteem (Smith & Mackie, 2007). The comments "I'm ok? My life's alright?" end with a question. She makes a concession by constructing this as a tentative account, because others who hear voices may have a different experience to hers and she therefore tries to pre-empt a potential counterclaim. In addition, by positioning herself within the new age discourse of one in four people have mental health problems (WHO, 2016), she is able to get on with her life despite her difficulties "I get on with it. I got to work".

Extract 6: Flo

F: Ahm:::: (2) it helps me::: by not (1.0) taking - things too seriously
at least in the moment of time that I'm (1.0) using humour.
R: Mhm
F: <It also:::: helps me help others. By (.) letting them kno::::w that I'm
ok>.
R: Mhm
F: (9.0)
R: Are you ok?
F: (1.0) Just that I know that (.) one friend in particular
worries a lot about me [], (.) cause I'm most honest with he:::r, so
R: [mhm]
F: if I take the piss out of myself (.) .hhh it means she doesn't have to
worry as much.
R: Mhm

F: .hhh so::::: (1.0) ahm:::: .hhh (1.0) yea I mean I wanna take the
piss out of myself because (.) it's sad.
Thank you. (5.0) It just (.) It makes it e:::asier:::. It's so::: hard and dark
so much of the ti:::me. .hhh You know, (.) you've (.) got to have a bit of light relie::f.

Flo in the above extract experiences an ideological dilemma, between seeking support from others in a time of need, but not worrying or upsetting them at the same time. Laughing about these distressing experiences, allows her to save face and reduce the guilt associated with being a burden to others. The negative consequences of this construction are others may not take seriously the distress that voice hearers experience and this distress gets missed. Honesty thus comes at a price. She is also constructing herself as a moral agent "it helps me help others", which contradicts dominant discourses that construct people who hear voices as dangerous or mad.

D.7.2 Discussion

All participants drew on both interpretative repertoires, of voice hearing as a distressing experience (maximising difference), and voice hearing as a normal, ordinary experience (minimising difference) bringing them in closer proximity with the rest of the population. These repertoires are contradictory; the former is associated with denigration and the later with idealisation (Reynolds & Wetherell, 2003). This poses implications for the identity work of people who hear voices. Reynolds & Wetherell (2003) have previously speculated that marginalised social categories often involve managing both denigrating and idealized positions simultaneously. The authors also suggest that a problem arises when there is an absence of collective methods of dealing with denigration, whereby positive constructions are overshadowed by the dominant denigrating ones. An example are the dominant discourses in society on voice hearing based on pathology and danger (Darrell-Berrill et al., 2016). The following discussion seeks to illustrate the identity work undertaken by people who hear voices, and in specific, the discursive strategies that they adopt in negotiating this.

The consequence of having to negotiate positive and negative constructions of voice hearing in the social domain, involves delicate footwork in identity work and in specific negotiating category membership (Reynolds & Wetherell, 2003). Identity is constructed by attending to insider/outsider issues, as categorisation is crucial to identity work (Bucholtz, 2009). Persons can only define themselves in comparison to others. This is what the discursive strategies of disclaiming, blaming and justifying achieve. It is what we expect from participants from a stigmatised group in trying to negotiate a 'spoiled' identity (Goffman, 1976). However, these strategies are not effective in constructing a positive identity for voice hearers, because they are overt in nature and by placing an emphasis on difference, increase the distance between the 'norm'. They are also less effective in reducing participants' stake in the accounts produced and may appear more biased. Participants appear to use these strategies as a last report and in the absence of alternative, more positive constructions. On the other hand, the discursive strategies of reframing, normalising and trivialising, are not normally what we would expect from participants trying to negotiate a troubled identity. They are covert strategies and thus less likely to attract criticism. This can be observed in the way that participants construct themselves as atypical category members, but also in the way that they attempt to normalise and trivialise their experiences to attain a closer proximity with the rest of the population, maximising sameness. The 'positioned as subject' strategies, construct accounts as routine, ordinary and familiar, and are effective ways of constructing factual accounts (Potter, 1996).

These strategies suggest that there is a lot of work required to negotiate the identity of being a voice hearer. It is a problematic identity. The question remains, whether it is possible for participants to draw upon the more positive and idealised repertoires, without having to construct themselves as atypical category members, minimise the distress they experience or resort to the discursive strategies of disclaiming, blaming and justifying. The dominant discourses of pathology and danger often associated with these experiences, are hard to resist, particularly as they inform our institutions and practices. There is also a material reality that needs to be acknowledged, because incarceration in a locked ward has real consequences for people who hear voices (Sims-Schouten et al., 2007). Within this setting, where the predominant discourse is a medical one, they have no freedom and little control over their treatment. Therefore, positioning oneself within a medical discourse, offers limited possibilities for action.

In the absence of more benign discourses of voice hearing, participants resort to the 'positioned as object' strategies of blaming, disclaiming and justifying. These strategies are less effective, because they are overt and serve to intensify difference. This was observed where participants attempt to create binaries that construct others as more 'crazy' or 'bad' than people who hear voices. Many participants attempted to do this by constructing an in-group/out-group division between good and bad people, where hearing voices is irrelevant. This tendency to formulate the world through binaries for example good vs bad, are discursive techniques that intensify notions of otherness (Wetherell et al., 2001). The ‘positioned as object’ strategies result in negative discursive practices that participants use to distance themselves from a rejected identity (Butzolch, 2009). Especially when their identity is under threat, when they are accused and made to account for their actions (Reynolds & Wetherell, 2003). The ‘positioned as object’ strategies aim to define what voice hearers are not and are thus other-oriented. On the contrary, the ‘positioned as subject’ discursive strategies of reframing, normalising and trivialising are positive discursive practices, that aim to define what voice hearers are like and are thus self-oriented.

The discursive strategies of reframing, normalising and trivialising, are more effective in constructing a positive identity and allow participants to attain a degree of proximity with the rest of the population. These strategies, however, reinforce the power of normalisation if participants minimise their experiences to appear ‘normal’ and highlights the lack of positive resources that may allow them to construct their identity in preferred ways. Even the ‘recovery’ and HVN (Hearing Voices Network) trauma discourses can be problematic. The recovery discourse suggests that individuals can ‘recover’ from their ‘mental illness’, even if this is not necessarily a complete cure. It aims to empower individuals to strive to attain a better quality of life despite difficulties. However, this construction is problematic if material conditions for example unemployment, financial difficulties due to reliance on benefits and isolation in terms of social support, prevent persons from achieving recovery. Recovery thus is not attained solely by the individual and requires other factors that sometimes may be out of peoples’ reach. In addition, the trauma based discourse of the HVN, can serve to victimise people who hear voices by suggesting again different therapeutic interventions that will enable an individual to overcome the trauma that they have sustained. It is argued that even ‘normalising’ discourses are not emancipatory in nature and serve to reinforce the status quo, by continuing to marginalise those in distress. They divert attention away from the social ills of society, locating problems in the individual. Whereas, other more critical discourses, such as anti-psychiatry for example, are rejected (Kitzinger, 1989). What is suggested here is that there is a lack of discursive resources that construct the experience of hearing voices in a positive light. Without a supporting cast, support by professionals and the public alike, such constructions will not gain momentum. What is troublesome about these findings is that participants want their experiences of hearing voices to be viewed more positively, however this becomes problematic if they acknowledge that they do not want to be members of the category, minimising the distress they experience. There is a desire to retain 'normality', which is almost impossible to achieve with the current available discourses that serve to perverse the status quo and the existing social order.

Navigating this dilemma posed by the polarised interpretative repertoires has proven to be very difficult for participants, because they are damned if they do and damned if they don't. Maximising difference, inequalities and oppression, may further serve to marginalise and exclude them from society. On the other hand, normalising and minimising serves to assimilate them into society. However, the cost of trivialising these experiences is high, leading to people that hear voices not being understood and not getting the support that they need. There is a price for negotiating a more positive identity for voice hearers, in trying to bring themselves closer in line with the rest of the population.

D.8 Conclusions

People who hear voices are faced with an ideological dilemma in negotiating identity. They construct themselves in a positive light using the discursive strategies of reframing, normalising and trivialising, however by doing so they are doing themselves a disservice because they minimise the distress they experience. Thus, the suffering they endure is missed. This can sometimes have severe consequences for people who hear voices if they do not get the support that they need. As one participant commented she lost a lot of friends to suicide. If people who hear voices choose to talk about their experiences, they risk being perceived by others as 'defective' and subjected to interventions available by the psy-complex to treat this 'deficiency' (Parker, 1994). There does not appear to be an easy solution on how to negotiate this identity in the social domain. The purpose of this research was to shed light on the ideological patterns present around the experience of voice hearing, with the purpose of constructing alternative views of this experience.

It has been suggested that working against a preferred sense of self, can be damaging for identity (Brown & Augusta-Scott, 2008). Identities are profoundly political and serve the interests of the dominant social order. As we have seen, even the discourses of recovery and trauma (HVN) are accommodative, and despite being better than more pathological constructions of voice hearing, they continue to reinforce the status quo by problematising the individual. We need to challenge these concepts if we are to enable people who hear voices, to construct preferred identities that do not reinforce the dominant social order. Working towards a preferred identity, should also be included as part of our interventions for people who hear voices, which is facilitated by an understanding of the discursive strategies that they employ to negotiate this identity. Furthermore, we should neither enforce our own theoretical models on people who hear voices, nor prescribe what is the right way to be or live. All we may do is facilitate the dialogical, so that people who hear voices can construct a preferred identity. Guildfoyle (2014) describes these as escape routes to oppressive ways of being. Professionals should thus support people who hear voices in the lives they want to pursue. Individual work is not sufficient however and efforts that engage in political action, to address problems in society, should be at the forefront of our agenda.

D.9 References

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APPENDICES

APPENDIX B.1 Study Advertisement

Research Request: Constructions of voice hearing

CITY UNIVERSITY
LONDON

Department of Psychology

PARTICIPANTS NEEDED FOR RESEARCH ON HEARING VOICES

Welcome,

My name is Rebecca Aloneftis and I am a trainee counselling psychologist at City University of London. As part of my doctoral training I would like to undertake a research project, which looks at how individuals construct meaning from their experience of hearing voices. My research approach assumes that we create meaning through language and through our interaction with others. In this meaning making process, we also draw upon collectively shared understandings in society e.g. from the media and our institutions. My research attempts to look at how individuals who hear voices talk about their experiences in the current socio-cultural and political climate, as well as the implications of talking about hearing voices in this way on identity and one’s sense of self.

You are eligible to take part in this study

- If you have a lived experience of hearing voices and are over the age of 18.
- If you are willing to spare 45-60 minutes of your time to attend an interview.

You will be asked to

- Sign a consent form to confirm that you wish to take part in this research.
- Take part in a 1:1 interview with the researcher, followed by a debriefing session.
- Let the researcher know if you have experienced any distress from taking part in this research. Contact details with be provided, together with a list of other available sources of support.

You have the right not to take part in this research and to withdraw from the study at any time without further consequences, in which case your data will be destroyed.

For further information about his study please download the participant information sheet or contact the researcher directly at [redacted] ☎ +[redacted] **Download: Participant Information Sheet**

This research has been reviewed and approved by the City University London Psychology Department Research Ethics Committee.

