



# ARE HEARING VOICES GROUPS EFFECTIVE? A PRELIMINARY EVALUATION

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## Introduction

It is generally accepted that approximately 10% general population hear voices (Tien, 1991). It is possible that lifetime prevalence may be much higher (Barrett and Etheridge, 1992). Many people who hear voices do not have mental health problems. They hold a variety of beliefs about the nature and origins of their experiences and deal with them in many ways. For some people, voices can be an asset or not pose any significant problem. For others, a variety of approaches can be helpful. Romme and Escher (1993) found that people who cope better with voices feel stronger, set more limits on voices, listen more selectively, communicate more about the voices and experience more support from others. They recommend encouraging people to meet others who also hear voices. Hearing voices groups have been organised by voluntary organisations for many years.

The first hearing voices group in the UK was started in 1988. In the UK, the hearing voices network links patients, non-patients, professionals and other allies who share beliefs that there is no one cause or treatment for voices and that they are not necessarily a sign of psychiatric problems (Cooke and Meddings, 1999). It is committed to raising awareness of voice hearing, creating spaces to talk freely about voices and to understand, learn and grow from them in their own way (Downs, 2001). Their vision is to create an acceptance that hearing voices is a valid experience for which there are many explanations.

Hearing voices groups have been described as having a number of advantages: people learn from each other, gain new coping strategies, feel heard, realise they are not alone and are not mad (Romme et al, 1992). The experience of hearing voices is normalised and fears reduced as people explore different ways of accepting and coping (Malecki and Pennings, 1993). Members can share experiences and develop new ways of coping with their voices and disabilities, they may regain some of their power through solidarity and establish new more positive senses of identity (Meddings, 1998). Downs (2001) suggests that hearing voices groups may minimise fear and distress, improve self-esteem, reduce stigma, help people to gain a sense of control and of power, feel understood, and less isolated.

Birchwood and Chadwick (1997) found beliefs about omnipotence (power) and control to be particularly important in affecting how people feel and cope with voices. Using a waiting list control study whereby each person acted as their own control, Chadwick, et. al. (2000) found that group based cognitive behavioral therapy for voices decreased the apparent omnipotence of the voices and increased perceived control over them, but did not decrease the prevalence or improve affect. Again, Wykes, et al, (1999) found, whilst not reducing the prevalence of voices, CBT groups

decreased the power of voices, improved perceived control over them and increased coping strategies.

Hearing voices groups could be placed under the broad heading of psychological therapies. Psychological therapy for psychoses has been shown to lead to a 25% reduction in symptoms (Kuipers et al, 1997). The NSF mental health recommends greater access to psychological therapies for people with severe and enduring mental health problems (2000). The NICE guidelines for schizophrenia state “psychological treatments should be an indispensable part of the treatment options available for service users and their families in the effort to promote recovery” (National Institute for Clinical Excellence, 2002,

p.16). Service users want greater access to psychological therapies (Beeforth et al, 1994; Read, 1996) and help with organising self-help groups (Mental health Foundation, 2000, Prince et al, 2000).

Despite positive descriptions of hearing voices groups over the past 15 years, there have been no published studies of the efficacy of hearing voices groups using standardised assessment tools. This study sought to examine the effectiveness of a hearing voices group borrowing from the methodology of studies of CBT groups for voices (Chadwick et al, 2000 and Wykes et al, 1999).

Mental health service users do not limit their conceptions of getting better or recovery to symptoms and hospital admissions alone, but also include factors such as general wellbeing, quality of life, empowerment and self-esteem (Meddings and Perkins, 2002). Furthermore, given that users and staff have different constructions of recovery, it is crucial to measure what users of services want, and not only what clinicians or researchers perceive as important. Thus the evaluation included broader conceptions of outcome and a qualitative element to its enquiry.

