Meaning-Making in the Voice-Hearing Experience: The Narratives of African-Caribbean Men who have heard voices

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ABSTRACT

There is a paucity of literature into the first-person account of hearing voices (HV)[1], particularly from diverse cultural groups. This research aimed to explore the meaning-making of African-Caribbean men who have heard voices, within a social constructionist framework. Five participants were recruited via community networks and individually interviewed. Narrative analysis was employed to illustrate both individual and collective stories of HV. Four emerging storylines were constructed: 'Storylines of the changing understandings of hearing voices over time', 'Recovery: Reformation, Redemption and Restoration', 'Storylines of family life and understandings of culture and race', and 'From Silence to Freedom: Speaking Out and Reaching Out'. Findings of this research suggest re-storying HV outside of a medical framework, with voice-hearers' meaning-making of the voices an integral part of understanding the phenomenon, in the context of psycho-social and cultural factors. Implications for de-mystifying voice-hearing, particularly in African-Caribbean communities, are considered in the context of promoting education and awareness of HV through community-based approaches, cross-cultural working and supporting the voice of expert by experience, in the hope of challenging dominant discourses attached to HV. Future research suggestions are discussed and researcher reflexivity concludes the study.

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[1] HV will be used as an acronym to replace the phrase 'hearing voices'.

OVERVIEW

The purpose of this thesis is to explore the cultural narratives of African-Caribbean men who have heard voices, to provide a cultural context to meaning-making of HV and create a more detailed, rich and reflective understanding of voice-hearing.

The background to this thesis topic is informed from diverse strands of evidencing literature around the experience diagnosed as 'psychosis' and influencing social-cultural factors, such as family history of migration (Bhugra, 2000; Bhugra and Jones, 2001). The research topic was constructed from multiple current debates linked to HV, such as critiques of psychiatric diagnoses (Cooke, 2008; Moncrieff, 2007, 2013; Johnstone, 2013), the active call to de-medicalise misery (Rapley et al. 2011; Bentall, 1999), the positive psychology and survivor movement (Longden, 2013), and the growing need to create a platform in research literature where lived experience of HV is better heard and understood within a socio-cultural context. A family history of migration has been suggested as a risk factor for 'psychosis' (Cantor-Graae and Selten, 2014) with vulnerabilities highlighted as pronounced in second-generation individuals of people who have migrated (Penny et al., 2009). In wider societal discourses, psychiatry has dominated the world view of mental health, yet there is a growing demand for a paradigm shift away from the medical model (Division of Clinical Psychology [DCP], 2013), to understand variation in human experience and HV as a response to environmental factors and life experience, as influenced by social and cultural factors (British Psychological Society [BPS], 2014). Furthermore, understanding the socio-cultural context of HV may invariably impact the meaning-making of HV and consequently the delivery of care offered. With an increasing cultural and ethnic diversity in the UK there is a need to match health and social care with culturally appropriate services.

This research was completed with current and previous voice-hearers sampled from community settings by connecting with the *Hearing Voices Network* (HVN) and third sector organisations. A narrative approach was utilised in this research to illuminate rich detail in meaning-making of HV over time, with attention to cultural context in the person's life story. The ethos of this research is attached to a voice-hearer survivor

perspective that "*an important question in mental health shouldn't be "What's wrong with you?" but, rather, "What's happened to you?*" (Longden, 2013).

The thesis is presented in the following chapters:

Chapter 1. The researcher's position and literature review

Contextualises the language and researcher's position of this study and details the background literature of HV in a Western context, further exploring psycho-social understandings of HV. The literature review examines first-person accounts of HV, and the clinical relevance establishes the practical importance of this study in health care, to support the research rationale and define the research question.

Chapter 2. Methodology

Describes a history of qualitative research and justifies the use of narrative inquiry. The research design and ethical implications are illustrated, and research procedure and analysis are detailed.

Chapter 3. Analysis

Presents five individual narratives as co-constructed with the researcher, and emerging storylines from the collective narratives.

Chapter 4. Discussion

Findings of the research are discussed in relation to existing literature, linking with recommendations for clinical relevance and service provision. The study is critically evaluated with suggestions for future research. Personal reflections highlight the researcher's learning from the research to conclude.

Chapter 1. THE RESEARCHER'S POSITION AND LITERATURE REVIEW

1.1 Language and context of the research project

Throughout this research, the language and words of the evidencing literature are used, as referenced in respective research. Research into HV as a phenomenon has historically been affiliated with 'auditory hallucinations' as a symptom of the diagnosis of 'psychosis', thus some wider background research reflects this medical framing. In reviewing the background literature, reference is made to some relevant historical studies with a clinical medical focus. This highlights the broader historical and social perspectives attached to HV at the time the research was conducted and the stance of the respective researchers.

In my epistemological framework, I do not use terminology such as 'schizophrenia' or 'psychosis' and do not believe that people should be labelled in such ways. In my own writings, I aim to refer to people as 'with a diagnosis of psychosis', indicating that a person may be living *with* a diagnosis rather than the diagnosis being part of an individual identity. My epistemology sits within a social constructionist framework (Gergen, 1985), not a medical model of illness, thus this research explored the sense-making of HV as a phenomenon.

1.2 Self as researcher: My epistemology

The nature of certainty, complexity and source of knowledge denote personal epistemological reflection, portraying the centrality of personal meaning-making in interpreting experience (Baxter Magolda, 2004). Making sense of the world, experiences and formulating beliefs depends upon the social and cultural context of one's experiences.

Neimeyer and Mahoney (1995) define the constructivist approach to knowledge, truth and science with several factors. The nature of knowledge may be influenced by a person's experience and validated by social consensus; the nature of truth may be multiple, contextual, historical and paradigmatic; the goal of science may be pluralist and employ qualitative and narrative methodologies (Neimeyer and Mahoney, 1995). Neimeyer and Mahoney (1995) suggest that a construct is the basic unit of meaning and that the relations between meanings may be systemic and hierarchical, with the role of language constituting social reality.

Through the meaning of my life experiences I have a developed a social constructionist stance in making sense of the world. In my journey of clinical psychology I am investing in learning more about narrative approaches, in therapy and research. This has been nurtured through my clinical practice in feeling privileged to hear people's stories and formulating them within the wider contexts in the diversity of human experience. I have learnt to attend to the language people use, the metaphors created, the emotional framework expressed and the value systems presented, indicative of one's cultural context. I would like to continue listening to individuals' stories whilst exploring their strengths, skills and sense-making in the context of being a voice-hearer.

Therefore, within this epistemology, social constructionism (Gergen, 1985) is the theoretical framework in which I operate. I hope to focus upon the complexity, multi-dimensionality and context of experience (Mason, 2002) in the richness of qualitative methodology. Specifically with narrative analysis (NA) I pay attention to stories, language, challenge dominant discourses and illuminate stories which are otherwise silenced, overlooked or marginalised.

In the exploration of voice-hearing across diverse socio-cultural contexts, different ways of making sense of and understanding HV may emerge, thus creating new boundaries to the phenomenon. Thinking systemically, it may be proposed that the power of organisational narratives and assumptions inform our thinking and judgement about mental health, and specifically, HV, reflecting discourses of

discrimination and stigma. There may be stability in human experience, yet *how* we understand the human experience is changing.

Personal significance

I have always had a curiosity about diversity, particularly cultural diversity. Reflecting upon my upbringing I wondered whether this interest in diversity was nurtured through growing up in a socio-cultural context which lacked diversity. I have always been curious about 'difference'; noticing, asking and wanting to learn more about what things made a difference, in people, places, values, lifestyles and ways of being. This relentless curiosity about people, places and cultural diversity inspired my work and travel abroad, which nurtured rich and meaningful culturally diverse experiences personally and professionally.

In international volunteer projects (Africa, Thailand, India) I was forced to step outside of the dominant discourses of a Western context and was challenged to make sense of variations of human experience in the context to which they were bound. I returned to the UK seeing the world in a different light. The content of what I was seeing had not changed; I was seeing the same things, but from a new and adjusted perspective: A social constructionist lens. My understandings of the world had expanded from thinking beyond the individual and group to wider social and culturally informed systems.

With a more inspired course of action towards a career in clinical psychology, my academic drive led me to two significant events in my professional journey. A training workshop on "Systemic Thinking" and a lecture series on "Mental Health, Race and Culture" with Suman Fernando, both supporting me to reflect upon my lived experiences, my social constructions about the world and the clinical psychologist in future that I hoped to be. This led to my curiosity in thinking more systemically from a critical and community psychology perspective, which was further nurtured in my

clinical training at the University of Hertfordshire, advancing my passion for social constructionism.

Living and working for the past six years in one of London's most socially disadvantaged boroughs I have gained insight into living alongside diverse communities from multiple backgrounds culturally and socially and the impact of inequality and poverty on mental well-being. I have connected with people who are stuck in systems of revolving doors as a result of social adversity and austerity: unemployment, difficult living situations, a family history of social care and traumatic life experiences represented the norm in one's background. When working in a local psychiatric hospital I noticed what I understood to be a disproportionate representation of African-Caribbean men in the acute inpatient wards, diagnosed with 'psychosis'. I started to wonder about people's backgrounds and the relationships, contexts and systems of their lived experiences, within a cultural context.