APPENDIX B.2 City University Ethics Form

CITY UNIVERSITY
LONDON

Psychology Department Standard Ethics Application Form:

Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? ***For each item, please place a 'x' in the appropriate column***	**Yes**	**No**
Persons under the age of 18		x
Vulnerable adults (e.g. with psychological difficulties)	x	
Use of deception		x
Questions about potentially sensitive topics	x	
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		x
Potential for psychological stress, anxiety, humiliation or pain	x	
Questions about illegal activities		x
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		x
Potential for adverse impact on employment or social standing		x
The collection of human tissue, blood or other biological samples		x
Access to potentially sensitive data via a third party (e.g. employee data)		x
Access to personal records or confidential information		x
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		x

If you answered 'no' to all the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. You cannot start your research until you have received this code.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. You cannot start your research until you have received this code.

Which of the following describes the main applicant? ***Please place a 'x' in the appropriate space***	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	x
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s).
Rebecca Aloneftis
2. Email(s).
[redacted]
3. Project title.
Constructions of voice hearing; a psychosocial approach
4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)
Prior research into the experience of hearing voices has attempted to look at appraisal of the voice hearing experience and links to distress (Mawson, Cohen & Berry, 2010). Others have taken a relational approach to voice hearing and suggest that social schemata play a part in how individuals relate to voices (Paulik, 2012). The experience of voice hearing can be argued to exist on a spectrum of normal experience, and is not inextricably linked to a diagnosis of psychopathology. Few studies have attempted to explore the subjective experience of voice hearing using a qualitative approach (Chin et al., 2009; Jackson et al., 2010; Larkin & Morrison, 2006; Andrews et al., 2008; Goldsmith, 2010). One of the findings of Chin et al.'s (2009) study was that individuals

sought different explanations to make sense of their experience of hearing voices. Goldsmith (2010) conducted a discourse analysis on voice hearers' published recovery stories but the sample was small as consent was obtained from only two individuals to use their stories. Using 1:1 interviews may be a more suitable method for generating the in-depth and rich data required to access voice hearers' subjective experiences.

This research will use a psychosocial approach to explore how individuals who hear voices construct their experience in the current socio-cultural-political climate. As part of the discursive analytic approach to the data, a tentative attempt is made to try to gain access to the implications on subjectivity that such discursive constructions have for individuals (stage 6 - Foucauldian Informed Discourse Analysis by Willig, 2013). There are questions as to whether subjectivity can be theorized based on discourse alone (Willig, 2013). Psychoanalytic concepts have previously been used for this purpose in a tentative attempt to explore the emotional investment that choosing one discourse over another has for individuals (Frosh and Saville Young, 2008).

The aim of the research is to look at the ways in which social and psychological factors may be implicated in individuals' constructions of their voice hearing experience. The psychosocial method aims to look at what discourses voice hearers draw upon, what subject positions these discourses allow and the intra-psychic factors that may be implicated in adopting these positions. The analysis will attend not only to what is said, but also to how it is said and what may not be said, by looking at the structure of language using Lacanian psychoanalytic theory (Parker, 2014).

5. Provide a summary of the design and methodology.

The research design is a flexible design suitable for a qualitative approach. The research paradigm is critical/ideological with a predominantly social constructionist framework and relativist ontology. A relativist stance suggests that the interpretations made by the researcher are tentative and offer a point of view set within a particular context. It does not aim to offer a final interpretation of the data, but to ask questions instead. The flexible research design suggests that research questions, method and analysis may be modified throughout the course of the research and thus the process of gaining consent shall be continuous. A qualitative study aims to capture the subjective experiences of participants and therefore in-depth semi-structured interviews will be carried out and prompts will be used.

The analytic approach used is a Foucauldian Informed Discourse Analysis, carried out in 6 stages as suggested by Carla Willig (2013). Step 1 involves identifying how voice hearing is constructed; step 2 aims to identify the different ways that voice hearing is constructed and focuses on differences between

these constructions; step 3 looks at the action orientation of discourses – what is the function of these constructions; step 4 identifies the subject positions that these constructions allow and locate discourses within a wider context; and stage 5 investigates how particular discourses open up or close down certain ways of being, limiting what can be said and done. The final stage 6, attempts to look at the implications for subjectivity of adopting such positions, by looking for example at what may be felt and experienced. Lacanian psychoanalytic theory is used to inform this stage of the analysis and to deconstruct what participants' say, by looking at how they talk about voice hearing, including what can and what cannot be said using language.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

1:1 in-depth interviews will be conducted of a duration between 45-60 minutes. The interviews will be audio-recorded following consent from the participants. The interview schedule employed will be used flexibly and is made up of topic areas that the researcher wishes to explore. Questions are open ended and prompts will be used by the researcher to follow up the participants' responses, with the purpose of gaining in-depth data for a qualitative analysis (please see attached interview schedule with topics of interest to the researcher).

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

It is possible that a participant may disclose issues of emotional and psychological concern when talking about hearing voices and private experiences. If the nature of the concern is related to distress experienced from hearing voices, then the researcher will contact the HVN group facilitators, who are either health professionals or persons with a lived experience of voice hearing, trained to deal with such issues that arise from talking about voices. If further support is required in addition to the support provided by the HVN, participants will be referred to their GP or for urgent mental health issues directly to Hertfordshire Partnership University NHS Foundation Trust on the following contact details: Single Point Access 0300 777 0707. Out of hours participants will be given the OOH mental health line on 01438 843322.

For individuals already known to mental health services, an up to date risk assessment plan is given to the HVN facilitators before the individual joins the group. The relevant local community mental health teams that support individuals can be contacted in this instance.

Support will be offered to participants upon completion of the study and the researcher’s contact details and other sources of support will be provided should any adverse effects be experienced during and after taking part in the study.

8. Location of data collection. (If any part of your research takes place outside England/Wales please also describe how you have identified and complied with all local requirements concerning ethical approval and research governance.)

The data collection will occur at ‘Hearing Voices Group’ premises due to the availability of group facilitators that may be able to offer support. Participants will be fully reimbursed for any costs that they incur to travel to the site of the interview.

9. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

Inclusion criteria: Participants will be over the age of 18, self-identify as having an experience of hearing voices, and have capacity to give consent to participate in the research i.e. understand the purpose and aims of the research, the implications of participation, including the possibility of adverse effects experienced from taking part. There are no other exclusion criteria.

10. How will participants be selected and recruited? Who will select and recruit participants?

Following permission from the Hearing Voices Network, the researcher will approach the local Hearing Voices groups in South East Herts, with the purpose of presenting in person the research aims, purpose, procedures and other relevant participation information (confidentiality, anonymity, use of data) to group members. The researcher will ask for individuals to contact her in confidence via email or telephone should they wish to participate or discuss participation further with no obligation. Should this recruitment strategy not generate sufficient numbers of participants, an advert will be placed on the national Hearing Voice website. Once sufficient numbers of participants is reached, in line with the requirements of the research method, the advertisement will be removed from the website, to ensure that no participants wanting to take part are excluded.

The researcher will be the sole individual responsible for the recruitment of participants.

It will be emphasised that group members’ willingness to participate will not in any way influence their HVN group membership. If recruitment in person is not possible, an advertisement may be placed on the Hearing Voices Website, where participants may contact the researcher directly if they wish to participate in the study (please see attached). The participation information sheet will also be published on the Hearing Voices Website, together with the advert requesting participation.

11. Provide details of any incentives participants will receive for taking part.

No financial incentives or gifts will be given. By taking part in this research study, participants are given the opportunity to talk about their experience of hearing voices. This research is emancipatory in nature, as it aims to give voice to certain groups in society, which may have not previously had the opportunity to have their views heard.

12. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

Informed consent will be obtained from all participants during the recruitment process (verbally) and prior to commencing the interview (in writing). It will also be emphasised that participants may withdraw consent at any time during the process, in which case any data already collected will not be used and will be immediately destroyed.

13. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

Prior to commencing the interviews, the participant information sheet (see attached) will be given to participants. Time will be given to participants to allow them to ask any questions that they have with regards to the research before they are asked to sign the consent form. Upon completion of the research, participants will be given some time with the researcher to discuss how they found the interview and if they have any issues that they would like to discuss, including any adverse effects that may have occurred. A debrief information sheet has been prepared for participants with support information (see attached).

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

In the eventuality of an inadvertent disclosure to the researcher of material of a sensitive or emotive nature, participants will be signposted to available resources for support. Furthermore, the researcher will not pose any direct questions relating to material of a sensitive nature (please see interview schedule for example questions). Aftercare will be provided and necessary referrals made to relevant services should the researcher and HVN existing

support currently in place are not sufficient to deal with any issues that may arise.	
15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.	
As above, there is a risk of disclosure of trauma or sensitive personal information to the researcher, which may have an indirect impact on the researcher. Supervision and personal therapy will be utilised in such an event, which are both currently in place.	
16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)	
Please place an 'X' in all appropriate spaces	
Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	**x**
Participants being referred to by pseudonym in any publication arising from the research	x
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	x
Use of direct quotes will be used with specific permission only and a signed consent form obtained.	
17. Which of the following methods of data storage will you employ?	
Please place an 'X' in all appropriate spaces	
Data will be kept in a locked filing cabinet	x
Data and identifiers will be kept in separate, locked filing cabinets	x
Access to computer files will be available by password only	**x**
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below.*	
18. Who will have access to the data?	

Please place an 'X' in the appropriate space	
Only researchers named in this application form	x
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist.

*Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	Not applicable
***Text for study advertisement**	x	
***Participant information sheet**	X	
***Participant consent form**	x	
Questionnaires to be employed		x
Debrief	x	
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation)		x
Topic guide for the interviewer	x	

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

In-depth qualitative interviews will be carried out to investigate how people who hear voices talk about these, to identify the discourses that they draw upon when talking about voices and the subjectivity that the subject positions enable, and to tentatively attempt to access subjects' emotional investment in talking about voices in this way. The psychosocial approach adopted tries to look at how voice hearers talk about the voices, in addition to what they say about these (content), and uses psychoanalytic theory in the final stage of discourse analysis to pay attention to what cannot be said using words.

Please place an 'X' in all appropriate spaces

	Yes	No
(b) Does the research involve any of the following:		

Children under the age of 5 years?		x
Pregnant women?		**x**
Clinical trials / intervention testing?		x
Over 5,000 participants?		x
(c) Is any part of the research taking place outside of the UK?		x

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to anna.ramberg.1@city.ac.uk, before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name ……………………………………………. Date……………………………

21. Information for reporting purposes.

Please place an 'X' in all appropriate spaces

(a) Does the research involve any of the following:	**Yes**	**No**
Persons under the age of 18 years?		x
Vulnerable adults?	**x**	
Participant recruitment outside England and Wales?		x
(b) Has the research received external funding?		x

22. Declarations by applicant(s)

Please confirm each of the statements below by placing an 'X' in the appropriate space

I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.	x
I accept the responsibility for the conduct of the procedures set out in the attached application.	x
I have attempted to identify all risks related to the research that may arise in conducting the project.	**x**

I understand that **no** research work involving human participants or data can commence until ethical approval has been given.	x

	Signature (Please type name)	**Date**
Student(s)	**Rebecca Aloneftis**	**22/02/15**
Supervisor	**Julianna Challenor**	**23/02/15**

Reviewer Feedback Form

Name of reviewer(s).			
Committee			
Email(s).			
Psychology.ethics@city.ac.uk			
Does this application require any revisions or further information?			
Please place an 'X' the appropriate space			
No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk, ccing to the supervisor.		**Yes** Reviewer(s) should provide further details below and email directly to the student and supervisor.	x
Revisions / further information required To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.			