Hypotheses were that after attending the hearing voices group:

- Members would have less and shorter admissions to hospital and these would be more likely to be informal
- Members would have more coping strategies and talk to more people about their voices
- They would show increased self esteem
- Increased sense of empowerment
- Members would perceive themselves as having more control, and the voices as being less powerful
- Members would use the group to achieve their own individualised aims

## The Group

The hearing voices group was set up in response to requests from service users. It was based in a town on the Sussex coast. The area does not have a particularly well-developed or active voluntary sector. The nearest hearing voices group was in London. Both the concepts of hearing voices approaches and of employing a user project worker were new in the area and a challenge to more traditional psychiatric practices. Nevertheless, there was a readiness in the area for such developments and enthusiasm from users, staff and managers.

From its launch in May 2002, the hearing voices group was popular. In the two years up to June 2004, when the evaluation was conducted, 60 people joined its mailing list and 21 people attended the group. Members came from across East Sussex. They included users of community mental health teams, assertive outreach teams, rehabilitation services, learning disability services and people who were not involved with mental health services. At any one time, the group was attended by on average 12 people, with a core of eight regular attenders. Attendance levels of the

core group members was usually between 75-100%. This is high for a hearing voices group as, in addition to ongoing disabilities, there is often pressure from voices not to attend the group. Most members were referred by mental health workers; others got in touch via the hearing voices network or by word of mouth via group members' recommendations.

## Intervention

The group was a weekly, ongoing, slow open hearing voices group which followed the model outlined by Romme and Escher (1989), Meddings (1998) and Downs (2001). The group was started by two psychologists along with a project worker who had experience of hearing voices and using mental health services. It was always intended that it would become a self-help group. The content of meetings was set by the members. We used a recovery paradigm, honoring a diversity of views and supporting people within their frames of reference. Flip charts were used to help people maintain focus. Facilitators took care to follow the lead of the group and wait for topics such as powerfulness of voices to be raised by members. Topics discussed by the group included: coping strategies, explanations for voices, famous people who heard voices, links between voices and past abuse, medication and recovery. Following each group, letters were sent both to attendees and members of the mailing list summarising the discussion and reminding people of the next group.

## Evaluation Method

### Design

Triangulation of methodologies was used to make our conclusions more robust: pre- and post-group comparison, clinical significance and qualitative interviews.

Outcome measures were completed prior to joining the group, after six months and after 18 months of attending the group. Results here are presented comparing measures prior to joining the group with the later assessment – for some people this is at six months, for most, 18 months as people joined and left this ongoing group at different times. Due to pragmatic and ethical considerations, we did not follow an initial intention for people to act as their own waiting list control. Prior to outcomes measures being used potential members met with two of the facilitators to find out about the group, consider whether they wanted to attend and discuss consent to taking part in the evaluation. Information about hospital admissions was obtained from NHS records.

Individual clinical significance was also computed for each individual on a case by case basis, taking account of variance in the population and reliability of each measure (Hansen and Lambert, 1996). The reliable change index was used (Jacobson, Follette and Revenstorf, 1984).

Qualitative semi-structured interviews were conducted with people after they had been attending the group for six months. Answers to these questions were grouped into categories according to the themes that emerged. These themes were fed back to the group and were used to form discussions on how to improve the group using action research: self-evaluative, collaborative enquiry with the aim of improving practice (Bannister *et. al.*, 1994).

### Participants

Seventeen people took part in a limited evaluation, allowing us to make use of existing records, but not all took part in the whole study. Twelve people fully took part in the more in depth evaluation including standardised questionnaires at both time points and qualitative interviews.

The average age of participants when they first joined the hearing voices group was 40.74 (SD =10.91), ranging from 27 to 57 years old. People had been hearing voices for an average of 13.3 years (SD=7.21) and had been involved with mental health services for an average of 11.7 years (SD=8.22). One person was working, and none in voluntary work or at college. Six were women and six were men.

## Measures

Measures were chosen for their validity and reliability and for their common usage.

### *Scale of voices questionnaire*

This was a series of likert-scale questions drawn from published scales.

- The Hustig and Hafner topography of voices rating scale - a five item self-report scale designed to measure the frequency, volume, clarity and intrusiveness of voices, and associated distress (Hustig and Hafner (1990).
- Belief conviction: omnipotence (power), control and personal meaning (Chadwick and Birchwood, 1995; Chadwick et al 2000).
- Selected items from the psychotic symptom ratings scales (PSYRATS) (Haddock et al., 1999).