Further inspirations for this research are notably from Jacqui Dillon, for sharing her personal account of HV and advocating for HV to be de-medicalised and understood in the context of a life story, and Angela Byrne, for empowering work with diverse communities and challenging stigmas associated with African-Caribbean men in the mental health system.

My hope is to re-present the stories of African-Caribbean men in their lived experience and meaning-making of HV, and provide the research literature with powerful narratives that challenge the dominant medical discourses around HV.

1.3 Background literature: Understanding hearing voices

The literature presents definitions and meanings of HV, considers how it is understood in a Western context and explores the psycho-social and cultural understandings, including the importance of cultural heritage, identity and personal context in the meaning-making of HV.

1.3.1 What is hearing voices?

HV was first defined as a phenomenon in its own right by Romme and Escher (1989). HV as a term is universally contended, yet is understood across clinical and non-clinical contexts (Woods et al., 2015). The BPS (BPS, 2000, p.8) defined HV as "hearing voices speaking when there is no-one there". With a similar definition the HVN additionally describe HV as presenting in a variety of forms, identities or familiarity, which may provide support and encouragement or be critical. HV is detailed in the *ICD-10 classification of mental and behavioural disorders* (ICD-10; World Health Organization [WHO], 1992) as giving a running commentary on an individual's behaviour, discussing an individual amongst themselves, or coming from some part of the body.

HV may be more common in the general population than previously thought (Jones and van Os, 2001) with estimates that 10% of the general population hear voices at some point in their life (BPS, 2014; Slade and Bentall, 1998), with a lifetime prevalence of HV suggested to be four per cent (Eaton, et al., 1991). There are multiple explanations offered as to why people HV, including trauma and life adversity, emotional distress, spiritual experiences, biochemical imbalances, cognitive error and individual differences (HVN). To reflect a social constructionist understanding of HV, there appear to be multiple truths.

In research with an ethnically diverse sample only 25% of respondents who hear voices met the diagnostic criteria for 'psychosis', highlighting HV as a phenomenon not always categorised as a symptom of 'psychosis' and demonstrating the potential cultural differences in the meaning-making and associated distress of the voice-hearing experience (Johns et al., 2002).

1.3.2 Sense-making of hearing voices: How is hearing voices understood in a Western context?

Dominant discourses of hearing voices in a Western context

The medical model is dominant in a Westernised context, which understands the phenomenon of HV through a framework of clinical descriptions and diagnostic guidelines, sitting within a psychiatric framework. In the clinical descriptions and diagnostic guidelines of the ICD-10 (WHO, 1992) and the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association [APA], 2013), HV is categorised as one of several groups of symptoms of an 'illness', classified as 'psychosis'.

With a revised edition of the DSM-5 (APA, 2013) there are changes to how mental health diagnoses are constructed in the medical and psychiatric profession. 'Hallucinations' are one of five domains categorised as symptoms of 'Schizophrenia spectrum disorder' (DSM-5, APA, 2013). As the DSM-5 (APA, 2013) has increased the threshold for diagnostic criteria of 'schizophrenia' from one symptom to two symptoms, it may be proposed that if an individual presents with HV alone and no other symptom criteria, the diagnostic threshold for 'schizophrenia' remains unmet. Additional changes to the diagnostic criteria of 'schizophrenia' in the DSM-5 eliminate 'schizophrenia' subtypes. This is due to predominant symptoms frequently changing and overlapping between subtypes (DSM-5 Fact sheet, accessed 21st March, 2016) and is therefore reflective of the difficulty in labelling individual experience by diagnostic classification.

However, Heckers et al., (2013) contend that the DSM-5 aims to capture the underlying dimensional structure of 'psychosis' by specifically assessing the frequency and duration of psychotic signs and symptoms. However, in highlighting the 'social and occupational dysfunction' caused *by* 'schizophrenia' ((DSM-5 Fact sheet, accessed

21st March, 2016), then the social, occupational and wider systemic factors as the cause *for* schizophrenia may be considered to better understand the experience.

With specific reference to cultural context, definitions by the DSM-5 (APA, 2013) have been criticised for low reliability, weak validity and limited stability in diagnosing in black minority ethnic (BME) populations (Fernando, 2010). There appears to be limited attention given to diverse cultural or ethnic backgrounds in understanding the phenomenon of HV.

Critiques of the psychiatric lens

Anderson (1997, p.33) defines diagnostic categories as cultural and professional codes; "professional and cultural labels classify and place people; they do not tell us about them". The power of the psychiatric diagnostic label is criticised by Moncrieff (2007) in its sterile and reductionist understandings of distress. Psychiatric diagnoses are further critiqued for dominance in healthcare across administrative, professional, psychological and social functions which are deemed unlikely to be served by alternatives (Boyle, 2007). The current psychiatric diagnostic system may ignore social, political and economic factors that may cause or contribute to mental health difficulties (Fernando, 1988). Re-thinking notions of normality and sanity, May (2007) contends that the diagnostic process locates a psychosocial problem within the individual, removing the personal, social and historical context. With limited research into what impact a diagnosis has upon an individual, May (2007) suggests that a diagnosis of 'schizophrenia' may create learned hopelessness for the recipient and those around them.

In relation to HV, the cultural appropriateness of the Westernised and Eurocentric assessment measures and techniques can therefore be questioned suggesting that the validity of the diagnostic criteria is not culturally valid outside of the Western medical framework. Bala (2005) contends that the individualised and de-contextualised understandings of distress are based on a narrow lens and consequently have ethical

implications. Thus, for culturally diverse groups, Western models of mental health may not be the best fit. Moving beyond current definitions of 'psychosis' and HV can lead to re-formulating the understanding of one's experience, with more accurate sense-making and a greater acceptance, in both the individual and the community. As opposed to 'psychiatric colonisation' and projections of the medical model, connecting with local resources and practices in diverse cultural community settings may create more positive trajectories for mental well-being and provide a platform for better understanding the variations in human experience. This highlights the need for humanistic value with a contextualised person-centred approach in the hope of improved understanding of HV in non-medical terms.

'Time for a paradigm shift': De-medicalising hearing voices

The BPS Division of Clinical Psychology (DCP) formulated a document and public position statement *'Time for a paradigm shift'* (2013) calling for a movement away from functional psychiatric diagnoses. As a response to the new version of the DSM-5 (APA, 2013) the position statement renounces the empirical limitations inherent in the psychiatric diagnostic classification system particularly the limited validity and reliability of 'psychosis' as a diagnosis. Concerns are also expressed by the DCP for emphasis of a 'disease' model and neglect of psychosocial factors that contribute to the variation in human experience.

The rationale for the paradigm shift identifies two core issues with the functional diagnoses: the concepts and models, and the impact on service-users. In the context of this research the psychiatric concepts and models of HV and 'psychosis' may de-contextualise a person's historical context including social, cultural and familial experiences. Medical models may also maintain an ethnocentric bias, in that diagnoses may be discriminatory against human diversity such as ethnicity, spirituality and culture when viewed only through a Westernised lens (DCP, 2013). On the individual micro-level, diagnoses may stigmatise identity, marginalise lived experience and

disempower individual agency and choice (DCP, 2013). Negative social attitudes attached to diagnostic labels may create stigma and discrimination at a macro-level.

Why people hear voices has been explored by the BPS in the recent publication *'Understanding Psychosis and Schizophrenia'* (BPS, 2014a) which seeks to offer understanding beyond the medical view of 'psychosis'. Contending that variation in human experience falls on a continuum and should not be categorised concretely, the publication details how life events, trauma and difficult relationships can have an effect upon well-being (BPS, 2014a). Traumatic life events may trigger HV since the experience is often related to memories, negative life experiences and unexpressed emotion (BPS, 2014a). Wider social adversity, such as inequality, poverty and social disadvantage, are contextualised as stressful life factors that may impact the development of 'psychosis'. The experience of living in a dense, urban environment may also be a risk factor for the development of HV or 'psychosis' (Kirkbride et al., 2014).

The BPS (2014a) recognises that cultural background must be accounted for in making sense of an individual's distress with a focus upon recovery and well-being approaches which match their need. The position statement (DCP, 2013) and the 'Understanding Psychosis' document (BPS, 2014a) therefore argue for context and multi-factorial understandings of human experience.

Spirituality: Another alternative for hearing voices

The BPS (2014a) acknowledges that some individuals, cultures and subcultures highly value HV, for example, the experience being received as a spiritual gift. Beyond medical symptomologies, experiences of HV can be viewed as a positive connection and spiritual development. Ritsher (2007) portrays the attributions of spiritual experiences in diverse cultures, such as a voice of a god, channelling deceased strangers, or guidance from ancestors. This conveys the possibility that HV may be a positive and protective experience for some individuals, depending upon their belief

system and social-cultural context, further highlighting the conflict of a diagnostic label. It is also suggested that HV may be a transformative crisis of spiritual growth (Clay, 1999).