Date: 1/4/2015

Comments:

1. The committee felt that the HVN logo should be removed from the advert to avoid giving the impression that City officially endorsed the work of HVN, or vice versa.
2. The committee noted that there was no information about psychiatric conditions in the Debrief. It felt that for the purposes of balance, some information about psychiatric conditions should be included (e.g. 'Hearing voices may in some instances be considered a symptom of conditions such as schizophrenia…..'), together with details of where participants might find further information and support (e.g. relevant NHS pages, contact details for MIND).
3. Please include more detail in section 7 about the way in which HVN procedures will be utilized and the other relevant services that participants may be signposted to. The

committee felt that more information should be provided about the way in which the researcher would respond to concerns raised by participants that they may be suffering from a clinical condition such as schizophrenia.

4. The committee felt that data collection should take place at the HVN premises where appropriate support would be available (Section 8).
5. The committee felt that it would be inappropriate for the researcher to provide psychological support to participants. Please adjust in section 14.
6. In section 15, please refer to the lone worker guidelines and complete and submit a risk assessment (both are available on Moodle).
7. In the information sheet, please provide some indication of when confidentiality may need to be breached.
8. Telephone numbers on the advert and debrief should be City University phone numbers. Please adjust.
9. In the advert and information sheet, please remove or rephrase the sentence ‘I am required to undertake a research project’. The committee felt this sounded like the applicant might be uninterested in the research!
10. Please use the correct name of the research committee in the advert and information sheet (City University London Psychology Department Research Ethics Committee).
11. Please insert the purpose of data collection into section 2 of the consent form (e.g. ‘to answer the research questions’).

Applicant response to reviewer comments

To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), with tracked changes directly back to the reviewer(s), ccing to your supervisor.

Date:3/4/15

Response:

1. The logo has been removed from the advert.
2. I have added an additional section on the debrief form about how voice hearing may be considered as a symptom of schizophrenia and when a participant may need to seek professional support e.g. if they experience distress from hearing voices. Details of the local NHS mental health services and MIND have been included on the debrief form.
3. In section 7, I have added more details on how I may respond to concerns raised by participants and particularly in response to participants that may either feel they are suffering from a clinical condition or that may already be known to mental health services.
4. I have amended the location of the interviews to be at VHN premises (section 8).
5. I have removed in section 14 the suggestion that the researcher can offer direct support to participants as suggested, although I did not mean it in a sense of psychological support but perhaps an empathic response to the concerns raised.
6. A lone worker risk assessment has been completed and attached.
7. On the information sheet, I have now included under which circumstances confidentiality may be breached.
8. Telephone numbers have been adjusted to City University main number.
9. I have changed the wording to show more enthusiasm towards my project.
10. The correct name for the research committee has been added to the relevant documents.
11. The purpose of the data collection has been added on the consent form (section 2).

	Signature (Please type name)	**Date**

APPENDIX B.3 Letter from Ethics Committee

From: Katy Tapper [mailto:[redacted]]
Sent: 22 April 2015 14:12
To: PG-Aloneftis, Rebecca
Cc: Challenor, Julianna; Hunt, Karen
Subject: Re: ethics application

Dear Rebecca

Thanks for these amendments. The project has been approved on the following conditions:

1. Please adjust the section in the Debrief that states ‘You may also enquire about Improved Access to Psychological Therapies’, as this does not really make sense in this particular context (and also includes a typo).

2. In the Debrief, please include an easy to access online source of information specifically about schizophrenia.

3. The sub-committee felt that some participants may want to access information about schizophrenia if even they weren’t experiencing distress. As such, please adjust the phrasing in the Debrief to reflect this.

I am ccing to Karen so that she may issue you with a formal letter of approval (stating the above conditions). Please forward Karen the final version of your Debrief together with your risk assessment when you have them, for our records.

Hope the research goes well!

Best wishes, Katy

APPENDIX B.4 Ethics Approval Certificate

CITY UNIVERSITY
LONDON

Psychology Research Ethics Committee

School of Social Sciences

City University London

London EC1R 0JD

24th April 2015

Dear Rebecca Aloneftis

Reference: PSYCH (P/F) 14/15 144

Project title: Constructions of voice hearing; a psychosocial approach

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee. Approval is conditional upon the following amendments:

1. Please adjust the section in the Debrief that states ‘You may also enquire about Improved Access to Psychological Therapies’, as this does not really make sense in this particular context (and also includes a typo).

2. In the Debrief, please include an easy to access online source of information specifically about schizophrenia.

3. The sub-committee felt that some participants may want to access information about schizophrenia if even they weren’t experiencing distress. As such, please adjust the phrasing in the Debrief to reflect this.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period, you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (anna.ramberg.1@city.ac.uk), in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Karen Hunt	Katy Tapper
Departmental Administrator	Chair
Email: [redacted]	Email: [redacted]

APPENDIX B.5 Letter of invitation to participants

LETTER OF INVITATION

Title: Constructions of voice hearing; a discursive approach.

Dear participant,

I am a second-year trainee Counselling Psychologist and as part of my doctorate studies, I am undertaking a research project. My chosen area of study is voice hearing, due to my extensive experience of working with individuals who hear voices.

I am interested in knowing more about how individuals who hear voices make sense of these, particularly in relation to current socio-cultural-political climate, and the impact that these views have on voice hearers' sense of self. In addition, as a practising clinician, I am also interested in how individuals talk about voices and why they talk about these in a certain way.

Anyone choosing to participate will be asked to sign a consent form to take part in one short audio taped interview with an estimated duration of approximately 45 to 60 minutes. Data gathered during this process will be treated as confidential and kept in a secure location that will only be accessed by the researcher for the purposes of this study. The data collected may be used for publication purposes. However, pseudonyms will be used instead of names and every effort will be made to conceal potentially identifiable information.

You have the right not to take part or to withdraw from the study at any time without further consequences.

I hope that you may see this as an opportunity to take part in a study, which will enable you to voice your views about how you make sense of your experience of hearing voices. This will contribute to a better understanding of the subject.

Thank you for taking time to read this sheet. If you have further questions before deciding to take part, please feel free to contact me at the details provided here below.

Researcher contact details
[redacted]

Supervisor contact details
[redacted]

CITY UNIVERSITY
LONDON

APPENDIX B.6 Participant information Sheet

Title of study: Constructions of voice hearing; a discursive approach

I would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

I am a 3rd year trainee counselling psychologist and as part of my doctorate studies, I would like to undertake a research project on hearing voices. I have chosen this area of study, due to my extensive experience of working with individuals who hear voices.

I am interested in knowing more about how individuals who hear voices make sense of these, particularly in relation to current socio-cultural-political views and practices in our society, and the impact that these views have on voice hearers' sense of self. In addition, as a practising clinician, I am also interested in how individuals talk about voices and why they talk about these in a certain way.

Why have I been invited?

You have been chosen to take part in this study because you have lived experience of hearing voices and thus have expert knowledge with regards to this subject. In addition, I have chosen to recruit participants from the Hearing Voices Network, because this network encourages the sharing of multiple explanations for hearing voices. I am looking to recruit no more than 8 participants to take part in this study. To take part, you need to be over the age of 18 and have or have had a lived experience of hearing voices.

Do I have to take part?

Participation is voluntary and therefore you have the right not to take part or to withdraw from the study at any time without further consequences. If you chose to withdraw from the study, any data gathered will be removed from the data set and will subsequently be destroyed. Participation will not in any way influence your group membership with the Hearing Voices Network. If you chose to take part in the study, you reserve the right to refuse to answer any questions that you may find too intrusive or personal.

It is up to you if you would like to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

- You will need to attend a 45 - 60 minute interview.
- The interviews will take place at 'Hearing Voices Network' premises wherever possible for ease of access, alternatively these can be held at City University London premises. You will be reimbursed for any travel expenses incurred.

- Prior to the interview you will be asked if you have any questions that you would like clarified.
- Following the interview. you will be asked to remain at a short debriefing session, lasting for approximately 15 minutes, where the interviewer will seek your feedback on how you found the interview and whether you have experienced any distress from taking part.

What do I have to do?

For the purposes of this study, you are required to answer questions about your experience of hearing voices. For example, you may be asked, how do you make sense of your experience of hearing voices? Where your views originated from? And how this impacts on your sense of self (who you think you are as a person)?

What are the possible disadvantages and risks of taking part?

It is likely that due to the nature of the subject under discussion – hearing voices – that information of a sensitive, personal or emotive nature may advertently or inadvertently be disclosed to the researcher, causing distress or embarrassment. The researcher will make every effort to create a safe environment for you to be able to discuss your experiences freely, by adopting an empathic, accepting and non-judgmental approach.

What are the possible benefits of taking part?

Taking part in this study is an opportunity to voice your views about how you make sense of the experience of hearing voices, which may contribute to a better understanding of the complex phenomenon of hearing voices; potentially informing current practices in many domains, as well as public perceptions on voice hearing.

What will happen when the research study stops?

Upon completion of the research audio recordings will be destroyed by being erased. The transcribed data from the interviews will be held for a period of 5 years following completion of the research.

Will my taking part in the study be kept confidential?

- The researcher and research supervisor will be the only individuals that will have access to the interview data.
- Audio recordings and transcribed interview data will be kept in a password protected laptop, kept in a locked and secure location.
- Pseudonyms will be used instead of real names to code the data. If direct quotations are used in the report every effort will be made by the researcher to remove any potentially identifiable information.
- There are some limits to confidentiality: if what is said in the meeting makes me think that you, or someone else, may be at significant risk of harm I would have to speak to my supervisor about this.

What will happen to the results of the research study?

The findings of this research study, in the form of a report, may be published in a journal, The British Library Service and the web. You may request a copy of the report from the researcher at the contact details provided. Direct quotations may be used in this report, but all identifiable information such as your name will be removed.

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

You have the right to withdraw from this study without explanation or penalty at any time.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Constructions of voice hearing; a discursive approach

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone’s negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee, [*ethics approval code PSYCH (P/F) 14/15 144*].

Further information and contact details

Researcher contact details

[redacted]

[redacted] ☎

Supervisor contact details

[redacted]

[redacted] ☎

Thank you for taking the time to read this information sheet.