The literature suggests that items included in this scale have good reliability: over .75; 0.9 and 0.93 respectively (Hustig and Hafner, 1990; Chadwick and Birchwood, 1995, Haddock et al, 1999).

All scale of voices items were converted into a scale (1-100) where the higher the score, the better the result, in keeping with Chadwick et al (2000).

### *Consumer constructed empowerment scale* (Sciarappa, Rogers and

Chamberlin (1994). This has a good reliability of 0.84 (Schneider, 2001).

*Rosenberg's self-esteem scale* (Rosenberg, 1965) in its form incorporated into the consumer constructed empowerment scale. In this form this has a good reliability of 0.89 (Schneider, 2001)

Questions were also asked to determine satisfaction with the group. These were anchored using a 1-7 Likert scale.

*Personal Constructs scale* –personal constructs (Kelly, 1955), individualised statements about what people wanted to get from the group, transformed into Likert scales, anchored at each end by people's own statements (from 1-100).

## Statistical Analysis

Results were analysed using SPSS. The majority of comparisons were made using paired sample related t-tests. Other relevant statistics were used as required. Cohen's d was employed as a measure of effect size.

## Results

### ***Hospital Admissions***

After joining the hearing voices group, **hospital bed use decreased** – people spent far fewer days in hospital – from an average of 39 days each per year over the three years prior to joining the group to 8 days each in the year after joining (1 SD,  $p < .05$ ). There was an almost significant trend for less admissions and less admissions under section.

In terms of individual changes, taking account of variance and reliability, 4 people showed clinically significant improvements and 13 no change in number of admissions and admissions on section, 6 people showed improvements and 11 no change in days admitted; no individual showed a worsening on any of these factors.

	Pre group average of 3 years prior to group  M (SD)	During 1 <sup>st</sup> year of attending group  M (SD)	t	df	Significance (2-tailed)	Cohen's d Effect size
<b>Number</b>	0.89	0.35	2.05	16	.057	0.70
<b>Admissions per year</b>	(1.06)	(0.49)				
<b>Admissions on section per year</b>	0.41 (0.83)	0.00 (0.00)	2.05	16	.058	0.99
<b>Days in hospital per year</b>	39.05 (46.65)	7.59 (16.63)	2.64	16	.018	0.99

### ***Coping Strategies and Talking about Voices***

After attending the hearing voices group people used **far more coping strategies**, increasing from an average of 2.9 to 5.7 strategies each (an increase of 1.3 SD's;  $p < .001$ ).

Seven individuals showed a clinically significant improvement compared with 5 showing no change and 0 becoming worse.

Perhaps unsurprisingly, after attending the group, **people were able to talk to far more people about their voices**, increasing from 2.7 to 14.9 people each (2.6 SD's;  $p < .000$ ). Most of these people were other group members, although it was clear from the numbers that participants had also spoken to others about their voices. One participant remarked on how it had made her much more open about her voices, to the extent that she often found it helpful to tell friends and acquaintances about them.

All 12 showed individual significant improvement.

### ***User Empowerment and Self Esteem***

**User empowerment was much increased** after joining the hearing voices group. People's sense of empowerment increased by 1.34 SDs ( $p < .001$ ).

Eight individuals showed a clinically significant improvement in self-empowerment, compared with 4 remaining the same and 0 decreasing.

People's **self-esteem was much higher** after attending the hearing voices group: an increase of 1.5 SDs ( $p < .000$ ). Again, people felt that they had greater control over their lives and could make things happen (an increase of 1.7 SDs,  $p < .001$ ). People felt that they were more OK, and less crazy (an increase of 1.16 SDs,  $p < .05$ ).

Seven individuals showed a clinically significant improvement, compared with 5 remaining the same and 0 worse.