Survivor movement: Living with voices

Positive experiences of HV are advocated through the survivor movement with the notion that living with voices can be understood as a sign of resilience, particularly overcoming difficult life experiences. As an alternative to a disempowered victim position, experiences of HV may be narrated in a story that acknowledges the hardship of the individual and their responses to adversity, whilst identifying the implicit skills, abilities and values they personally hold as a source of strength.

The service-user perspective on recovery moves beyond medical definitions and symptom reduction to include personal development in empowerment, self-esteem, general well-being and quality of life (Meddings and Perkins, 2002). This reflects the return to well-being as a 'bouncing back', overcoming adversity and hardship (Masten and Powell, 2003). Such resilience and positive adaptations are also defined in the process of 'post-traumatic growth' by survivors of traumatic events (Tedeschi and Calhoun, 1996). This conveys the notion that resilience can be a transformative process, in which new identities, meanings and values in life are established. The re-storying of surviving adversity may also illuminate the stories of voice-hearers to improve understanding of HV and challenge dominant discourses attached to HV.

This position is echoed by the words of experts by experience, such as in the HVN, a members organisation *by* people who hear voices *for* people who hear voices. The HVN campaign for the lived experience of voice-hearing to be a more respected aspect of healthcare systems. Illuminating the experience of voice-hearers and listening to their personal accounts of HV may provide expert insight which will likely support the development of understanding the experience of HV.

1.3.3 Psycho-social and cultural influences of mental health difficulties and hearing voices

1.3.3.1 Culture

"African-Caribbean"

This study explores the narratives of African-Caribbean men who have heard voices. The term 'African-Caribbean' refers to individuals of African or Caribbean cultural heritage who self-describe their identity with this term. The term 'Black' also refers to African-Caribbean, African, or Caribbean communities, and was also used as a self-identifier by some of the participants in this study.

What is "culture"?

Race and culture may be understood as a socially constructed categorization (Lewis, et al., 1990). Culture may be defined as "*a set of beliefs, customs, ideas, sentiments, institutions, and achievements that are internalized and externalized in varying degrees by a group of people, which in turn regulate and guide thoughts, conduct, practices, and social personal relationships*" (Khan, 2002, p.98).

Akinyela (2002) highlights the danger in defining culture as something static and unchanging, whereas it may be better understood as something that is constantly evolving. Culture may be viewed as a complex set of interactions between asymmetrical class, gender, religions and languages, in a constant dialectical process of construction and reconstruction, with contending and complimentary social groups continually producing and reproducing culture (Akinyela, 2002). Weidman (1978) defines ethnicity as something that is culturally transmitted across meaning structure,

linguistic terms, marriage patterns, ethnic friendships networks, socialization and self-definition. Khan (2002) acknowledges the importance of attending to socio-economic and political contexts, such as class, poverty and culture, in making sense of an individual's experience and the institutions that they inhabit.

It may be contended as a misconception that individuals of the same colour share the same culture, whereas invisible differences exist from people of the same racial group (Khan, 2002). Misunderstandings in dominant discourses around culture may assert that culture is associated with certain ethnic groups whereas culture may be understood as something we all have (Khan, 2002)

Triandis (1995) distinguishes between individualistic and collectivist cultures on conceptions of the self (self-autonomous versus interdependence and group identity), goal-setting (personal goal versus shared group goal) and meeting needs (benefits to the individual versus the needs of the group). Traditionally, African and Caribbean cultures may be more collectivist and share the value of 'we and us' rather than 'I'.

Importance of cultural heritage

Cultural identity has both a personal and political value. Finding and establishing one's cultural identity in a multi-cultural country such as the UK is what creates the richness of diversity. However, the sense of diversity in the variations of experience in mental health appear to be less understood and thus under-valued in a Westernised medical model. In challenging current medical perceptions of 'psychosis' in the call for equality, Thomas (2014) argues for placing

> "cultural heritage and identity at the centre of our attempts to help people who experience psychosis and distress, then we will end up with systems of help and support that are fair and equitable for all people".

The impact of interpersonal, cultural and socio-economic contexts are often overlooked in the dominant medical discourse, particularly in constructing an

individual's insight of 'psychosis' (Tranulis et al., 2008). In Tranulis et al.'s (2008) study in Canada comparing African, Caribbean or Canadian born people first diagnosed with 'psychosis', it was found that socio-cultural factors influenced insight and that the meanings constructed reflected the individual's cultural background, life experiences and social determinants, including stigma. This highlights the influence of social cultural factors on an individual's sense-making of mental health experiences.

The context of culture should always be considered in relation to an individual's reference group and identity to better understand the meaning of the voice-hearing experience; consequently this may help them to be mindful of causal factors, minimize stigma and discrimination and guide specific and relevant support (Ritsher et al., 2004).

Identity, personal context and individual sense-making of hearing voices

The cultural framework in which a narrative is told may highlight the personal constructions and meanings that are attached to an individual's experience. Larsen (2004) discovered that creative explanatory models provided more resourceful understandings of 'psychosis' than an illness narrative. Nichter (1981) suggests individual sense-making of distress may be supported with the use of personal idioms in language and meaning.

In qualitative research with people diagnosed with 'schizophrenia' and their relatives, it was highlighted that narratives about the self are associated with a changing sense of self and related issues to self-development and identity (Barker et al., 2001). This portrays the temporal nature of how experiences in mental health can be made sense of over time, with accounts of the experiences being related to particular events, including those of the self and the other. Dutta et al. (2007) suggest that as communities and subcultural groups within one context undergo socio-cultural changes, the understanding of 'psychosis' is intrinsically embedded in a network of local meanings which may vary between local subgroups. This reflects how personal

meaning-making may shift with wider socio-cultural understandings, and thus may be further impacted by cultural influences of migration.

Migration and cross-cultural contexts

Migration may be defined as "*the process of social change whereby an individual moves from one cultural setting to another for the purposes of settling down either permanently or for a prolonged period*" (Bhugra and Jones, 2001, p.216). Migration involves the crossing of social boundaries, and may involve an interplay of adaptive and defensive processes, as the individual negotiates which social values to sustain (Bhugra, 2000). Owusu-Bempah (2002) contends that modern migratory patterns have ensured that almost every culture in the world is at least represented in any given country in the West (as has happened in the reverse). With an increase in ethnic and cultural diversity, particularly in urban areas with new migration, asylum and refugees, working cross-culturally in health and social care has become more paramount (Thomas, 2002).

Khan (2002) identifies that individuals and families with a history of migration may undergo a process of navigation between different cultural frames: the culture of the country of origin and its heritage, the culture of the country of residence, the culture one creates, and the culture which is defined as a fusion of all such experiences. It is acknowledged that the weaving of multiple different cultural narratives and experiences may lead to conflicting narratives, as one grapples to make coherence of background and identity (Khan, 2002).

The cultural dislocation and relocation process may create a mismatch between original and current contexts, which may present a threat to individual or group values and identity. With a sense of identity as crucial for all human beings, it may be

suggested that second generation individuals of families who have migrated may form different cultural constructions of the self, group and cultural norms to those of their parents as the people who migrated. As a consequence of the migration process cultural dynamics may create differences in identities, relationships, power, socio-economic status and vulnerabilities.

Migration and mental health difficulties

In a model of the stages of migration, Bhugra and Jones (2001) suggest personal vulnerability factors to psychological distress with each stage of the migratory process: vulnerabilities during pre-migration (preparing and planning) may be influenced by age, gender, personality, reason for migration; vulnerabilities during migration (physical transition) may be influenced by the support available, the process, and whether migrating alone or in a group; vulnerabilities during post-migration (adjusting to the social and cultural frameworks of the new society) may be influenced by social support networks, cultural identity, self-esteem and self concept, and culture shock. Wider societal relational factors between migration and psychological distress may include an individual's social and economic status, financial position, employment, level of education, language ability, and ethnic density of new living circumstance (Bhugra and Jones, 2001).

Bhugra (2000) hypothesises that the increased incidences of 'schizophrenia' in individuals who have migrated may be due to higher rates in the country of origin, 'schizophrenia' causing people to migrate, migration producing stress, and misdiagnosis in the country settled. Morgan, et al. (2010) highlights research that evidences the incidences of 'schizophrenia' to be elevated in migrant groups and BME populations, consistent across a range of ethnic groups in many countries including the UK, the Netherlands, Denmark, Sweden, Australia and the USA. In consideration of the reasons why individuals and families migrate Morgan, et al. (2010) convey that the pursuit of economic betterment as a very different circumstance to fleeing war,

however, the stresses of transition and acculturation may be similar. Such stresses may include unfamiliar cultural practices and beliefs, different climate and environment and challenging interactions (Morgan, et al., 2010).