APPENDIX B.7 Participant consent form

CITY UNIVERSITY
LONDON

Title of Study: Constructions of voice hearing; a discursive approach

Ethics approval code: [*PSYCH (P/F) 14/15 144*]

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped • being asked questions about my experience of hearing voices • the findings of the research being published in a journal or the web.	
2.	This information will be held and processed for the following purpose(s): The sole purpose of the data collection is to answer the research questions posed by this study. I understand that any information I provide is confidential, and even though direct quotations may be used in the write up, that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that audio recordings will be destroyed upon completion of the research study, which is estimated to be after a period of 2 years. Written transcriptions of the interviews will be kept for 5 years following completion of the research.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all the project, and that I can withdraw at any	

	stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University of London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

______________________ ______________________________ ______________

Name of Participant Signature Date

______________________ ______________________________ ______________

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

APPENDIX B.8 Interview Guide

Themes	Possible questions
Defining the experiences of hearing voices in relation to self	How would you describe yourself?
	Tell me a little bit about yourself.
	Tell me what is it like to hear voices?
	Tell me about your experience of hearing voices.
Talking about the experience of hearing voices to others	How do you make sense of your experience of hearing voices?
	How would you describe your experiences?
	How would you talk about it to someone?
	Is voice hearer a term that you would apply to yourself?
	How else would you describe your experiences?
Making sense of the experience. Impact on sense of self	What does it mean to you, to be someone who hears voices?
	How does this experience affect you?

APPENDIX B.9 Debrief Sheet

Debrief Questions

1.How did you find the experience of taking part in this interview?

2.Have any questions caused you to feel any discomfort or brought up uncomfortable feelings or memories for you?

3.How do you feel after taking part in this research?

4.Would you like any additional support from the researcher?

5.Is there any feedback that you would like to give to the researcher about the way that the interview has been carried out?

6.Is there anything that you think could have been done differently or better?

APPENDIX B.10 Post-interview support sheet

CITY UNIVERSITY
LONDON

Constructions of voice hearing: a discursive approach

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished I'd like to explain the rationale behind the work.

The purpose of this research was to look at how you make sense of your experience of hearing voices within the current cultural-socio-political climate and the impact that such constructions have on your sense of self.

Should you experience distress from taking part in this research either now or in the future, you may find the following resources useful:

- **Hearing Voices Network**.

  C/o Sheffield Hearing Voices Network,
  Limbrick Day Service, Limbrick Road,
  Sheffield, S6 2PE

  Email: nhvn@hotmail.co.uk | **Phone**: 0114 271 8210

  Web: http://www.hearing-voices.org/

- **Samaritans** offer emotional support 24/7 08457 90 90 90

- Who to contact if you need urgent support

  If you feel like harming or hurting yourself or other people:

  - Dial 999
  - Go to your nearest Accident and Emergency department (A&E). You can search for your local department through the NHS Choices website.

  For non-emergency situations:

- Visit your GP
- Call NHS 111 (NHS Direct) – open 24 hours a day, 365 days a year. They can tell you about your local crisis support services or your nearest A&E.
  Tel: 111
  Web: www.nhsdirect.nhs.uk

Hearing voices may in some instances be described to be a symptom of schizophrenia or otherwise known as psychosis. If you wish to know more about schizophrenia or wish to seek support, you may utilise the following sources:

- Understanding Psychosis and Schizophrenia
  http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/understanding-psychosis-and-schizophrenia

- Camden and Islington NHS Foundation Trust
  St. Pancras Hospital, 4 St. Pancras Way, London, NW1 0PE General Enquiries 02033173500 Out of hours 08009882149

- MIND in Camden
  Tel: 0207 911 0822
  http://www.mindincamden.org.uk/ Email: admin@mindincamden.org.uk

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact me:

Researcher contact details

[redacted]

Tel. [redacted]

If you wish to make a complaint or discuss any issues with regards to this research, you may wish to contact my research supervisor at the following:

Supervisor contact details

[redacted]

Tel. [redacted]

Ethics approval code: *[PSYCH (P/F) 14/15 144]*

APPENDIX B.11 Risk Assessment Form

Hazard	**Type of injury or harm**	**People affected and any specific considerations**	**Current Control Measures already in place**	**Risk level** Med High Low	**Further Control Measures required**	**Implementation date & Person responsible**	**Completed**
Working off site City University Being a lone worker	Injury to self or others	The researcher, participants	Details of interview (date/time) will be given to safety contact – either supervisor or fellow student. Interviews will be conducted during office hours and in a public place (Community building). I will ensure that I will not be the sole person in the building when the interviews are conducted. Mobile number will be given and notifications made on my arrival and departure from the location to my safety contact. 7/15 3 x members who run the Hearing Voices Group will also be present in the building during my interview with 2 x participants and made themselves available should any issue arise. Site manager within easy reach and contactable by phone.	**Low**	Knowledge will be gained of the local area prior to the interviews and of security procedures in the building e.g. who to contact, fire exits etc. Discussed issues of potential risk with site manager. None anticipated.	**Rebecca Aloneftis**	**Yes**

APPENDIX B.12 Transcription Annotation

[ ]	Square brackets mark the start and end of overlapping speech. They are aligned to mark the precise position of overlap.
↑↓	Vertical arrows precede marked pitch movement, over and above normal rhythms of speech. They are used for notable changes in pitch beyond those represented by stops, commas and question marks.
→	Side arrows are used to draw attention to features of talk that are relevant to the current analysis.
Underlining	indicates emphasis; the extent of underlining within individual words locates emphasis and indicates how heavy it is.
CAPITALS	mark speech that is hearably louder than surrounding speech. This is beyond the increase in volume that comes as a by-product of emphasis.
°↑I know it,°	'degree' signs enclose hearably quieter speech.
that's r*ight.	Asterisks precede a 'squeaky' vocal delivery.
(0.4)	Numbers in brackets measure pauses in seconds (in this case, 4 tenths of a second). If they are not part of a speaker's talk, they should be on a new line. If in doubt use a new line.
(.)	A micropause, hearable but too short to measure.
((stoccato))	Additional comments from the transcriber, e.g. about features of context or delivery.
she wa::nted	Colons show degrees of elongation of the prior sound; the more colons, the more elongation.
hhh	Aspiration (out-breaths); proportionally as for colons.

.hhh	Inspiration (in-breaths); proportionally as for colons.
Yeh,	‘Continuation’ marker, speaker has not finished; marked by fall-rise or weak rising intonation, as when delivering a list.
y’know?	Question marks signal stronger, ‘questioning’ intonation, irrespective of grammar.
Yeh.	Full stops mark falling, stopping intonation (‘final contour’), irrespective of grammar, and not necessarily followed by a pause.
bu-u-	hyphens mark a cut-off of the preceding sound.
>he said<	‘greater than’ and ‘lesser than’ signs enclose speeded-up talk. Occasionally they are used the other way round for slower talk.
<he said>	Arrows in this direction show that the pace of the speech has slowed down.
solid.= =We had	‘Equals’ signs mark the immediate ‘latching’ of successive talk, whether of one or more speakers, with no interval.
heh heh or (H) (h)	Voiced laughter. Can have other symbols added, such as underlinings, pitch movement, extra aspiration, etc.
sto(h)p i(h)t	Laughter within speech is signalled by h’s in brackets.
~indeed~	Indicates a wobble in speech.

For more detail on this scheme see Jefferson (2004).

APPENDIX B.13 Detailed Analytic notes

1. Rhetorical Devices

Main references: Edwards & Potter (1992) Discursive Psychology. Potter (1996) Representing reality: discourse, rhetoric and social construction.

Rhetorical Devices used to determine action orientation of talk	
Rhetorical Devices	**Example extracts from participants**
Stake Inoculation: in situations where descriptions might be undermined as interested, stake inoculation presents a counter interest. Effective stake management is probably done implicitly rather than explicitly.	“I’m not ashamed (.) of being a voice hearer. (.) ◦I am::::: (.)◦ - No I’m not ashamed. (.)> **I think I was to start of with**, it was:: like a huge taboo, you don’t talk about it” (V2L587). “**I~ thought it was a bit offensive** but, like just to be diagnosed over a cup of coffee .hhh ahm by somebody (h) who is clearly not a medical profession, but I did read up on it and I (.) **it almost made my eyes pop out”** (V3L203). (reduced stake in the conversation)
Stake confession: It puts potential objectors in the position of making a point that has already been conceded. Hence others will be bringing up something already known/stated if they try to present a counter claim. Stake is both a potential problem for those wishing to establish the facticity of their accounts and a resource for those wishing to undermine it.	“**ignorance is a strong word ~and it’s probably not (.) being too fair (.) but**:: (.) I think (.) →fear is a better word []. I think people (.) people who:: – I’ve experience it meself like I said when I, when I was first in a psychiatrist clinic and spoke to somebody who heard voices, .hhh I remember (.) being quite wary (.) .hhh and::: (.) lo and behold (.) I’m now in a position where (laugh) I hear voices meself (laugh) and so ↑I can understand, I can understand that↓ (.) initial (.) →weariness and fear of the label attached to (.) schizophrenia (.) of people who haven’t (.) had a great deal of experience in mental health issues, because **I was like it ◦meself so:::::◦, I can’t really cast the first stone**” (V1L610).
Category Entitlement: for example, expert view that holds authority over other views due to power of knowledge (and especially professional or scientific endeavour). Participants work up category entitlements in	“from somebody (.) who really knows what they are talking about and studied at **Cambridge University** ◦and stuff like that◦” (V3L208). “So (.) they’re ◦pseudo (.) psychosis◦. That was how it was explained to be by (.) one of my (.) earlier (.) **psychiatrists**” (V6L739).

various ways. In the same way, they can undermine the category of others. This rhetorical device can enhance accounts. Some category entitlements are especially credible if presented with official credentials, whereas others are highly localised and negotiable.	
Empiricist Discourse: Based on scientific evidence, facts, numbers, statistics.	“very little is known and there isn’t a:: (2) a:::: cast iron test for voices. I thought (.) as a layman that you would be able to pick that up on scans (.), on **CT scans and CAT scans and and MRI::s** but you can’t do that. You basically (.) the psychiatrist is is working with basically all - all →his got to arm himself is what you can tell him, cause there is no physical test for them .hhh and::::: they have their::: certain **scales and questionnaires”** (.) (V1L193). “And →schizophrenia has not moved (.) at all. It’s still (.) at even with all of this (.) .hhh, you know, **1 in 4 people have mental health problems**::, lots of mental health this mental health that everywhere, it’s all about every mental health problem other than psychosis?” (V4L585). “I’ve got my special interests and that’s what I’ll do all day and (.) I like being on my own (h) and so just like - if I just so (.) but yea I →dissociate, I hear voices and I hurt myself, clearly and that isn’t even **core criteria** (for BPD). ‘Get lost’” (V3L172). (Refers to DSM).
Corroboration (Consensus): Using others as evidence of the facticity of the claims made. This rhetoric strategy makes an account seem plausible. Can also distance a person from an event, if they present a view as coming from someone else or from someone else’s friend	“And **a lot of** voice hearers, I think, do not wanna go into hospital. It’s a horrible place” (V2L595). “**X**, who comes here (.) [] he is like, he finds this group much easier than the Friday group and I’m not sure why” (V2L134).

and so forth, because it cannot be checked for facticity.	
Detail and Narrative: Detail can be used to make something seem more factual. These details may not even seem directly relevant. They work to make what is described graphic and believable. Constructs the narrator as a proper witness with first-hand knowledge.	"I couldn't cope with my itinerary::::I thought there were →angels deciding whether I could get on the ferry or not. So I was (.) approaching the ferry and moving away and acting very strange? And (.) in the end several ferries left. I'd already missed my flight (.) and I was just sort of (.) crouched do::wn at the ferry po::rt (.) and (.) ah:: security called an ambulance ? And they took me in, and I was - resisting (.) a (.) little bit, I think, so they~ weren't sure whether (.) what to make of me, because they'd only just found me and they strapped me down. It was the first time I'd been (.) strapped down which is horrid" (V5L71).
Vagueness: this rhetoric device can also be effective as it makes it difficult for others to pick it apart and evaluate the claims made. Use of idiomatic expressions for vagueness to change topic.	"I have kind of (1) →agonised over whether it (.) whether the →illness model (.) makes sense (2). **And it doesn't feel like it really does?** Ahm:::: (3) but then also::: anything else feel like it (.) it's (.) it would be seen as slightly →irrational?" (V4L366). (Doesn't elaborate on the reasons hard to unpick it)
Disclaimer: This is used when participants anticipate, and then subsequently reject negative attributions e.g. it rejects possible attributions in the light of the comments that are about to follow (Hewitt & Stokes, 1975).	"Because °I just want to be a person. Just a person°, (.) without 'O:::::h there is something wrong with this person (.) with this (.) voice hearer. →You can't call (.) this person a person. You must (.) call them by another name like voice hearer or' (.) °I don't know°. **But then** I accept if some people, feel it's appropriate then (.) and so what do people refer to like that, .hhh that is absolutely fine with me" (V4L447).
Extreme Case Formulation: Claims and evaluations are taken to their extreme to provide an effective warrant (Pomerantz, 1986).	"I think some of **the nicest people I've ever met** (.) are:::: voice hearers" (V2L597). "looking back on it's:: **quite a serious addiction** (sad) .hhh <I don't feel (2) I had a choice in that" (V1L463).