**Table showing significance and effect size of changes after attending the group**

(NB: all items have been converted so that a higher score is always a preferred result with the exception of clarity where there was no consensus as to whether more or less clarity was preferable)

	Pre group M (SD)	After 18 months of group	t	df	Significance (2-tailed)	Cohen's d Effect size
<b>Number of coping strategies</b>	2.92 (2.02)	5.67 (2.19)	-4.29	11	.001	1.31
<b>Number people can talk to about voices</b>	2.69 (1.38)	14.92 (7.86)	-5.84	12	.000	2.65
<b>User empowerment Scale (1-4)</b>	2.25 (0.40)	2.73 (0.31)	-4.22	11	.001	1.34
<b>Self-esteem (1-4)</b>	2.20 (0.64)	2.93 (0.32)	-4.90	11	.000	1.50
<b>Frequency (1-100)</b>	32.92 (31.44)	52.92 (29.50)	-2.24	11	.047	0.66
<b>Volume</b>	49.58 (29.11)	65.00 (18.22)	-1.74	11	.109	0.65
<b>Clarity</b>	85.83 (15.64)	78.75 (25.86)	1.56	11	.147	0.34
<b>Distress (how upsetting voices are)</b>	25 (26.11)	25 (19.07)	.00	11	1.00	0.00
<b>Distract (how distracting voices are)</b>	23.75 (30.31)	30.42 (22.91)	-1.19	11	.258	0.25
<b>Powerfulness of voices relative to hearer</b>	33.75 (26.64)	55.83 (30.36)	-2.59	11	.025	0.78
<b>Control (extent voices control person)</b>	38.18 (30.84)	60.00 (25.69)	-2.03	10	.070	0.77

<b>Universality (I alone hear voices)</b>	59.55 (31.34)	86.36 (25.60)	-2.03	10	.070	0.94
<b>I cope (how well I cope with voices)</b>	38.36 (31.49)	70.45 (23.29)	-3.00	10	.013	1.17
<b>Self-belief (that are OK, not crazy)</b>	30.91 (29.57)	65.00 (29.33)	-2.73	10	.021	1.16
<b>Control over life – make things happen</b>	24.17 (27.62)	70.83 (27.78)	-4.61	11	.001	1.69
<b>Personal constructs</b>	30.98 (23.37)	58.49 (15.08)	-4.98	10	.001	1.43

**Significance** 0.05 = a statistically significant finding (ie: there is less than a one in 20 chance of this improvement being due to chance);

0.01 = very significant;

0.1 = a non-significant trend and, with such a small sample, possible Type II error.

**Cohen's d** 0.2 (just under ¼ SD) = small effect size

0.5 (1/2 SD) = medium effect

0.8 (3/4 SD) = large effect size

### **Scale of Voices**

In terms of the voices themselves:

People **heard voices less frequently** after attending the group (0.66

SDs,  $p < .05$ )

The **voices were perceived as less powerful relative to the person hearing them** (0.78 SDs,  $p < .05$ )

People felt **much better able to cope with their voices** (1.17 SDs,  $p < .05$ )

There were also trends towards showing:

People may have felt less controlled by the voices ( $p = .07$ )

Increased universality – people may have been more likely to feel that they were not alone in hearing voices ( $p = .07$ )

There were no differences in terms of clarity of voices, volume, how upsetting the voices were or how distracting they were.

## Personal Constructs

Some of the more common personal constructs about what people hoped to gain from the group were:

- To hear voices less often (5 people)
- To feel more normal / less insane (4 people)
- To cope better with the voices (5 people)
- To meet others who heard voices (4 people)
- To feel less isolated, a sense of belonging (4 people)
- To feel less anxious/frightened or panic (5 people)
- People also talked about wanting to move on with their lives (2), self acceptance (2), persecution (1) and finding positives in their voices (1).

There was a **large improvement for group members about their own individual personal constructs or what they themselves wanted to get from the group**, from 30.98 to 58.49, an increase of 1.4 SDs ( $p < .001$ ).

## Work status

**More people were in work, voluntary work or at college** after attending the group; an increase from one to six of the thirteen people who took part in the detailed evaluation (chi-square = 4.89;  $p < .05$ ).