Thinking about post-migration ethnic density versus social isolation, high rates of 'schizophrenia' in the African-Caribbean population may be influenced by a scattering of the population, altered cultural and social identity and delayed recognition of mental health difficulties (Bhugra and Jones, 2001). For example, this may be in contrast to Asian families who migrate and live in high density areas with more social contact, thus maintaining traditional cultural customs and values. This may act as a protection against acculturation, the stress of migration and developing mental health difficulties (Bhugra, 2000). Acculturation (similar to assimilation, where cultural differences disappear) and deculturation (loss of cultural identity) have been highlighted as processes of migration which may change an individual's cultural identity and consequently may impact an individual's psychological distress (Bhugra, 2000).

Boast and Chesterman (1995) contend that despite research showing African-Caribbean communities as sharing similar mental health difficulties to other migrant groups, specific risk factors persist which delay help-seeking behaviour and engagement with psychiatric services, which include few targeted community mental health facilities and adverse staff attitudes.

Family history of migration: Risk factor for hearing voices?

Previous research examining family history of migration has explored this is in the context of 'psychosis' only, with HV as part of this experience. In considering an individual's family system in the wider socio-cultural context, it has been suggested that a family history of migration is a risk factor for 'psychosis' (Bhugra, 2000; Bhugra and Jones, 2001). Research findings claim that people who have migrated to Western cultures are over-represented in the 'psychosis' population, particularly second-

generation of people who have migrated (Penny et al., 2009), with statistics suggesting the risk of developing 'psychosis' is between two and eight times greater for migrant groups and their children (HM Government, 2011).

Specifically focusing upon African-Caribbean populations, a personal or family history of migration from the Caribbean to the UK has been identified as a major risk factor for 'psychosis' (Harrison et al., 1997). Furthermore, people of African and African-Caribbean origin living in the UK are more likely to be diagnosed with 'psychosis' than White British people (Fearon et al., 2006) despite there being no difference in rates between their home country and the UK.

In a wider socio-cultural context, families who migrate may experience difficulties in the process of adjustment and acculturation, with conflict between the norms and values of their country of origin and the country settled, consequently impacting on mental and emotional well-being. It may be that the social, political and material expectation of migration may not be matched by the lived reality for the migrated family. Long-term psychological impact of social and cultural dislocation (and similarly, international relocation) demonstrates challenges in social, educational and vocational adjustments that can lead to stresses in the process of acculturation (Murray et al., 2010). Relationship difficulties may persist in establishing new social networks, and the change in employment may require a shift to a different mode, rank or status in work. Therefore, shifts in social and cultural contexts may create experiences of social inequality which may be a contributing risk factor in the development of mental distress for people who migrate (Cantor-Graae and Selten, 2014). An alternative explanation for the effect of migration suggests that variations in emotional expression may be readily pathologised in the crossing of cultural contexts in migrating from socio-centric cultures to Western individualistic cultures (Bhugra and McKenzie, 2003).

Individualistic and collectivist cultures may share differing values about the self and identity in terms of goals and needs (Triandis, 1995). There may be experiences of loss of one's familiar way of life and cultural norms in the process of resettlement to the new community and its societal values (Murray et al., 2010). This is defined by

Eisenbruch (1991) as 'cultural bereavement', conforming to the norms of the new dominant culture, which may involve letting go of parts of one's own in the values and practices of daily life. Furthermore, in experiencing difficulty in acculturation there may be low awareness of the service of support, or other barriers to engagement in services such as racial stigma and discrimination

Racism, institutional racism and Black communities in mental health services

Boast and Chesterman (1995, p.219) define racism as "*discriminatory political, economic, and social processes, linked to factors in history, which continue to allocate power and resources on a differential basis*". Keating and Robertson (2004) suggest that a component of race relations and racism can manifest into a sense of 'othering' Black people, which can affect the treatment of Black people in mental health services and other institutions, such as the police and prisons.

Keating and Robertson (2004) highlight the historic aspect of race relations, such that negative experiences of the mental health system may mirror controlling and oppressive dimensions of services in wider society. Such institutional racism may be experienced as degrading and alienating, with the practice of psychiatry likened to colonial racism where Black culture is viewed as pathological, evoking social control and collective oppression (Boast and Chesterman, 1995). Factors highlighting institutional racism include the provision and uptake of mental health services by Black communities, diagnostic practices in psychiatric settings, rates of arrest and convictions in the criminal justice system, and the role of stereotypes (Boast and Chesterman, 1995).

A fear of mental health services within Black communities can lead to a social distance (Corrigan, et al., 2001) and social rejection, which can negatively impact on therapeutic engagement. A suspicion within Black communities of mental health services may be validated by the stigmatization experienced; this may be as a consequence of the services' majority White culture lacking understanding of Black

families' cultural values and norms (Anane-Ageyi, et al., 2002). Furthermore, a wariness of services by Black communities may be misinterpreted as an unwillingness to engage, this facilitating a vicious cycle of fear for both (Anane-Ageyi, et al., 2002).

In exploring the circular notion of fear between mental health services and Black people, Keating and Robertson (2004) highlighted Black service users as fearing the stigma attached to a diagnostic label and its impact upon their quality of life, and professionals as maintaining prejudices of perceived dangerousness and violence from experiences of control and restraint in psychiatric settings. Consequences of this fear were detailed as limiting trust and engagement with mental health services, perpetuating secrecy and shame within Black communities to hide a diagnosis, and silencing staff in talking about issues related to race and culture (Keating and Robertson, 2004).

It may be questioned whether wider socio-economic disadvantages, such as unemployment and housing, are over-looked in considering influences of mental health difficulties and crime involvement in Black communities. Szmukler, et al. (1981) stated typical demographics of an individual detained under the Mental Health Act as young, single, unemployed male, who is socially poorly integrated, living alone in unsettled accommodation and has a long history of mental illness.

In a review of the relationship between mental health services and African and Caribbean communities, Keating, et al. (2002) stated ten key findings: circles of fear stop Black people from engaging with services; Black service users are not treated with respect, their voices are not heard and they experience services as inhumane, unhelpful and inappropriate; care pathways of Black people are problematic and they engage with services when they are already in crisis, reinforcing the circles of fear; primary care involvement is limited and community-based crisis care is lacking; acute care is perceived negatively and does not aid recovery; there is a divergence in professional and lay discourse on mental health difficulties; service user, family and carer involvement is lacking; the concept of 'culture' has been used to address conflicts between professionals and service users, yet can divert professionals away from looking at individual histories, characteristics and needs; Black-led community

initiatives are not valued; stigma and social inclusion are important dimensions in the lives of service users.

Therefore, Akinyela (2002) states that having an awareness of the everyday effects of racism is critical to the development of culturally appropriate therapy. In specific relation to clinical psychology, Patel (2004) advocates for the need of clinical psychologists to operationalise a social and political analysis of culture and racialism oppression in their psychological thinking and clinical practice.

Cultural and ethnic diversity and the experience of hearing voices in the UK

Historical studies examine diversity and mental health through diagnostic frameworks in social psychiatry. Experiences diagnosed as 'schizophrenia' in non-White ethnic minority groups in London have been found to be greater when living in areas where their cultural community represented only a small proportion of the local population, i.e. the 'group density effect' (Boydell et al., 2001). This may be explained in terms of reduced protection against stress and life events (Boydell et al., 2001) as well as experiences of discrimination, institutionalised racism, alienation and isolation in ethnic minority groups (Williams, 1995).

In a comparison of Whites and BME groups in London, unemployment was found to be an explanatory factor for African-Caribbeans diagnosed with 'schizophrenia' (Bhugra et al., 1997). Further considering age and gender, high incidences of the diagnosis of 'schizophrenia' were found in African-Caribbean females under the age of 30, yet in African-Caribbean males of all ages (Bhugra et al., 1997). Reflecting upon the factors of race, age, gender and employment more systemically in terms of diversity and diagnosis of 'psychosis', it may be suggested that an African-Caribbean man who is unemployed living in London and experiencing mental health difficulties may be vulnerable to psychiatric labelling by the medical system.

In a comparison of biological, social and supernatural explanatory models in diverse ethnic groups in the UK, it was found that African-Caribbeans cited social causes more frequently than their counterparts (McCabe and Priebe, 2004). This portrays how the context of an individual's ethnicity and culture may lend to diverse meaning-making trying to understand the causal influences for a particular mental health experience.

Personal accounts of hearing voices: The voice of Experts by Experience

Despite a growing interest in the phenomena of HV, there is a paucity of literature exploring personal accounts of the voice-hearing experiences. Beavan's (2011) qualitative research of voice-hearers' subjective accounts suggested five characteristics: the content of the voice(s) is personally meaningful, the voice(s) have a characterised identity, the person has a relationship with their voice(s), the experience has a significant impact on the voice-hearer's life, and the experience has a compelling sense of reality. This illustrates key components which may guide people in making sense of voice-hearing. Exploring beyond the voice content acknowledges the meaning of what is said in the context of the person's life and their relationship to the voice(s). Validating the reality of the voice(s) is also an important part of the process in understanding its significance and meaning.