Footing, neutrality and alignment: the range of relationship that speakers have towards their descriptions. This rhetorical device is more concerned with how one manages accountability than facticity per se. Look for a display of neutrality through shifting footing. Footing shifts when more contentious factual claims are made and when dealing with controversial topics. It demonstrates someone's alignment with, or scepticism about a claim.	"And whenever **you** find out something about somebody's ways of thinking or::: (.) .hhh beliefs and things, **you're** like ↑'What?'" (V4L292). "**I** don't think it (.), you know, **I** relate it quite often to (.) .hhh to **my** voices, are quite often troublesome to **me** (.) in the night? That, you know, If **I'm** stressed [] (.) they'll wake me up at like 3 in the morning, and kind of make lots of no::ise, but **I know** from (.) **other people** that don't hear voices, that when **they're** stressed **they** wake up at 3 o'clock in the morning with **their** thoughts racing round in their heads. And that's completely no::rmal. And I'm like 'Well it's not so:::: different from that!'" (V4L295).
Active Voicing: Using quotes to produce accounts of extraordinary events. It also makes the reported not accountable about what is being quoted.	**"well::::: if you were drinking at the ti::::::me then (.) you suffered a psychosis and::: (.), if you hadn't have been drinking to excess you probably wouldn't have suffered that psychosis"** (V1L455). **"Oh I just escaped the BPD label"**, because she's got some scars, - and I'm **"How did you do that?" "Oh I got diagnosed with Aspergers"** and then she said **"You got it bad" – "hmmm"** (V3L199).
Gerrymandering: In making descriptions the speaker selects relevant phenomena and ignores other potential ones that can undermine the overall account. One of the powers of descriptions often lies with what they fail to describe, what is ignored or left out.	"And I get scared by the voices at night. More scared at night than I do at day? But then (.) other people get scared in the night? (.) You know, cause it's da::rk and you're awake, and it's lonely and the house makes weird noises (.)~or you know,~ it's not~ – **it's not massively different**?" .hhh (.) (V4L312). (Omits the severe distress that can be associated with this experience).

Extrematisation and minimisation: For example, use of minimisation to downplay violence 'he was only acting in defence'.	"even professionals, **they can panic at bit** and think 'Oh she needs to be in the hospital" (V2L594). "some of the **nicest people I've ever met** (.) are:::: voice hearers" (V2L598).
Normalisation/Abnormalisation: The issue of normality is closely connected to the issue of regularity. Actions in relationships can be established as ordinary or unproblematic, or undermined as weird and deviant. The issue of what is normal and routine is a fundamental one in human affairs as it is so bound up with which actions should be treated as accountable and which not.	"I know from (.) other people that don't hear voices, that when they're stressed they wake up at 3 o'clock in the morning with their thoughts racing round in their heads. And that's **completely no::rmal.** And I'm like 'Well it's not so:::: different from that!'" (V4L299). "Mental health (.) health (.) ill (.) ill health has got no boundaries. It's (.) **it could be anybody**. It c c could be you tomorrow" (V8L45).
Three part lists: Emphasises the generality of something suggestive of a conventional or normative stance. Can be drawn to construct some events or actions as common place or normal. Create an impact, arouse emotion.	"some of the nicest people I've ever met (.) are:::: voice hearers. Cause **they're understanding, they're gentle, they're kind**" (V2L598).
Nominalisation: is a device displaying neutrality. The verb is transformed into a noun. Such transformations obscure patterns of agency e.g. 'Yesterday's killing was severe' (absence of agent)	"I went for three years without getting any help at all, because I was frightened that (.) **they'd** lock we me up" (V2L591). (Does not directly apportion blame). "It hurts when you:::: (.) .hhh when **people** question:::: the fact that 'well:::::: if you were drinking at the ti::::::me then'" (V1L453).
Generalisation: strengthens the account and is more persuasive.	"well (.) **everyone** (.) the inside of **everyone's** head is pretty weird" (V4L291). "you wake up grumpy and tired the next day and we're **all** 309. **in the same boat** (h). [] .hhh so ◦I don't know◦ (V4L309).

Offensive rhetoric: a contrasting description is undermined.	"it's →your fault (.) that you've suffered it (.) and the other respect is (.) in some in some (.) →warped sense you you must be →weak in so:::me respect or suffered a breakdown .hhh And:::::: that's absolute rubbish on ◦all three fronts◦ (.) know a lot of the people that I associate with wouldn't have had the mental capacity or strength to do the job that I used to do" (V1L504).
Defensive rhetoric: a contrasting description is supported.	"you hear about in the papers is (1) 'Paranoid schizophrenic (.), stabbed somebody:::', and so on and so forth and (.) .hhh, been arreste:::d and:: (.) they're usually down on the grou::nd or something. Being manhandled by the police. And:::: (.) it's probably the voices telling them to do it. And they're more frightened of the (.) police than... anybody needs to be frightened of them" (V8L111).

2. Example analytic notes at each stage of the analysis

STAGE 1 Looking for discursive constructions of the object (hearing voices) through each interview. Sample interview Zoe
VH constructed as a normal experience → solid core of people that went every week. .hhh **And we used to go to the pub afterwards which I liked (h) [] and it was very →no::rmalising** and kind of (.) .hhh (25) **It was really interesting hearing people like (.) talking - about (.) voices in a really →normal way [] (.) as if it was just like** (.) just (.) ~ I yea. I don't know. (31)
VH constructed as abnormal **which is far from (h) at the moment**. Well ◦It is normal but it's not seen that way I don't think by other people◦. (263) people are still kind of immature enough to be making jokes about (.) all of those (.) you know, about **being →crazy and (.), ahm going →schizo** (615)
VH as a stigmatised experience due to attached labels

So I have got that →label? .hhh Ahm:: (1) ↑Which I don't. Which it doesn't really worry me now. It doesn't really bother me now. [] I think I think it would have been massive at the time, when I was like (.) 22 [] (.) ahm:: (.) but like now I'm kind of like '**It is just a →label**
(181)
the:::: →stigma (.) around (.) HIV? from like the early 80s until now [] and how much it has massively improved. There's still stigma but it's (.) completely different to how it was 30 years ago. And →schizophrenia has not moved (580)

VH constructed as difficult to talk about
I don't think – before that **I don't think I even had the vocabulary to talk about my experiences [] despite being like quite →educated and::: articulate. I hadn't ever really talked to anyone about (.) voices [] so I hadn't got (.)→words to (.) to express it.** (34)
And::: (1) so I guess I was really - put off from talking about it (.) and:::: (.)~ yea I cause I didn't wanna get that →diagnosis, cause I didn't (.) want my life to (.) become like the lives of those people in my family that had had that (66)

HV constructed as something to be hidden from others
I might just deny it because I can just sense how →uncomfortable it makes everyone? (131)

VH constructed as something that needs to be made sense of /an unknown experience
I don't think I actually have really made sense of it. Because (.) I've worked through so many different explanations (.) or possible explanations (.) and I haven't really come down on one? (318)
[]? I'm not exactly sure how it works and **I've stopped trying to work it out**, cause actually that gets~ gets me in more of a→ state? (371)

VH constructed as an object of fear (other are afraid of)
I think by some people it's just seen as kind of (.) → **weird and incomprehensible** (271)
Either it's (.) →**scary cause you might be dangerous or it's scary cause it's completely weird** [] and
people just can't understand what I'd be like (284)

VH as constructed as an experience that others do not know about or do not understand
I don't understand why kids aren't being taught this (.) in schools? (586)
I don't blame people that are ignorant about it, because it's not their fault, **there's just not enough information out there** unless you go looking for it and of course, you know, .hhh most people aren't going to go looking for it, (618)

VH constructed as a distressing experience
Because hospital's been horrendously traumatic (515) really distressing for people who experience
it and (.) the whole thing would be so much less distressing if there was no →shame about it? (597)

just something that isn't [] .hhh (.) yea just just terrifying.

STAGE 2

INTERPRETATIVE REPERTOIRES – Two main interpretative repertoires identified from STAGE 1

1. **Voice hearing constructed as a distressing experience**

(Extracts from all eight participants V1-8 L-Line no)

V1L260. the::: experience of hearing voices it's (.) it's a very →strange one↓ (.) ahm:::: (2) ~for the life of me I wouldn't want I~ >I can't understand why anybody would want to go and buy (hallucinenic) (.) drugs to experience it< =ahm:: ~That for the life of me I I I I can't understand why somebody would actually pay to experience (.) what we experience [] .hhh it's::: .hhh (3) [mhm] its very very →difficult.

V1L294. some of the voice hearing group that I associate with, .hhh they tend to have voices that are more aggressive and mo::re demeaning and attacking<.

V1L298. most of the group (.) their voices eh::::: can be at times ↓distressing dark aggressive (sad) (.) .hhh and cause them some (2) quite some distress.

V2L46. They normally call me a fat ugly bitch and:: (.) .hhh ah:::: what was the latest one is that I'm 'Who::::re' [], they call me whore (.) ahm::: Ye::a so - it's pretty negative really my →voice hearing (.)

V2L57. Very negative [] yea:::: [yeaa] (.) and when I was ↑→sectioned, it's like, the voices got worse. I don't know what why when you're in hospital (.) for me my voices get worse.

V2L378. Like a lot of people don't understand, they're like →'Oh can't you just igno:::re them?'. But (.)you ↑can't (.), you know, mine tell me to cut myself and I know in the end I will cut myself, however far I put if o::ff (.).

V2L666. I saw my own notes. And my doctor had said I was →manipulative and controlling? .hhh I've ↑never forgotten it. It was years and years ago and it still →wounds me now [] (.) →WHY:::: would I (.) sacrifice my whole life (.) [] just because I want a bit of - attention?