## Satisfaction with the group

Members were satisfied with both the group ( $M=5.32$ ,  $SD=1.15$ ) and the mail out letters ( $M=5.18$ ,  $SD=1.89$ ). They were more satisfied with the group after six months than with their lives as a whole at the start of the group ( $M=3.91$ ,  $SD=1.17$ ;  $p > .05$ ). There was a trend for people to be more satisfied with the group and mail out letters than a control in the form of satisfaction with the NHS as a whole about which they felt mixed ( $M=4.22$ ,  $SD=1.69$ ;  $p = .06$ ).

**Table showing the number of individuals with a clinically significant change for each measure**, using the reliable change index (Jacobson, Follette and Revenstorf, 1984).

	Number of individuals showing:		
	Clinically significant improvement	No change	Clinically significant worsening
Number admissions per year	4	13	0
Admissions on section per year	4	13	0
Days in hospital per year	6	11	0

<b>Number of coping strategies</b>	7	5	0
<b>Number people can talk to about voices</b>	12	0	0
<b>User empowerment scale (1-4)</b>	8	4	0
<b>Self-esteem (1-4)</b>	7	5	0
<b>Frequency (1-100)</b>	4 / 5*	7 / 6*	1
<b>Volume</b>	4 / 5*	7 / 6*	1
<b>Clarity</b>	0	11	1 less clear
<b>Distress (how upsetting voices are)</b>	5	5	1
<b>Distract (how distracting voices are)</b>	2	9	0
<b>Powerfulness of voices</b>	6	5	1
<b>Control (extent voices control person)</b>	5	6	1
<b>Universality (I alone hear voices)</b>	8	3	1
<b>I cope (how well cope with voices)</b>	8	3	1
<b>Self belief (that are OK, not crazy)</b>	8	3	1
<b>Control over life – make things happen</b>	9	3	0
<b>Personal constructs (combined average)</b>	9	3	0

\*two figures due to Hustig and Hafner having lower reported reliability and thus showing less significant change for same item as PSYRATS which, for the same item has higher reported reliability

Individual clinical significance is a robust way of looking at change for individuals as it takes account of the reliability of the measure and also the variance: the change is greater than you'd expect from normal day to day variations.

## Qualitative Findings - Participants' experience of the Group

### Helpful Aspects of the Group

Participants' feedback about the group was almost entirely positive. Individual comments included: 'enjoy it', 'very helpful', 'very useful – the only thing that's really ever helped'.

*"I love it – I wake up on a Thursday [day of the group] and think great, I'm going to the voices group today – it's changed my life."*

Most members found the group supportive eg. 'good support element' and safe 'the hearing voices group is the only place where I feel safe being with other people'. Two also valued the experience of being able to support others as well as feeling supported themselves: 'enjoy helping others'.

Aspects of the group related to universality were identified as being some of the most helpful. People described 'being with people in the same boat' 'relating to others' problems', 'sharing experiences' and 'listening to others' opinions of voices' as being very helpful. "to talk to other people with the same problem makes me less anxious because what I'm experiencing isn't uncommon". One group member also valued the opportunity to have their opinions heard and valued by the group.

Similarly, a number of people reported the benefits of the group de-stigmatising or normalising their experience of hearing voices:

*"realising you're not strange, a weirdo, it happens to other people – members of the group have enabled me to normalise and to know you can have a fulfilling life even with voices."*

One group member particularly valued discussing famous people who heard voices. Others valued knowing that people who hear voices can lead a normal life, get a job, get married, have their own flat.

Several people felt less isolated as a result of the group e.g. 'I feel less isolated', 'you're not alone' and this could be mirrored by the large increase in people they could talk to about their voices. One participant valued being able to be open in the group, and felt that although people were generally isolated, they were gradually getting closer to each other.

Participants found the information provided in the group extremely helpful. They valued a talk by a pharmacist on medication and side effects, being taught theories and strategies by other members, and watching the Horizon Ron Coleman video 'Hearing Voices'. One group member valued strategies to cope during a crisis, while another group member found that the sympathy and understanding they had received because of their anxiety had helped them to work out what was causing it and reduce it.