This notion is further supported by the findings that the function of the voice(s) and understanding the voice(s) are two of the main components for developing a sophisticated framework in making meaning of the voice-hearing experience (Fenekou, and Georgaca, 2010).

1.4 Systematic review of literature: First person account of hearing voices

The aim of this review was to systematically locate and appraise research exploring the sense-making of HV by voice-hearers within a cultural context (see Appendix A). Despite the extensive scientific literature on the topic of 'psychosis', and more specifically HV, there remains to be minimal research on voice-hearers' interpretation of HV (Knudson and Coyle, 2002). In addition to the background literature discussed, a systematic review of the literature was conducted to specifically locate research on the HV experience within a cultural framework to answer the research question of cultural meaning-making of HV in African-Caribbean men who HV.

An initial search (see Appendix B) was conducted to review existing literature of African-Caribbean men and HV. However, after thorough examination of the 112 total articles yielded within this search it was evident that the remaining 13 articles maintained a medical lens and did not represent first-person accounts or meaning-making of HV. Therefore, a second-wave of the systematic review was conducted in order to locate research on voice-hearers' account of HV within a cultural framework.

1.4.1 Systematic review

The systematic review was attempting to specifically answer the question 'what are the first person accounts of African-Caribbean/BME/ethnic groups who HV?'. Further to consultation with the research team, the key search terms were revised (see Table 1) and four key databases were searched for the review: PubMed; PsycNet/PsycARTICLES; Scopus; PsycINFO.

Domain	Search terms
TITLE	"hear* voice*"
ABSTRACT	"lived experienc*" or "personal" or "account*" or "narrat*" or "story" or "explor*" or "interview" or "case" or "qualitative" or "factor" or "theme" or "thematic" or "interpretative"
ALL FIELDS	"ethnic minorit*" or "minority ethnic" or "Black" or "BME" or "BAME" or "culture" or "cultural" or "divers*" or "migrant"

Table 1: Key search terms

By extending out the specific terms of "African-Caribbean" men into terms for "ethnic minority" and removing the term "UK" (amendments to initial review search terms), it was hoped search results might highlight similarity in meaning-making of HV from a minority group perspective, with attention to cultural context. The aim of adding in "lived experience" was to elicit more qualitative research of personal accounts of HV.

Exclusion

Exclusion criteria were applied to exclude repetitions, irrelevant research, no first person account, clinical trials and quantitative research with no lived experience (see Figure 1).

Database	Total articles = 34	Reps. excluded	Title screen = 30	Abstract screen = 24	Total per database	Following full text screen = 11
PsycINFO	17	1 rep 16 remain	Exclude 6 10 remain	Exclude 2 8 remain	8	**6**
PsycNet/ PsycARTICLES [2]	6	1 rep 5 remain	5 remain	Exclude 1 4 remain	4	**4**
Scopus	11	2 reps 9 remain	9 remain	Exclude 5 4 remain	4	**1**
PubMed [3]	0	-	-	-	-	-[4]
Cumulative total	**34**	**4 reps 30 remain**	**6 excluded 24 remain**	**8 excluded 16 remain**	**16 (No full text = 2) 14 total**	**11 included**

Table 2: Total no. of articles per database per screen stage

It must be noted that of the 11 articles included in the systematic review, none researched the personal accounts of African-Caribbean men who have heard voices, highlighting a gap in the research literature and demonstrating a distinct lack of ethnic and cultural diversity within the research of meaning-making of HV. Therefore, this research is original in exploring the cultural sense-making of HV by African-Caribbean men who HV.

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[2] *Difficulty with quoted phrasing found; various amendments made to respective search terms in order to extend out the search. Amendments to search terms: "ethnic minorit*" etc. removed and "HV" changed to abstract

[3] As above - Amendments to search terms: "ethnic minorities" etc. removed

[4] Following amendments, articles found = 426; Title screened = 24 selected for relevance; Abstract screened = 3 articles selected, used to inform wider literature (not review); studies are repetitions from a meta-ethnographic synthesis of literature (Holt & Tickle, 2014) which was already sourced via PsycInfo and included in the final screen

Figure 1: Process of systematic review

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                 │                          │ Excluded following Title screen N = 6│
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                 │                          │ No relevant, not first person        │
                 │                          │ account = 6                          │
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        │ Abstracts        │
        │ screened         │
        │    N = 24        │
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                 │                          │ Excluded following Abstract Screen = 8       │
                 │                          │ Not HV specific - voices of acute inpatient=1│
                 │                          │ No first person account; not qualitative. = 1│
                 │                          │ Not relevant - clinical trial only = 1       │
                 │                          │ Not relevant - not HV = 4                    │
                 │                          │ Rep/Erratum only = 1                         │
                 │                          │ No full text available = 2                   │
                 │                          │ Total excluded  10                           │
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        │ Full copies retrieved and assessed for         │
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                 │                          │                                                    │
                 │                          │ No lived experience, focus emotional expression only=1│
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        │ Remaining studies from search N = 11       │
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1.4.2 Review of selected articles

Of the 11 articles yielded in the systematic review, three are personal testimonials and eight are a variety of research methodologies (one meta-ethnographic synthesis; one mixed methodology; one Q-methodology; two secondary analyses; three qualitative). The articles are presented in five distinct sections divided by the focus of the research: the phenomenon of hearing voices; sense-making of HV (primary and secondary analysis); meta-ethnographic literature review; personal testimonies. All research articles have been reviewed using Yardley's (2008) guiding framework for quality criteria to evaluate sensitivity to context, commitment and rigour, transparency and coherence, impact and importance of the research.

The phenomenon of hearing voices

The phenomenon of hearing voices was the focus of one study located within the systematic review. Woods et al. (2015) provide the largest mixed-methods study of HV to date conveying its impact and importance in the HV and scientific communities. The study aimed to record detailed and diverse experiences of voice-hearing in first person accounts by voice-hearers. The theoretical framework drew on approaches from psychiatry, psychology, medical humanities and service-user perspectives which guided the study design and maintain sensitivity to context. The study recruited a broad participant sample from 16-84 year olds with the experience of HV, recruited online from a range of networks including clinical networks, service-user groups and mental health forums, further portraying sensitivity to context. The study employed a mixed-methodology design, using a 13-item online questionnaire of open and closed questions. There were 153 responses, which were analysed with inductive thematic analysis and Chi-square, in a coherent and transparent process.

A strength of the study is its contribution of service-user perspective to the field of HV, conveying a diverse collection of experiences. The findings highlighted that 81% of participants heard multiple voices, with 69% detailing characterful qualities, and 66% reporting bodily sensations while they heard voices. Associated emotions included fear, positivity, anxiety, and depression, however, 31% of participants reported positive emotions with voice-hearing. Respondents highlighted structural transformations in the voices over time and engaging with the voices directly to explore meaning and influence the voice. The statistical analysis showed that voices were more likely to be internally located and be conversational in nature. Respondents highlighted structural transformations in the voices over time and engaging with the voices directly to explore meaning and influence the voice. Societal stigma was reported as experienced with fear and loneliness, conveying negative attitudes in the wider context. Transparency and coherence were evidenced with the use of direct quotes to illuminate first-person account and rich demographic data regarding the character, emotion and experiences associated with the voices.

Transparency and coherence were also demonstrated in the critical evaluation of the study. Multiple strengths were appraised. The inclusion of the service-user perspective in the theoretical framework and design and the non-medical considerations, such as the use of language, demonstrate transparency, coherence and sensitivity to context. The study to date is the largest mixed methodology research of the HV phenomenon, and may be praised for its analysis of first-person account of voice-hearing, highlighting its impact and importance. High demographic data was recorded, which conveyed a diverse sample, for example, 17% of participants had never received a diagnosis for voice-hearing. The use of direct verbatim quotes supports transparency in the study.

Methodological limits in this study are located in data collection via internet resources, thus limiting accuracy of findings and over-representing computer-literate individuals and social media users, and in the under-representation of men and BME individuals, displaying a bias in the findings in gender and ethnicity. This may be reflective of a lower representation of BME individuals in member groups and services. There was no means of 'checking' the participant information, which limits

the comparative use of findings and the study's rigour. However, the exploratory stance fits the social constructionist framework of the study portraying consistency in the conceptual context, highlighting the study's commitment.

Sense-making of hearing voices

Four qualitative studies explored the sense-making of HV (Kalhovde et al., 2014; Fenekou and Georgaca,2010; Holt and Tickle, 2015; Jones et al., 2003). The studies aimed to explore the complexity of the voice-hearing phenomenon and its meaning for the voice-hearer (Fenekou and Georgaca, 2010), how the experience of voice-hearing may be constructed (Holt and Tickle, 2015; Jones et al., 2003), and how people with a mental health diagnosis deal with distressing voices in daily life (Kalhovde et al., 2014). The theoretical framework was made transparent by Holt and Tickle (2015) in the definition of the epistemological stance as social constructionist; studies by Fenekou and Georgaca (2010) and Jones et al. (2003) may also sit within social constructionism, although the theoretical framework was not defined in either. Kalhovde et al. (2014) explained the study's perspective as a hermeneutical phenomenological approach, with an ontological approach to understanding by challenging their own assumptions as part of the study process.