V3L275. I've seen so many people (.) suffering so badly with hearing voices (.) but it doesn't seem to be really related to violence.

V3L430. Because (.) if emotions build up and I just start feeling worse and worse and worse somehow and I've got no idea why (.) .hhh ahm (.) yea that makes voices worse (.) and I end up self-harming and stuff like that.

V3L538. it's → this pathologising of everything I think that makes all the symptoms even worse, because people end up feeling →worse about themselves.

V4L111. the voices were< (.) quite in →control of me then, so I was quite (.) unsure of my (.) sense of self and things like that.

V4L515. I've got like (.) a collection of kind of hillarious stories about things that have happened when I've been (.) in hospital (.) ahm [] because hospital's been horrendously traumatic.

V4L598. just something that isn't [] .hhh (.) yea just just terrifying and, you know, lots of people have their first experiences in their late teens and early 20s? (.) and:::: you know, w~ when people are really worried about self-image and being popular and what people think about them and (.) .hhh people are still kind of immature enough to be making jokes about (.) all of those (.) you know, about being →crazy and (.), ahm going →schizo (.).

V4L621. people are more frightened to come out and (1) .hhh speak about (.) →a psychotic experience (1) because (.) I think (.) people are scared (.) justifiably::: that (.) the reaction would be to think that they were →unpredictable:: chaotic:: ahm::: bit scary::: (.) ahm (1) unstable?

V5L11. At it's most extreme (.) ahm [] I didn't get any sleep, one voice (.) as soon as I'd – I'd be afraid to go to sleep? because I knew the voice would come and wake me up. And::: ah::: and it would be so:::: bombarding and traumatising that I'd have to go running at night [] to try and shake it off.

V5L111. And::: I was there:: for 3 days and that was really horrid. Because [] I've never (.) had to stay in an acute ward before [] and there were people with quite extre::me states of →mental health [] who were scre:::aming and (.) you get your stuff nicked [] and it was all a bit (.) it was a bit like being in →prison. .hhh [] Everything was locked, you couldn't get out.

V5L293. (.) Ah:::: (3) Becau::::se people who::: have symptoms experience pain [] (.) and::: ah::: (3) it just (.) →sym-symbolises lots of pain [] I think. Ahm::: (.) and struggle (.).

V5L752. I'd ended up on the train tracks and tried to jump [] in front of a tra::in I couldn't do it::::. And I'd taken (.), tried to (.) you know, I (.) hadn't (.) didn't take it (.), but I'd - bought (.) like rat poison [] to put on my cereal to take that [] .hhh so those were kind of (.) hhh, you know, extre::me moments of darkness.

V6L101. (.). I find it a very [Yea] negative experience []. Very negative. I don’t accept it. I fight it [] .hhh <ahm::: (.) I have (.) various different voice::s. They::: (2) are much worse now than when I was younger. [] And::: (1). Although some could be argued that they are (.) neutral (.), I don’t (.) like them being in my head and I have a couple (.) that are (.) very negative and aggressive and abusive [] and (.) I find them very difficult. But I find them (.) very hard to (.) .hhh ah react to [] (.) ah whereas more neutral ones I find easier (.) to::: (.) react to negatively>. But I’m scared by the (.) scary ones.

V6L145. I don’t want (.) peoples’ (.) voice::s (.) in my head. It’s intrusive. It’s ru::de. It’s unfa:::::ir, it’s it’s (.) abusive, it’s (.) my territory, not (.) not the voices territory.

V6L485. if my →PTS(.)D has been (.) particularly ba:::d (.) that day [] then ahm (.) I have various different voices, and one of the voices (.) that I have:: is I have two men who take it in turns to threaten me::: (.) .hhh [] ahm and will (.) ahm (.) say they’re going to kill me:::? .hhh ahm:: and (.) the PTSD will bring (.) them (.) on mo:::re.

V6L621. .hhh so::::: (1) ahm:::: .hhh (1) yea I mean I wanna take the piss out of myself because (.) it’s sad. Thank you. (5) It just (.) It makes it e:::asier:::. It’s so::: hard and dark so much of the ti:::me.

V6L634. I get →PTSD voices, which are worse than the scary voices. They are threatening (.) abusive ones [] (.). The one’s that say they’re gonna kill me. PTSD voices just say (.) words are to do with the PTSD. .hhh and:::: (.) °they scare the hell out of me and they’re not for joking about [] or responding to or but do anything but sit there like this and wait til they’re over°.

V7L27. I started t~ (.) hearing (.) at f~ (.) first just voices telling me how useless I was [] (1) ahm (1) and:::: it got louder and louder, and they were .hhh more (.) critical voices::: getting quite verbally abusive. And then it culminated (.) ahm::: when I was 15 (.) just b (.) not long before my 16th birthday, telling me that I ought to kill myself.

V7L42. I was hospitalized just before (.) my 16th birthday. (.) .hhh And I spent a couple of day::s on a (.) children’s wa:::rd (.) mental health, and then (.) .hhh I was transferred to an adolescent unit, (.) quite a ~ long (.) way away from my home (.) ahm (3) and then:: (1) I left schoo::l (.) a couple of months (.) later after my hospital admission.

V7L72. distressing, irritating (.) [] ahm:: overwhelming (1) ahm (3) very difficult to concentrate [] (.), ah poor memory (1), get distracted very easily (.) by them .hhh ahm just find it (.) hard day to da::y (.) [] living with them (.) really.

V7L134. the voices start screaming at me ‘You’re USELESS, USELESS, USELESS, USELESS, you can’t get anything right. [] .hhh, you’d be better off (.) dead (.), you shouldn’t have been born’.

V7L385. So I’ve ruin – I’ve ruined (.) my body. I’ve so many scars from self-harming. And I think if people saw the sca::rs and they start asking questions (.), .hhh that’s even worse than having to explain hearing voices.

V7L433. I don’t know. I’ve lost (.) so many friends due to suicide (1). They didn’t make it. .hhh (.) And I’m still here so (.) don’t know if that’s a good thing or a bad thing really (1).

V8L124. Afterwards::::: someone’s told me and::: I (.) couldn’t believe it was me. [] (.) It’s like you’re a different person (1) [], but you’re very frightened. Cause hearing voices is frightening.

V8L160. I ended up in (1) sectioned in an:: (.) it was 6 months in (.) one hospital [] (.) it was 8 months in another hospital. A secure unit. (1) And then::: I was (.) 6 months (.) back in the other (.) hospital. Before I was allowed to (.) .hhh go ahm (.) out escorted and (.) stuff like that.

V8L171. I’m scared of traffic, I’m scared of people, I’m scared of (.) of everything, cause::: you’re losing it. [] And::: (1) that’s one of the most scariest part of it. [] (.) You can feel yourself losing it.

V8L200. the number my husband’s::: told to ring if I get to that stage::: [] is (.) actually 999. Not the hospital or the doctor or th~ the CPN or anybody like that. It’s 999. And that to me::::, it makes me feel like a monster. Because the only way out of::: (.) the situation, is to call the police. And then you get manhandled. And taken to the nearest place (.). Which sometimes has been a (.) police cell. (1) And that’s not (.) e:::~e:: even more frightening.

V8L266. but sometimes my voices just (2) just ah:::: (.) are derogatory and they (.) just run me down (.) and that gets me down::: and then I can’t sleep and then (.) I start to spiral. And I need catching before I fall on the floor.

V8L591. They don’t get the misery that (.) the medication causes when you put on we:::ight and (1), you’re got that to cope with apart from everything else. (1) And::: ahm (4) side effects (1) stuff like that. I’ve had locked ja:::w (2), I’ve had t~ t t ~ open my mouth so far:::: I can’t~can’t speak, (1) I needed something (1) t – t ge be given something to (.) take that away:::: (4). And I don’t think they listen enough. (5) So ho:::w do they expect (.) general public to listen, if they don’t listen.

2. Voice hearing constructed as a normal/ordinary experience

(Extracts from all eight participants)

V1L43. I would consider meself [laugh] Ah::::: an →average type of person. I just have .hhh an →↑illness which:::h (3) I don't know I I~ I feel a lot of people out there don't understand.

V1L71. You tend to find if I put you in a room like we::: .hhh we meet up (.) ~we meet up once a week on a Wednesday and once a week on a Friday and (now) if anybody entered that room [].hhh without (.) given any knowledge of what (.) th the:: the →patients (2) disorder was [](1) t~often they'd be astounded. I I I I (.) don't think (3) .hhh that they would have any – if they went in with no preconceptions (.) [] [mm mm] they'd be extremely surprised at just how →normal in inverted commas (.) voice hearers are in the main.

V1L132. and I think that's a very very very good move because (.) It's a it's a very good swing to (2)~towards .hhh allowing people with voices to to live →normal lives [], which are more than capable ◦of doing◦.

V1L164. And I think (.) people who hear voices those channels are (.) actually:: .hhh eh become active ↑naturally is is is ↑mhm! is is how I I personally:: is its a personal view of mine .hhh [] and (1) [mm↓] So it's a →perfectly natural process (.) ahm:::: somebody (who) takes a trip on LSD will see things, they'll hear things, they'll see hallucinations. So it's in →all of us.

V1L243. but having visited support groups and got involved with other (.) voice hearers .hhh you tend to find they're just:::: they're just the extreme exception (.) the reality is that (.) voice hearers (.) if you met one (.) (and) i i i in a pub or in a restaurant or in a shop (.) .hhh unless you had a a (.) pre knowledge of their condition (1), you'd find them as →normal as ◦anybody else◦ and so we:::: (.) we::: we sometimes laugh and joke and (2) say (amongst us) we're a a a →crazy gang and that lot but it's light hearted you know [] it's not .hhh we'r::e (2)~ in terms of:: of:: (.) the →average population I would say we are, you know, what is what is normal? There is no preconception of →normal is there? .hhh (cough) but::: .hhh we::'re we're just →average people ◦really◦. We're no we're no →different to anybody else.

V1L309. are in a small percentage of the population that have an illness where (.) dormant channels in the mind have become active and:: basically the meaning I attach to it is that →I'm no different to anybody else, I am a →perfectly normal person.

V1L530. I think it (.) to have a breakdown under the pressure that I was under and under the addiction, stresses that I put meself under, (.) again and that that I I found myself under (.) .hhh I think to have a breakdown (.) I think you're →normal. I think 9 out of 10 people, if not 99 out of 100 would probably have suffered the same ◦fate◦.

V2L596. voice hearers~. I think some of the →nicest people I've ever met (.) are:::: voice hearers. Cause they're →understanding, they're gentle, they're kind.

V3L111. 'Oh wait a second (.) ~ahm (.) and (.) hhh (.) it's not actually ahm →the devil talking (.) it's actually, (.) potentially ahm (.) just (.) my mind and my body trying to digest →trauma'.

V3L446. Because ◦I just want to be a person. Just a person◦, (.) without 'O:::::h there is something wrong with this person (.) with this (.) voice hearer. →You can't call (.) this person a person. You must (.) call them by another name like voice hearer.

V4L23. the group at the time were quite a li:::vely group, they were quite a kind of→ solid core of people that went every week. .hhh And we used to go to the pub afterwards which I liked (h) [] and it was very →no::rmalising.