Being able to recognize the positive and negative aspects of the voices as well as discovering that voices can work for the voice hearer were also seen as benefits of the group.

### Least Helpful Aspects of the Group or Potential Improvements

Least helpful aspects of the group were all very individual. Comments related to the content or process of the group: that people were 'moaning' too much; that the group 'brings it home that I am not well'; that people 'go off on tangents'. For one member, the group sometimes brought on the voices. Another found some of what was said too complicated: "I try my hardest to understand what people are talking about, but sometimes it's hard"

Another: "overall it's helped me but sometimes when I come back from the group I'm a bit distracted because the discussion was intense and I can't switch off straight away."

Some suggested improvements included a request that discussions should be more focused on hearing voices; that the facilitators should use less complicated language; to have therapy connected to the group; to have more members join the group to give more perspectives, and 'more good feelings'. Practical issues mentioned included making provision for transport.

We had been aware of most these issues and have tried to address them both within the group and via people's care co-ordinators.

### **What Has Changed as a Result of the Group**

Four group members talked about the social benefits of the group which included: relating better, reduced isolation, increased social opportunities and feeling more confident socially. Other group members discussed the impact the voices group had on their emotions: feeling cheered up, feeling relieved at having got things off their chest, feeling less withdrawn and not so paranoid. One group member felt the group had "*turned me into a proper person*". Most people mentioned their self confidence or esteem and three said it had made them confident enough to think about work.

*"Being in the group has helped me to be more confident and now I'm a volunteer driver and take people to the group."*

However, one group member said their voices had become more persistent

### **What Group Members Would Say to Someone Thinking About Group**

Almost all of the group members would urge a voice hearer to join the group, often citing how helpful it was for them to discuss things. One member emphasised the importance of being able to open up, while another would encourage people to stick with it even in the initial stages when it feels daunting because members barely know each other.

*"definitely go ahead and join – stick with it because it can be daunting when you don't know people and hopefully you'll get something from it."*

The participant who no longer attends the group said he would also recommend it but would warn people not to take things 'to heart' as he did.

### **What Participants' Significant Others Would Say About the Group**

Members were both positive and negative about what their significant others thoughts about the group. Most predicted their parent/friend/partner would or does say that the group helps them.

*"My partner says I've totally changed since I've been in the group – I'm much better – they'd say it's a very good thing for you."*

Two participants, on the other hand believed that their significant other would question their reasons for going to the group: one because they would argue that the voice hearer had no knowledge about voices and the other because they should be able to sort themselves out without help.

### **What the Voices Would Say About the Group**

Six participants had voices that commented about the group, five negatively. These ranged from demands not to go (either because the group might help or definitely would not do so) to threats that if the person did go, they would get in trouble with the police. Voices also harassed one group member saying they were mentally ill. One member heard a running commentary during the group, which often made her laugh. This is consistent with reports about psychological therapy. It could be suggested that voices may not want people to talk to others or attend groups that might decrease the power of the voices.

*“the voices don’t like it that I’m going to the group and I’m being positive whereas they prefer me to be negative – it’s a way of defeating them so they don’t like it”.*

## Discussion

### Methodological considerations

A particular strength of the study is the involvement of a user-consultant in the design of the research, in some of the interviews and its write up. Users may have different perspectives from professionals on the questions we ask in research and the way in which we go about it. Whilst randomised controlled trials are often seen as the gold standard in terms of outcome research, a well-designed non-RCT may be preferable to a small poorly designed RCT and there is no evidence that the results of the two kinds of studies inevitably differ (Britton, et al 1998). Again, Marzillier (2004) suggests that more stringent research, may often be less value to clinicians.

Nevertheless, there are methodological limitations to the present study. Repeated measurement was kept to a minimum, due to pragmatic and ethical considerations. In discussion with our user-consultant, it was decided that it would be too burdensome and potentially upsetting of members to ask them to complete lengthy assessments more than once before the group actually began. Again, it would have been counter to the philosophy of hearing voices groups to have denied some people access in order to form a control group. Nevertheless, a triangulation process involving qualitative interviews and the use of standardised measures, analysing group means and individual clinically significant change makes the findings more robust.