The informants of each study were adults who hear voices. Clinical populations with a diagnosis of a 'psychotic disorder' were sampled in both community and outpatient adult mental health services in two studies (Kalhovde et al., 2014; Fenekou and Georgaca, 2010) and Holt and Tickle (2015) employed theoretical sampling to recruit people who were distressed by the experience of voice-hearing. Wider sampling was used by Jones et al. (2003) to include voice-hearers from both mental health services and spiritual churches, HVN and the wider community.

The research methodology used in-depth semi-structured interviews with people who hear voices with either an hermeneutic phenomenological approach (Kalhovde et al., 2014), Q-methodology design (Jones et al., 2003) or grounded theory (Fenekou and

Georgaca, 2010; Holt and Tickle, 2015). Throughout the methodology, the studies demonstrate commitment and rigour in a variety of ways: integrating service-user perspective to ensure sensitivity to context (Holt and Tickle, 2015); voice-hearer perspective to build Q-items for interview (Jones et al., 2003); respondent validation of the data (Kalhovde et al., 2014); a second author to monitor and ratify the analytical process through triangulation, hence increasing reliability and validity of the analysis (Fenekou and Georgaca, 2010); and adhering to guiding frameworks for reflection (Holt and Tickle, 2015). All four studies made explicit the research process, detailed the stages of analysis and utilised verbatim quotes reflecting coherence and transparency in the research process (except Jones et al., 2003, with no direct quotes detailed). The studies were all grounded in the participants' language highlighting sensitivity to context.

The findings of the studies portrayed how people who hear voices make-meaning of the experience and deal with the voice-hearing in daily life. Kalhovde et al. (2014) suggest that people who hear voices try to block out the voices, navigate health care services for support, and struggle to come to terms with the limitations of HV. Jones et al., (2003) suggest voice-hearers make sense of voices from six different perspectives: positive spiritual, personal relevance, resigned pessimistic, pragmatic response, passivity to forces and generic mental illness. The themes of the function of the voices and how the individual understands the voices (Fenekou and Georgaca, 2010) were mirrored in the search for meaning of the voices (Holt and Tickle, 2015).

The framework for understanding the voices was suggested as influencing how an individual copes with the voices (Fenekou and Georgaca, 2010) with a variety of explanations including stress, trauma, attachment difficulties, spirituality, and anxiety and depression (Holt and Tickle, 2015). The effect of voices on the individual's life was defined as a theme (Fenekou and Georgaca, 2010) and echoed in the varying sense of agency an individual experiences in relation to the voice and as well as coping with societal stigma (Holt and Tickle, 2015). Meaning-making of the voices may also be defined on three personal levels: interpersonal; intrapersonal; parapersonal (Holt and Tickle, 2015).

In further critical appraisal of the studies, all studies explored voice-hearing with current voice-hearers, demonstrating commitment and rigour to the phenomenon and sensitivity to context. The studies appropriately reflected the sense-making of hearing voices by voice-hearers; however, Fenekou and Georgaca (2010) and Kalhovde et al. (2014) explored voice-hearing with individuals who had a diagnosis; clinical samples may have biased meaning-making of the voices with a medical discourse, particularly in the psychiatric setting in Fenekou and Georgaca's (2010) study. All of the studies had a small sample size, ranging from 8 participants (Holt and Tickle, 2015) to 20 participants (Jones et al, 2003), however, this may reflect the nature of qualitative research methodology and practical limitations upon sample size number for analysis.

The studies may be criticised for the lack of ethnic and cultural diversity: the participants in the respective studies were all White British (Holt and Tickle, 2015), Greek (Fenekou and Georgaca; 2010), or individual participant ethnicity was not defined (Kalhovde et al., 2014; Jones et al, 2003). The research differentiated in the country of origin, yet all studies were conducted in Westernised European countries: Norway (Kalhovde et al., 2014), Greece (Fenekou and Georgaca, 2010) and the UK (Holt and Tickle, 2015; Jones et al, 2003). It may be hypothesised that wider socio-cultural influences of the respective countries may influence how an individual makes sense of HV within that context. However, the shared similarities reported in the sense-making of HV suggest a universality and generalisability in some aspects of how a person understands HV, and may be further reflective of the dominant Western discourse within each of the countries.

All four respective studies bear impact and importance as representing emerging qualitative research concerned with how the individual makes sense of HV. This is a novel addition to previous research on the HV phenomenon, portraying the sophisticated frameworks individuals construct to make sense of HV.

Goldsmith (2012) and Jones and Coffey (2012) employed secondary analysis to explore the sense-making of HV by voice-hearers. Secondary analysis is the use of existing data collected from a previous study, to explore a research question distinct from the original inquiry (Szabo and Strang,1997). A critique of secondary analysis may suggest that relational reflexivity is limited since the process lies between the researcher and the data, rather than the researcher and the original informant of the data. However, the benefits of secondary analysis include generating new knowledge and new hypotheses to support existing theories and permit broader use of data (Jones and Coffey, 2012).

The studies aimed to examine the explanatory devices deployed by individuals in their accounts of voice hearing (Jones and Coffey, 2012), and explore the range of discursive constructions 'recovered' voice hearers employ, further considering positioning and subjectivity (Goldsmith, 2012). Goldsmith (2012) defined the theoretical framework as sitting within a Foucauldian discourse perspective, defining the epistemological stance as social constructionist which was evidenced in the language throughout the article, additionally drawing on postmodern discourses to evaluate the data. Jones and Coffey (2012) highlight that understanding mental health may involve accepting multiple heterogenous paradigms, including biological, cognitive, interpersonal and psychodynamic.

Goldsmith (2012) utilised a discursive approach to explore two narrative accounts of HV and recovery. However, the theoretical sampling of the study selected existing texts by authors as the data to analyse, suggesting a potential bias in the level of education reflected in the narratives. Goldsmith (2012) questioned how a discourse of HV affects what the narrator may think and feel, and employed Antaki, et al.'s (2003) quality criteria to research the question. Jones and Coffey (2012) employed a larger sample size (n=20) for a secondary analysis of interview transcripts of conversations with people who hear voices and received mental health care in the community.

In Goldsmith's (2012) study, four key discourses were analysed from the narratives: having many selves; taking lead in recovery; voices as an imagined world; voices as a coping strategy for trauma. Goldsmith (2012) concluded that the active constructing experience of HV affects the nature of the voice-hearing experience, and suggests that the 'authentic reality' of the voice-hearing may be the 'reality' of the psychotic experience. Jones and Coffey (2012) employed thematic analysis and constructed three main themes: bio-medical responses; personal meanings; and self/identity. Both studies maintained transparency and coherence by evidencing the analysis with direct verbatim quotes, a particular strength of the studies. The authors of both studies shared reflections and critical appraisals of their respective studies, which demonstrated commitment and rigour. Goldsmith (2012) acknowledged the limitations to the generalisability of the findings due to the small sample size, which further constrained the opportunities to compare and contrast the accounts. However, the first-person perspective of the research positions the narratives as important, with direct quotes of the data conveying research transparency. Jones and Coffey (2012) identified the weaknesses of this study as forced choice questions, which possibly limited the stories and meanings told, and the unavailability of audio recordings of the interviews, which may have restricted the analysis and overlooked the dialogue and performative aspects of the narratives.

Meta-ethnographic literature review

Holt and Tickle (2014) conducted a meta-ethnographic synthesis of the literature (peer-reviewed journal articles only) with the aim to identify, appraise, and synthesize the current qualitative literature which explores first-person perspective of HV[5]. Meta-ethnography (Noblit & Hare, 1988) is defined as the synthesis of qualitative literature in a rigorous process exploring human experiential phenomena, with the intention of

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[5] Two studies in Holt and Tickle's (2014) literature review were also located in the systematic review of this research.

engaging difference in perspective to enrich human discourse (Thorne, et al., 2004). The review is located within a social constructionist framework, with detail in its introduction challenging Western medical discourses of 'psychosis'. The review was conducted in three phases of systematic searching, critical appraisal and a meta-ethnographic synthesis across six electronic databases with specified search terms (Hearing voices, voice hearer, auditory hallucinat*1 , hallucinat*, positive symptoms, psychosis, qualitative, discourse analysis, thematic analysis, interpretative phenomenological analysis, phenomenological analysis, grounded theory, content analysis, ethnograph*). Sensitivity to context was conveyed in the search terms, for example, 'schizophrenia' was not utilised as a search term as it was reported to yield heterogenous results about 'psychosis'. The literature review process was clearly defined, with transparency and coherence of the review, and employed an appraisal tool (Walsh and Downe, 2005) which demonstrated rigour in the methodology. Seven studies of various methods met the defined criteria for the meta-ethnographic synthesis. Verbatim quotes from each study were utilised further demonstrating transparency and coherence. Five key themes were identified in the sense-making of HV: identity of voice(s); power of voice(s); impact of HV on relationships; relationships with voice(s); distinction between thoughts and voice(s). The reviewed studies did not all declare their theoretical framework, which may be a weakness of this review. However, the review maintains impact and importance within the research community and serves to further understand the perspective of voice-hearers in their experience of HV.