V4L235. <Ah:: I just think kind of (.) ahm::: (1) mo:::::re accessible kind of →normal terms, like, →emotional (.) distress, and - actually the old fashion term →nervous breakdown []> (.) I kind of think breakdown is, you know, to say I had a breakdown I ◦I wouldn't mind saying that, you know, (.) I was in hospital cause I had a breakdown◦ (.) [] like – cause that's kind of what it's like.

V4L252. 'Oh I~ I have this synaesthesia' and it's kinda like 'Oh:::wow that's really interesting. What's that like?' (excited) cause I just can't imagine it (.)[] I'm like, I can't imagine being able to associate you know, so I think that that's like an interesting [] (.) .hhh mental event that I haven't experienced, so I'm~ I'd like it to be a bit like that to just be like 'I'm a →voice hearer' and people to be like 'Oh really? So what? Do you::? (.) You know, what (.) what's that like? And (.) how does that happen and stuff?' For it just to be::: (.) [] →normal.

V4L284. Either it's (.) →scary cause you might be dangerous or it's scary cause it's completely weird and people just can't understand what I'd be like so they just kinda like (.) ph:::: →I can't relate the inside of my head to the inside of your head, which is really bizarre, cause the inside of my head works in (.) a similar way to (.) well (.) everyone (.) the inside of everyone's head is pretty weird. And whenever you find out something about somebody's ways of thinking or::: (.) .hhh beliefs and things, you're like ↑'What?' (H) It doesn't make any sense! (h). So →everyone's different and weird.

V4L299. other people that don’t hear voices, that when they’re stressed they wake up at 3 o’clock in the morning with their thoughts racing round in their heads. And that’s [mhm] →completely no::rmal. And I’m like ‘Well it’s not so:::: different from that!’. It’s just like (.) my bod~ body and my brain reacting to the fact that. I’m stressed (.) and (.) disrupting my sleep. →And (.) for you it’s your thoughts, for me it’s the voices. (.) But that triggers off the thoughts anyway. And it’s all~, you know~, (.) and the consequence - you’ve had a crap night’s sleep and you wake up grumpy and tired the next day and we’re all in the →same boat (h). [] .hhh so ◦I don’ know◦.

V4L442. I just have to live with not knowing it, but they’re loads of things I don’t know. (.) Like anything about quantum mechanics (H) [] I’m kind of like [] yea that’s (h) stuff that’s happening everywhere all the time, that (.) some people understand and I don’t. (.) I’m alright with that (h) (.) [] I can’t know everything .hhh.

V4L471. I also think it’s really reassuring to people .hhh (.) ahm::: if I present it in a way that you know, ‘I’ve been hearing these voices, for such a long time [] (.) and::: (1), you know, but I’m ok? (.) My life’s alright? You know:: (.), →I get on with it, I go to work, I~:: I do the things that I’m doi::ng and:::: I have these (.) these (.) experiences but (.) I’m →used to it so:::::.

V5L186. I put them in a (.) little plate by my bed, so I always remember to take them at night, it doesn’t make me feel like I’m just some (.) .hhh →person taking loads of drugs it makes me fee::l[] it - creates a sense of →dignity::: and:::[] just like self ca::re [] rather than (.) I’m a (.) →crazy person who needs to take this (.) strong →medication, you know?

V5L477. No:: because like (.) no::w (.), you know, →I’m like any other person (.) [] and have enthusiastic days, flat days, [] at the moment I feel a bit flat, but I’m basically well.

V6L366. Everything would be fine. I just - want to have (.) parts of my life that (.) are:: or areas of my life [] that are not (.) ahm::: (1) when my (.) →illness (.) is not part of that. That I’m just a::::: professional for (.) a few hours (.) in the day.

V6L476. No::: I I see it as stress induced and illness induced ahm (.) phenomena (.) that is a hallucination [] and that is ahm::: a mixture of (.) wiring gone wrong in the brain ahm:: so::: ah neurological physiological and::: ahm::: psychological whe::re it’s not necessarily neurotransmitter or something [] but it – it is (.) ahm (.) literally:: ah::: →psychological stress [] that is spurring on something more physiological.

V7L188. (.) have worked with a group of teenagers who're doing a citizen's (.) award sche (.) award scheme. Ahm:: (.) .hhh and:::: a (.) these large groups that we get, we have them come in the summer (.) and we talk about our group and our experiences of hearing voices (.) and they're just so open and receptive, and they ask like - thousands of questions, they're so [] (.) interested in the experience. (1) And:::: I (.) I think, you know, (.) like I said to them, 1 in 4 people experience a mental health problem at any time in their life [] (.) .hhh so we kind of normalise it for them.

V7L454. when people are bullied at school (1) ahm (.) awful (1) though it is (.) and (.) trolls on the internet, say some really (.) really nasty things to people [] (.) it's (1) it's no different. It's just it's not (.) voices:::, you you can't (.) see or identify the person's who's doing (.) or people that are doing it [] (.). But the experience (.) is felt the sa:::me.

V8L39. it could be anybody with a mental illness. You could be sitting next to em and not know. [] (.) You could be sitting opposite them (.) .hhh, you know, opposite a →manic depressive:::, you could be sitting (.) .hhh next to somebody whose:: suffering from anxi::ety:: (1), it's all walks of life. [] (.) Mental health (.) health (.) ill (.) ill health has got no boundaries. It's (.) it could be anybody. [] It c c could be you tomorrow.

V8L53. And ah::::: (.) show people that (.) we're not people that walk around with .hhh (1) knives and guns and (.) go shooting people and (.) stabbing people and (.) .hhhh things like that. (.) That were were ordinary people.

V8L66. it's just to show that (.) were just ordinary people. And it could be anybody.

STAGE 3 – Discursive Management

Action orientation of talk (what participants are trying to accomplish in the interaction).

Example Extract 5 - Ros

586. Ros: =li:::ke (.) <I'm allo:::wed to feel the way I am now [] (.) and I'm not ashamed (.)[]
587. R: [mhm] [mhm]
588. Ros: of being a voice hearer. (.) ◦I am::::: (.)◦ - No I'm not ashamed. (.)> I think I was
589. to start of with, it was::like a huge taboo, you don't talk about it, that's
590. why .hhh I went for three years without getting any help at all, because
591. I was [] frightened that (.) they'd lock we me up. And of course as soon
592. R: [Ah::::: ok]
593. Ros: as they found out I got sectioned, so (.), you know, people::: (.)
594. even professionals, they can panic at bit and think 'Oh she needs to
595. be in the hospital'. And a lot of voice hearers, I think, do not

596. wanna go into hospital. It’s a horrible place (.) **but yea:::: voice hearers~.**
597. I think some of the nicest people I’ve ever met (.) are:::: voice hearers.
598. Cause they’re understanding, they’re gentle, they’re kind.
599. And they go through this ↑shitty illness [], (.) you know, and all the:::::
600. R: [mhm]
601. Ros: stereotypes people ha::::ve, (.) you kno:::::w, (.) gonna mu::rder
602. people and:: (.) all – even just (.) tut – or they, they’re not worth anything.

Coding highlighted in bold: part of text selected based on the research question looking at how participants negotiate the voice hearing identity through talk.

Discursive Constructions

Voice hearing constructed as something to be ashamed of, a taboo. Line 586

Voice hearers constructed as understanding, gentle and kind. Line 598

Rhetorical Devices used

Passive (nominalisation). ‘They’d lock me up’. Does not directly apportion blame. Line 591

Minimisation= ‘Panic a bit’. Line 594. Serves the minimise the impact of the accusation.

Extreme case formulation= ‘It’s a horrible place’ line 596. ‘some of the nicest people I’ve ever met’ line 597.

Active Voicing= use of quote ‘Oh she needs to be in hospital’ line 594.

Generalisation and consensus= ‘A lot of voice hearers’ line 595.

Three-part-list= ‘They’re understanding, they’re gentle, they’re kind’ line 598. Serves to normalise.

Repetition: ‘I think’ line 588, 595, 597. Serves to make the claims tentative so as not to attract counterclaim. Also ‘you know’ line 593, 599, 601 serves to construct the account as self-evident making it harder to dispute.

Footing: Talks from the first person and being a witness in describing her own experiences. Sudden change in footing on line 596 ‘You don’t talk about it’ appealing directly to the audience. It is not her that doesn’t want to talk about it but she refers to the audience ‘you don’t want to talk about it’.

Stake Inoculation= ‘I think I was to start with’ line 588.

Discourses

Draws on the medical model of illness line 595 and 599, the discourse of violence associated with voice hearing line 601. Also, uses psychology discourse when referring to panic line 594.

Use of emotional discourse to justify position line 591 ‘I was frightened’

Positioning

Does not position herself within the discourse of violence. She rejects this and choses to position herself in the alternative construction of voice hearers as gentle and kind (moral agents)

Action Orientation

Serves to create a division between us and them = health professionals and voice hearers. Health professionals are constructed as not making a sensible choice when they are sectioning people drawing on a psychology discourse (panic). Voice hearers on the other hand are constructed as ‘some of the nicest people I’ve ever met’ ‘gentle and kind’, that ‘go through this shitty illness’. By doing this the speak is disclaiming the problematic identity associated with voice hearers.

Consequences of Discursive strategy: Disclaiming

The consequence of this strategy is to outright disclaim the discourse of violence associated with the experience of hearing voices. It serves to question the need to lock up individuals of such a kind and gentle disposition and render those acts as questionable, even immoral.

Example Extract 8 - Jack

J: It hurts when you:::: (.) .hhh when people question:::: the fact that
‘well:::::: if you were drinking at the ti::::::me then (.) you suffered a
psychosis and::: (.), if you hadn’t have been drinking to excess
you probably wouldn’t have suffered that psychosis’. It hurts because
I’ll say well:::::: (.) after all (.) the traumatic stress factors
that I’d been through (.) the drinking wasn’t (.) like
you go down the pub and have a drink (.) it’s involuntary
it was it was it was keeping me::: at the time (.) it was s~ it it was something
I did (.) basically just to get through 24 hours of the ◦day◦ (.) .hhh
and it it was addiction (.) and looking back on it’s:: quite a
serious addiction (sad) .hhh <I don’t feel (2) I had a choice in that (.)
I feel I was ill (.) a dual diag dually diagnosis ill, I was depressed,
I was an addict (.) and I was suffering from psychotic (.) symptoms> .hhh
And I don’t think I had a choice in any of ◦that.
And when somebody comes across and says well::::: points the finger (.) and
it does hurt (.) I must admit, it does (.) it can be very hurtful◦ (1)

Discursive constructions:

Voice hearing is constructed as the result of traumatic stress factors, which the individual has no control over.

Voice hearing is constructed as an illness.

Rhetorical devices used:

-Passive noun: ‘when people question’, ‘somebody comes across’ – does not directly apportion blame to someone

-Emotional discourse ‘It hurts’ to persuade and evoke emotion in audience.

-Active voicing: using quotes ‘Well if you were drinking at the time…’

- Repetition: it hurts (line 453, 456), it does hurt (line 468), it can be very hurtful (line 468)

-Extreme Case formulation ‘After all the traumatic stressors’, ‘quite a serious addiction’

-Footing: Change in footing from ‘I’d been through’ to ‘you go down the pub and have a drink’. Serves to distance him from the problematic behaviour.