Consideration must be given to the possibility that change occurred, not due to the voices group, but to other factors. We can only know that these improvements coincided with the group. Nevertheless, measures used had good test-re-test reliability, most members reported that they had experienced little or no improvement in the three years prior to joining the group; people’s voices and mental health service use was longstanding. Whilst it could have been possible to compare some of our outcome data with outcome data for services as a whole, this would not have been a true comparison – people who choose to join a hearing voices group may well be different from people who do not. In setting up the group and mailing list which went out to over 60 users and staff, the intention was to impact upon the whole system, rendering an RCT inappropriate.

Estimates of change are rendered more conservative as people met with facilitators, received information about both the group and voices and in some cases were on the mailing list for some time, before completing pre-group questionnaires. Any effect due to optimism of joining a group was also thus reduced.

### Findings

The present study found that after attending the hearing voices group, members’ hospital bed use decreased and there was a trend for less formal admissions. Hospital admission data could be influenced by other factors, however, during the time of the study itself there was no known change in policy around admissions and the number of beds remained stable. Again, no one in the group changed their medication during the study period, with the exception of two people who either reduced or discontinued their medication.

People used far more coping strategies and were able to talk to far more people about their voices after attending the group. Learning coping strategies was something people valued about the group and one of the common topics was to explore and experiment with different coping strategies. Similarly, Wykes et al (1999) study of CBT groups also reported increased coping strategies. This may in turn influence people’s sense of control and power over their voices. Finding alternative ways of coping with voices could also decrease the reliance on more traditional psychiatric interventions such as medication and staff support. Whilst the group data on universality did not quite reach statistical significance, individual clinical significance and qualitative data suggest that gains were made in this.

After attending the group, self-esteem increased, mirroring Wykes et al (1999) and the more anecdotal hearing voices literature (e.g. Downs, 2001). User empowerment also increased supporting anecdotal reports of hearing voices groups which had not been formally examined elsewhere. Feeling more empowered was one of the aims of the group particularly valued by users and may be associated, not only with the voices themselves, but also with other aspects of recovery and getting better. In the qualitative interviews people especially spoke about the group helping them to feel less alone and normalising or de-stigmatising the experience. This may in turn affect confidence and social inclusion. Members cited the group as increasing their empowerment to the extent that they were able to move their lives forward into work or college. More people were in work, voluntary work or at college after attending the group.

The qualitative interviews highlighted the value which participants placed on group processes: universality, instillation of hope, self-disclosure, mutual support and improved social functioning (Yalom, 1995). Whilst it can be quite daunting for socially isolated voice hearers to attend, hearing voices groups which attend to group process, can be a transformative experience.

People's relationships with the voices were mostly improved. They heard the voices less frequently, the voices were perceived as less powerful (omnipotent) relative to them, people felt much better able to cope with their voices, and there were trends towards people feeling less controlled by their voices and feeling less alone. Similarly, Chadwick *et al.*'s (2000) study of a CBT group for hearing voices also reported significant effects for power and control although not frequency. Neither of the studies found any impact upon clarity or how distressing or distracting the voices were. Wykes *et al.* (1999) study of a CBT group for auditory hallucinations found improvements on PSYRATS, particularly for distress and disruption, but no significant effect for frequency, control or power. Power and control may be key improvements as they have been found to relate to a number of other variables including violence and depression which could, in turn relate to distress and admissions (Chadwick et al 2000; Cheung et al, 1997). The voices themselves were little affected by people attending the group – there were no significant changes in volume, clarity or how upsetting or distracting they were. It may be that we can support people with relational aspects of hearing voices rather than changing the voices themselves.

Members reported that they were satisfied with the hearing voices group, as with other reported groups (Chadwick et al, 2000; Wykes, 1999). People spoke very positively about it and almost all of the group members said they would urge other voice hearers to join the group.

Perhaps most importantly, the evaluation shows that people improved in relation to what they had identified as their own goals for the group, their personal constructs. The constructs themselves are consistent with those reported in the literature about what getting better means to users (Meddings and Perkins, 2002). Perhaps the format of the group, whereby members set the agenda and supported each other particularly lent itself to improvement in individualised aims.