Personal testimonies

Three personal testimonies were yielded in the review which offer first person accounts of HV in the context of 'schizophrenia'. Although the articles are limited in representing the voice of one individual, the impact and importance lie within the accounts, offering personal insights and meanings of their voice-hearing experience. Sensitivity to context is implicit as the authors represent peer voice-hearers who may

have shared similar experiences. Nonetheless, a universality of experience is not assumed by the authors, demonstrating transparency in their individual accounts. Transparency is inherent in the testimonies as each author speaks out to the wider community by reflecting upon their lived experience of voice-hearing.

The impact of mental distress and voice-hearing upon social networks is highlighted, as feelings of loneliness were prevalent in the context of feeling like there was nowhere to go and no-one to tell (Markwood, 2005). A disconnect from reality was described through the experiences of social isolation, visual distortions, and unusual beliefs as part of the experience (Bellamy, 2000). Medical language described paranoia (Markwood, 2005; Bellamy, 2000), which was storied as further escalating social isolation.

One's sense of self is portrayed as distinguishable from the thoughts and voices (Markwood, 2005), with voices and visions disturbing daily life with negative commentary (Bayley, 1996). Unhelpful ways of coping with the voices are reported with examples of self-harm and suicide attempts (Bellamy, 2000; Bayley, 1996), indicative of the distress and despair experienced by the individuals.

All three testimonies describe similar courses of treatment, documenting varying experiences of acute crisis care, hospitalisation, sectioning and medication. Bellamy (2000) offers insights into psychological therapies and contends the importance of creative outlet in therapeutic support, including writing and art.

Western values are echoed in the testimonies with reflections on social positions, education and employment, and the negative consequence of 'schizophrenia' on each individual (Markwood, 2005; Bayley, 1996). Spirituality is reflected in two accounts in different ways, one as an element of the voices and visions (Bellamy, 2000), the other as personal support in recovery (Markwood, 2005). Acceptance of peer support in the community (Markwood, 2005) and a self-acceptance with compassion (Bayley, 1996) are storied as paramount to recovery.

Therefore, the reviewed articles suggest that the nature of HV is influenced by the active constructing of the voice-hearing experience by the voice-hearer (Goldsmith, 2012; Fenekou and Georgaca, 2010) from a variety of perspectives (Jones et al., 2003) with individuals creating sophisticated frames of reference for understanding the voice(s) (Holt and Tickle, 2014). The voice-hearers' relationship with the voice(s) may also be impacted by one's sense of identity (Jones and Coffey, 2012), agency and power (Holt and Tickle, 2015) in relation to the voice(s). Wider societal discourses and the impact of stigma (Holt and Tickle, 2015) were also considered as influencing the sense-making of HV.

1.5 Clinical relevance

It is important to consider the clinical relevance of this research to further establish its place and value within the health and social care context and relevant policies. This section reviews the need for culturally-sensitive practice and discusses issues of race and culture highlighted in relevant policy documents, concluding with a call for cultural competency.

1.5.1 Cultural competence for culturally-sensitive practice in health and social care

There is a need for greater cohesion in the sense-making of cross-cultural work in mental health services. It is suggested that clinical and cultural conceptions of mental health difficulties may lead to conflicting and contradictory positions (Estroff, 1989) in health and social care. This reflects the notion that how an experience is made sense of may impact how it is understood and, consequently, treated. Thus, a greater

cohesion between clinical and cultural perspectives in the sense-making of mental health would benefit cross-cultural clinical practice. Onwumere et al. (2009) posit that with an increasingly evolving demographic in the UK, particularly in urban areas, the policies and guidelines of healthcare must match the ethnically, racially and culturally diverse groups. Good practice recommendations outline the need for services to be culturally sensitive and accessible for ethnic minorities (Department of Health, 2005). In order to develop more cultural competence, mental health services need to evolve in cultural practice, with more culturally sensitive communication, local knowledge and an integration of scientific and humanistic research (Peavy, 1996).

It can be argued that the NHS offers a culturally-sensitive yet not a culturally-matched approach in its delivery of care. Speed (1991) suggests how clinicians and mental health professionals understand 'problems' determine what the 'problems' are. If world views and dominant discourses inherent in a society shape the health care that is delivered then there needs to be a shift in the cultural appropriateness to match the needs of an ethnically and culturally diverse population; services that manage discomfort in difference, without judgement and with shared values of trust and understanding. These core values need to be modelled at all levels of the system. In working directly with clients it is paramount that practitioners employ skills in reflexivity, to increase awareness of their own cultural values, and how this impacts on the relationship in working with clients. Gaining knowledge of the client's culture can support the therapeutic care as appropriate and meaningful (Sue et al., 2008).

Cultural barriers may impede upon individuals' access, utilization and effectiveness of services (Paniagua, 2005). This also reflects the importance of a culturally diverse workforce, such that individuals with cultural similarities may feel better heard and supported when there is a shared context to ethnic background.

1.5.2 NICE Guidelines

The National Institute for Health and Care Excellence ([NICE], 2014) guidance on 'Psychosis and schizophrenia in adults: prevention and management' states:

> "Mental health services should work with local voluntary Black, Asian and minority ethnic groups to jointly ensure that culturally appropriate psychological and psychosocial treatment, consistent with this guideline and delivered by competent practitioners, is provided to people from diverse ethnic and cultural backgrounds" (NICE, 2014, p.11).

The guidelines (NICE, 2014) affirm that cultural and ethnic differences need to be addressed regarding biological, social and family influences as well as in relation to treatment expectations of the 'psychosis', across all phases of care. However, the treatment recommendations may be questioned for their lack of cultural sensitivity. Medication and psychological therapies sit within a eurocentric Westernised framework and may not be appropriate to individuals who have alternative sense-making repertoires of their experience. This portrays the need for individual sensitivity and specificity in understanding one's experience with attention to social and cultural context.

1.5.3 No health without Mental Health (Department of Health, 2011)

'No health without mental health' was created by the Coalition Government as a call to make mental health 'everyone's business' with the aim of improving mental health and well-being for the population (HM Government, 2011). The government strategy created six mental health objectives: for more people to have good mental health, recover from mental health difficulties, have good physical health, have positive experiences of care and support, with fewer people to suffer harm or experience stigma and discrimination.

In a health inequalities approach, the policy document also considers the social gradient in health outcomes for disadvantaged groups, such that BME groups may be

more likely to experience social adversity as a result of ethnic identity, socio-economic status and living environment if living in deprived areas (HM Government, 2011). Therefore, as the policy document defines 'psychosis' as "a symptom of other conditions" (2011, p.89) it may be suggested that the 'condition' itself may be 'symptoms' reflective of the social and economic condition in which people live.

1.5.4 Delivering Race Equality in Mental Health Care: A review (Department of Health, 2009)

The Department of Health ([DoH], 2009) conveys the complexities inherent in working with diverse communities, such that variation exists both between and within communities, and that this individuality continues to exist across race, culture, ethnicity, geography, sexuality and faith. In the race equality action plan of Delivering Race Equality in Mental Health Care (DoH, 2010) research recommendations highlight the need for knowledge generation for 'psychosis' for ethnic minority groups, including culturally sensitive therapies and the exploration of service users' views.

1.5.5 A call for cultural competency in mental health care

On both a societal and systemic level, clinical psychology may be viewed as benefitting from advancing its understanding of diverse cultural constructions of 'psychosis', and more specifically, HV. The profession of clinical psychology is questioned by Patel (2003) suggesting the discipline reaffirms current oppressive belief systems and reinforces inequality by overlooking the individual within their cultural context. Further critique aligns clinical psychology and therapy with the practice of medical psychiatric diagnosis, with criticism that both disciplines are flawed in their respective thinking about 'psychosis' (Kalathil, cited in Thomas, 2014).

Good (1997) suggests that mental health professionals may be susceptible to cultural interpretations in making sense of mental health difficulties, which may influence how an individual is treated. It is further questioned whether UK professionals uncover certain 'symptoms' of mental health difficulties due to the dominance of psychiatry in mental health services. This reflects the influence of medical discourses and suggests an inherent bias towards psychiatry in the healthcare systems in which professionals are trained and operate (Suhail and Cochrane, 2002). Anane-Ageyi et al. (2002) contend a lack of understanding of Black families' values and norms by services that present a visibly White culture, escalating a suspicion and stigma of Black people in cross-cultural working.