-Concession: ‘and looking back on it’ – he appears to have considered this carefully before reaching a conclusion. Presents himself as balanced and informed. This opinion is constructed as based on evidence rather than his own personal agenda.

-3-part list: ‘I was depressed, I was an addict, and I was suffering from psychotic symptoms’. A convincing rhetorical strategy. Normalises the account.

Discourses:

-Medical model discourse ‘Illness’, ‘dual diagnosis’, ‘psychosis’

-Discourse of addiction (AA) – Lack of choice involuntary.

-Discourse of trauma – voice hearing caused by traumatic life experiences (life stressors).

-Psychological discourse – ‘I was depressed’.

Positioning

Jack positions himself within a hybrid of discourses. Trauma has caused him to become ill and drinking is what he used to cope leading to an addiction. This position serves to make him not accountable for his problems.

Action Orientation

Jack is trying to justify why he is not to blame for causing his psychosis in response to health professionals attributing the blame on himself for his drinking.

Consequence of the discursive strategy: Justifying

Jake constructs himself as non-accountable for his drinking and the subsequent psychosis, which absolves him from responsibility. It also allows for a less problematic identity, which would not be the case if his addiction was seen to cause his psychosis, for example, if he was constructed as an addict that just goes down the pub to have a drink.

Example Extract 13 - Neve

198. N: ‘Oh I just escaped the BPD label’, because she’s got some scars, - and I’m
199. ‘How did you do that?’ ‘Oh I got diagnosed with Aspergers’.
202. and then she said ‘You got it bad’ - ‘hmmm’. I~ thought it was
203. a bit offensive but, like just to be diagnosed over a cup of coffee .hhh ahm
204. by somebody (h) who is clearly not a medical profession, but I did
205. read up on it and I (.) it almost made my eyes pop out (.) ahm
206. so I pursued the whole thing, and I got a (.) diagnosis
207. of severe aspergers now from somebody (.) who really knows what they
208. are talking about and studied at Cambridge University ◦and stuff
209. like that◦.

Discursive constructions:

Voice hearing is constructed in terms of another diagnosis -autism.

Rhetorical devices used:

Active voicing – makes the argument more reliable and believable. Use of quotes.

Detail – builds specificity and make the account seem more informed, reliable and accurate. Particularly in the use of dialogue between herself and her friend.

Stake Inoculation – ‘I thought it was a bit offensive’, ‘it made my eyes pop out’ (The speaker rebuts the potential claim that they have a stake before they can be challenged on it). Participant constructs herself as initially sceptical and surprised about this finding to reduce her stake in the account produced.

Categorisation - ‘by somebody who is clearly not a medical profession’. The participant talks about the informal diagnosis as being so self-evident that even someone who is not trained can easily detect it. It serves to strengthen her account.

Category entitlement - ‘from someone who really knows what they are talking about and studied at Cambridge University’. Use of category entitlement gives a special credence to an account. Build on the credibility of the claim.

Discourses:

Medical model and the language of diagnosis – Aspergers, BPD, diagnosed, medical profession.

Positioning:

Participant is positioning herself in the medical model, even though this contrasts with an earlier account where she said she doesn't like labels. Why does she do this?

Action Orientation:
The action of this positioning is to distance herself from the more pathological mental health label of schizophrenia and BPD, by positioning herself in the discourse of autism and aspergers. It seems like she is trying to reframe her experience to something else, which is less problematic. Discursive strategy: Reframing.

Consequence of the discursive strategy: Reframing
Constructing herself as an atypical category member of being a voice hearer allows for a less problematic identity. In addition, the discourse of autism constructs individuals as having a lifelong developmental difficult that the surrounding environment needs to adjust to (using reasonable adjustments). The alternative to this construction would be to be constructed as having a mental health illness and to be seen (as she says earlier in the interview) as a fake (putting in on) and having to face the stigma attached to this label.

STAGE 4

Naming of discursive strategies. Example

Name considerations for the discursive strategy of reframing

Replacing	Substituting	Diverting	Reconceptualising
Redirecting	Reworking	Displacing	Redressing
Tweaking	Transforming	**Reframing**	Recasting
Reshaping	Re-describing	Redefining	Remodifying

STAGE 5

Separate files were created for each discursive strategy. Extracts were added from each interview to the relevant strategy.
This phase involved separating discursive strategies into two groups in terms of the consequences of the constructions and the way that participants are positioning themselves in discourse.
Questions: What kind of identity arises and is made relevant in the interaction?

<table>
<tr><td colspan="2">Reference: New sociolinguistic reader Coupland & A. Jaworski (2009)
This part of the analysis involved looking at Insider- Outsider issues and how these were attended to in talk and in relation to the strategies adopted.
*The strategies were grouped into two different categories as they have different consequences and implications for identity construction as below:</td></tr>
<tr><td>DISCURSIVE STRATEGY</td><td>CONSEQUENCE</td></tr>
<tr><td>Discursive strategy of Justifying =></td><td>Increases gap (creates distance from others)</td></tr>
<tr><td colspan="2">Example Extract
“Ah:: my brother said (.) ‘Yea::: well everything you say when you’re:: (.) when you’re unwell is all gobbledygook’. And that really really hurt. Because it was like (.) .hhh you know ‘I’m maybe →unbalanced and not and confused and not remember things, but its still::: I’m still me?? And to →scrub out (.) everything I’m about when I was showing those symptoms is very hurtful” (V5L236).</td></tr>
<tr><td>Discursive strategy of Blaming =></td><td>Increases gap (creates distance from others)</td></tr>
<tr><td colspan="2">Example Extract
“I tend to find well that’s →↑their problem, they’re the one with the problem I haven’t got the problem. They’re the one with the::::: with the problem of →ignorance towards the condition (1)↓ (.) At first I tended to find that I I felt and a lot of the people felt the same in group that (.) .hhh y:::ea it was (.) maybe it was their →own fault (.) (we’d) become ill. When:: that (.) as you (.) you tend to live with it more (.) you think well no it’s not my fault, it’s it’s something that’s happened →to me through various different factors” (V1L415).</td></tr>
<tr><td>Discursive strategy of Normalising =></td><td>Reduces gap (closer proximity with others)</td></tr>
<tr><td colspan="2">“people just can’t understand what I’d be like so they just kinda like (.) ph:::: →’I can’t relate the inside of my head to the inside of your head’, which is really bizarre, cause the inside of my head works in (.) a similar way to (.) well (.) everyone (.) the inside of everyone’s head is pretty weird. And whenever you find out something about somebody’s ways of thinking or::: (.) .hhh beliefs and things, you’re like ↑‘What?’ (H) It doesn’t make any sense! (h). So →everyone’s different and weird (V4L288).</td></tr>
<tr><td>Discursive strategy of Trivialising =></td><td>Reduces gap (closer proximity with others)</td></tr>
<tr><td colspan="2">“hospital’s been horrendously traumatic (.) and but usually (.) a few thing happened that are quite funny, and they’re particularly funny if it’s something silly that I’ve done, cause I</td></tr>
</table>

<table>
<tr><td colspan="2">like (.) making fun of myself (.) .hhh so::: I'll maybe say to somebody:: 'Oh (.) like that time when I was in hospital (.) and dadadadada happened and then they'll laugh and::: someone might be like 'Oh!:: what hospital were you in?' or something, and then - I'll like (.) make →light of it" (V4L523).</td></tr>
<tr><td>Discursive strategy of Reframing =></td><td>Reduces gap (closer proximity with others)</td></tr>
<tr><td colspan="2">"I wonder if, other people (1) were labelled with something slightly more useful, because lots of people (.) labelled with personality disorder hear voices (.) and (.) and even people with →schizophrenia (.) a lof of them is more →trauma that has came out in this (.) way; than (.) it fits in four or five (.) in some boxes that has a label schizophrenia. But if they looked at the person themselves (.), (like) the →hearing voices groups (.) I don't think they would have () people cycling in and out of hospital if they would stop (.) hhh putting (.) this as a 'Oh it's a →pathology' 'oh you're nuts' that kind of thing. Ah I really must →keep you away because, from society, because you're a bit of an →embarrassment. Ahm (.) but if they help to under (.) for (.) people (.) for them to understand that (.) a lot of it is an →injury, it's nothing to do with (.) →pathology" (V3L521).</td></tr>
<tr><td>Discursive strategy of Disclaiming =></td><td>Increases gap (us versus them)</td></tr>
<tr><td colspan="2">"if (.) somebody says (.) something (.) derogatory or inappropriate about people with (.) →psychosis or schizophrenia or, you know, (.) but I will just say (1) I, you know, I've got schizophrenia, or (.) I've got (.) schizoaffective disorder (.) or (.) I hear voices or some(thing), you know, if it ~just comes up (.) .hhh just to make everyone go (.)↑'Oh' and then I get a bit of air time to say ↑'We're not all dangerous and crazy::: (.) and this (.) article that you're reading is completely written ↑wrong' (h). Look at this (h) .hhh" (V4L568).</td></tr>
</table>

STAGE 6

Naming convention of the two groupings of discursive strategies

Naming of the two groupings of discursive strategies was based on Hollway's (2001) distinction between the subject/object of a discourse. For example, in Hollway's research men are the subject of the discourse of sexuality, whereas women are the object of this.

Discourse of sexuality	=>	Men: subject	Women: object
Discourse of have and to hold	=>	Men: object	Women: subject

Consider the investment in these positions and in relation to the strategies being adopted. One set of strategies is other-oriented (object), one set of strategies is self-oriented (subject).

<table>
<tr><td>Discursive as object strategies
=>
(other-oriented strategies)
Negative discursive practices
(construct what voice hearers are not like)</td><td>Blaming, Disclaiming, Justifying
Voice hearers: object
Consequence: Create distance from others</td></tr>
<tr><td colspan="2">Example Extract
“There is NO need to shout abuse and be →violent you see so I don’t actually (.) accept that (.) ahm (.) it’s directly related to hearing voices (.) and I think society is so full of prejudice. The people I’m really scared of is the →normal people. (.) Those are the ones that are dangerous and that is what we also ascertained in the →hearing voices group (h) a few times (.) that is not us we need to be scared of, it’s →normal people we need to be scared of (.)” (V3L298).</td></tr>
<tr><td>Discursive as subject strategies
=>
(self-oriented strategies)
Positive discursive practices
(construct what voice hearers are like)</td><td>Normalising, Trivialising, Reframing
Voice hearers: subject
Consequence: Bring into closer proximity with others</td></tr>
<tr><td colspan="2">Example Extract
“media amplification of crime and the fact that they never (.) publish and they they very rarely publish, if never, th~e the →good that is out there in →mental health patients. And what they what they can strive to achieve and what they can (.) what they can do and (.) th~they some (.) you tend to find that some are very gifted in certain ◦areas◦ (.) <in the:: in the a::rts and:: writing and:: painting and and~ different bits> .hhh I~ I I I know we had one fella (.) ~I shan’t name him but he::::: (.) he always looked upon his voices as a →gift. As as being as being →↑special and::: he’s a very →intelligent lad he had a degree ◦as well◦. And he always looked upon that as as rather than (.)the →↑dark connotations of of of of illness and distress it it it is actually a →gift to have ◦voices◦ (.)” (V1L343).</td></tr>
</table>

APPENDIX C.1 Structure of therapy