## **Exceptions**

Whilst group data was positive, it was also important to look at exceptions. Tests of individual clinical significance showed that, whilst most people showed clinically significant improvements on most measures, many showed no change on one measure and a minority showed a clinically significant worsening on more than one measure. It is hard to draw a firm conclusion from this as there were no patterns and often a person with a worsening on one measure showed several other improvements.

The interviews showed that one member did not find the group beneficial. Attempts were made to work with the issues that he was presenting, however they were not resolved. The evaluation helped this member to decide to leave the group and seek alternative support after two years' attendance. Despite a longstanding history of serious mental health problems which had rendered him unable to work for many years, he later contacted the group to say that he was in full time employment and no longer had contact with mental health services.

Thus, hearing voices groups are not suitable for everyone. Although mental health service users often opt out of groups which they do not see as beneficial to them, others may attend groups out

of compliance or lack of alternatives. This further highlights the importance of evaluating the effect of interventions for individuals in routine practice.

## Implications

It is not possible to generalise from the evaluation of one group. It could be that the enthusiasm of the initial facilitators and members in creating something new may have resulted in a positive experience that could not be replicated. Nevertheless, the large effect sizes and the triangulation of group and individual data with qualitative interviews suggests that it is meaningful. Members were extremely positive in the qualitative interviews. The study adds to a growing literature on approaches with voices and hearing voices groups in particular. It suggests that the hearing voices group approach may be an important element in the recovery of people who hear voices, supporting people troubled by them, improving self-esteem and empowerment.

One way in which hearing voices groups differ from many approaches is in their ongoing nature. Here findings are presented after 18 months rather than the two to six months often reported. Such long-term groups could be perceived as expensive, however, the group has impacted upon 21 members and over 60 people in total, whereas most groups might affect 5-8 people (Chadwick et al 2000 and Wykes et al 1999). Drop-out rates were relatively low. It is hoped that, by creating a self-help group that can continue for many years, gains will be maintained and improved well beyond the withdrawal of professional facilitators whereas Wykes (1999) found that only gains in self-esteem and coping strategies were maintained at 3 month follow up.

Developing self-help hearing voices groups could be part of a wider exercise in capacity building amongst the local community.

It is intended that the group be further evaluated after a year of being a self-help group to determine longer term benefits. Further groups will also be evaluated to improve generalisability.

Overall, the results of this preliminary evaluation are positive: improved coping strategies, self-esteem and empowerment; hearing less voices, them being less powerful and being better able to cope with them; and most importantly in relation to personal constructs. Almost all of the group members would urge other voice hearers to join such a group.

Two other quotes:

*" regularly attending the Eastbourne hearing voices group has played a major role in my healing process - I dread to think what would have happened to me without the group..."*

*"I know for a fact, that without attending the Eastbourne hearing voices group I wouldn't be as well as I am now."*

## Summary

- People attending a hearing voices group were very positive about it and would urge others to attend
- People found the group normalising and de-stigmatising. Confidence and self esteem improved leading to greater social inclusion.
- After the group, people's relationships with their voices improved, e.g. voices were seen as relatively less powerful, and they were better able to cope with them

- People heard voices less often although other aspects of the voices themselves did not change
- A minority of people may not benefit from hearing voices groups
- The results of this preliminary study indicate that hearing voices groups may be efficacious / very helpful and their development should be supported

## Post script

Since the completion of the evaluation, the hearing voices group has successfully completed a transition to self-help status. The group formally became a self-help group on its second birthday, May 2004. Since then the group has taken on more new members and has continued to flourish. New groups are being set up in other parts of Sussex along similar lines and connected through a local hearing voices network and website: [www.sussexvoice.org.uk](http://www.sussexvoice.org.uk).

## Acknowledgements

Our sincerest thanks to the members of the hearing voices group, without whose participation this study would not have been possible. Thanks also to Mark Hayward and Norma Timmermans for their comments on earlier drafts.

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