Fernando (1995) advocates for advances in mental health care to support BME individuals to feel listened to and heard and to be treated as an individual rather than as part of a homogenous group. Therefore, a model of developing cultural competence (Papadopoulos, 2006) conveys the importance of cultural awareness, knowledge, sensitivity and competence to promote successful clinician practice in healthcare.

1.6 Cultural community in focus: Second-generation African-Caribbean men

Research to date has documented an over-representation of BME groups in the 'psychosis' population, and it is argued that Black people are more likely to receive physical and medical treatments and have lower access to talking therapies (Fernando, 2010). Gaining a more detailed understanding of first-person accounts and associated meaning-making of HV within a cultural context may add a greater depth of understanding HV.

Takei et al. (1998) conducted a population-based longitudinal study of African-Caribbean men diagnosed with 'schizophrenia' and found they experienced more adverse psychiatric care than White counterparts. This is supported by Cole et al. (1995) in a comparison of ethnic groups which found that compulsory psychiatric admission was more likely for African-Caribbean individuals presenting with 'first

episode psychosis', which was further linked to lower social support and police involvement. A literature review by Sharpley et al. (2001) hypothesises cultural variation in symptom reporting, the use of phenomenological constructs by psychiatrists and social disadvantage as accounting for increased rates of 'schizophrenia' diagnoses in African-Caribbean men.

McKenzie et al. (1995) account for a greater incidence of 'psychosis' in African-Caribbean men living in the UK as due to a greater exposure to precipitants in the social environment. Thinking about social markers to highlight circumstance, Karlsen et al. (2005) found African-Caribbean people were most likely to report racial harassment than other ethnic minority groups, significantly associating the experience of verbal racial abuse, physical assaults and work-place discrimination with the risk of 'psychosis'. This reflects what seems to be the double stigmatisation of individuals from a BME background diagnosed with 'psychosis'.

1.7 Research rationale and aims

1.7.1 Rationale

The rationale for this study supports a shift in the research literature away from HV as a symptom of 'psychosis' within a medical discourse, to exploring HV as a phenomenon. This study is building on emerging literature of the phenomenon of HV with qualitative research methodology to explore the first person account of the voice-hearing experience by people who hear voices. Understanding the relational aspect between the voice-hearer and the voices heard may highlight how the individual understands the voice and the meaning they construct from the experience (Goldsmith, 2012; Fenekou and Georgaca, 2010; Jones et al., 2003; Holt and Tickle, 2014). Exploring the voice-hearer's relationship with the voice may also convey issues related to identity (Jones and Coffey, 2012), stigma (Holt and Tickle, 2015) and wider societal discourses associated with HV.

Research to investigate the incidence and prognosis of African-Caribbean men living with 'psychosis' is not a new area to study; however, exploring the narratives of second-generation African-Caribbean men who have heard voices (living with a diagnosis of 'psychosis') is identified as a gap in the scientific literature and therefore an original aspect to research. The rationale for this also study focuses upon the narratives of African-Caribbean men because they are the most over-represented minority ethnic group within the 'psychosis' and the least likely to be offered talking therapies and non-psychiatric treatment (Fernando, 2010). This study may serve as a platform to challenge the 'vicious circle of fear' (Keating and Robertson, 2004) attached to Black service users and mental health services, offering alternative discourses to misconceptions, misunderstandings and racism that can be attached to Black men. This study is original in its research as there is an identified gap in the literature which exposes a lack of ethnic and cultural diversity within the first person accounts of voice-hearing and meaning-making of HV. The chosen research methodology also makes this study different to other studies, since in the research literature reviewed to date, narrative analysis has not been employed with a BME group of participants to explore HV. The co-construction of narratives between the researcher and participant are interpreted by the researcher and constructed into stories of the participants' accounts; this highlights the individual sense-making of an experience over time, with attention to cultural context and wider societal discourses, a strength of this study.

This study focuses on the meaning-making of HV by second-generation African-Caribbean men. Research highlights that as an ethnic minority group, African-Caribbean/Black men are over represented in the 'psychosis' population (Bhugra, et al., 1997), and, in general mental health, are more likely to receive a diagnosis, receive compulsory psychiatric treatment, be detained under the Mental Health Act, and are least likely to be offered talking therapies (Fernando, 2010). In the context of a family history of migration, historical research with medical theoretical frameworks have suggested that migration may be linked to elevated incidences of 'psychosis' (Bhugra, 2000; Bhugra and Jones, 2001). Research also suggests that vulnerability factors for the risk of developing 'psychosis' is greater in second-generation individuals of

families who have migrated (Penny et al., 2009; Harrison, et al., 1988). From a social and cultural perspective, research suggests that migration may lead to conflicting cultural narratives, as one grapples to define background and identity (Khan, 2002). Vulnerability factors associated with a family history of migration may include conflicts and adjustments to social and cultural frameworks between the family context and wider society (Bhugra and Jones, 2001).

Furthermore, African-Caribbean men can be subject to stigmatisation in health and social care with the discriminatory label of 'hard to reach' and referred to as 'difficult to engage', and as a consequence are less visible in both therapeutic services and as participants in the scientific research literature. In exploring cultural context and diversity issues, this study may also portray personal accounts of racism and institutional racism of African-Caribbean men as experienced in the mental health system. This may be viewed as a 'circle of fear' (Keating, et al., 2002) between Black communities and mental health services, with limited trust and engagement between the two (Keating and Robertson, 2004).

This study therefore proposes to re-present the stories of a sometimes stigmatised and 'unheard' group in their narratives and meaning-making of HV as well as illuminate the cultural context in exploring issues around diversity, identity and socio-cultural factors of being second-generation of a family with migration history. This study offers the opportunity to create a platform in which the personal accounts and meaning-making of voice-hearing by African-Caribbean men may be heard by wider society, and seeks to challenge negative stereotypes and discriminatory discourses associated to both the phenomenon of HV and African-Caribbean men with mental health difficulties. This is an important aspect of research for clinical psychology as there are emerging debates within the profession for 'de-medicalising misery' (Rapley et al. 2011; Bentall, 1999); it is integral to challenge the diagnostic and theoretical stories which are heard as clinicians, allowing movement for meaning-making of personal accounts of HV.

1.7.2 Aims

Much (1995) states that cultures provide frameworks for making sense of experience. The exploration of multiple perspectives and cultural contexts of people's life stories as a voice-hearer can therefore enhance understanding of HV. Good (1997, p234) states that '*multiple interpretations are often available and provide flexibility in the understanding and interpretation'*.

Therefore, the aim of this research was to explore the first-person account of HV with African-Caribbean men who identify as second-generation, exploring their narratives and meaning making of HV, with an appreciation of cultural context.

1.7.3 Research question

What are the narratives of African-Caribbean men who have heard voices, and what is their meaning-making of HV?

Chapter 2. METHODOLOGY

2.1 Overview

This chapter describes the research methodology of this study. The history and context of qualitative research is detailed, the researcher's epistemological stance defined and justification for the use of narrative inquiry (NI) is described. The research design is outlined which provides support for who was part of the research, how and why. Key ethical considerations are discussed with examples of how ethical practice was maintained throughout the research process. The research procedure and data analysis are specified, which guides the reader through each stage of the research process, including reflexivity. The validity and trustworthiness of the research are discussed using Yardley's (2008) guidance framework.

2.2 Methodology

2.2.1 Qualitative research

The understanding of human nature and human behaviour from the modernist perspective illustrated ideas around determined fixed truths which ignored the ever-changing social, economic, political and interpersonal world in which we live (Anderson, 1997). With social transformations across culture, economics and politics qualitative forms of research have emerged, questioning the meta-narratives, certainty, methods and practices of modernism in traditional science (Anderson, 1997).

Moving beyond modernist psychology and the conceptions of truth, rationality, objectivity and individual knowledge, postmodernism advocates for communal rhetoric and a socially constructed world with an emphasis on language (Gergen,

2001). Gergen (2001, p.803) contends that postmodernism invites a new range of questions "vitally concerned with the significance of such inquiry in cultural life".

Anderson (1997) defines postmodern thought as a plurality of narratives that are more local, contextual, and fluid in a move towards knowledge as a discursive practice. This emphasises the relational nature of knowledge, truth, language, history, self and power. Social processes are emphasised in qualitative research approaches to human science with creativity and exploration in methodology. Qualitative research methods from a social constructionist perspective (Gergen, 1985) question the appropriateness of 'finding truth'.

Burnell (2010) argues against the concept of truth in science:

> Scientists should never claim that something is absolutely true… Science is a quest for understanding... We all have understandings of what truth is …and we are in danger of each believing that our truth is *the one and only* absolute truth… a search for understanding is much more serviceable to humankind.

In such a quest for understanding, qualitative methods emphasise the active role of the researcher in the research process. Gergen (2001, p.806) argues that to do science is to "participate actively in the interpretive conventions and practices of a particular culture". This highlights qualitative inquiry as collaborative, explorative and relational.

2.2.2 Epistemological position

The epistemological position reflects the assumptions made by the researchers between the data and the world (Harper, 2011). This research sits within a social constructionist framework (Gergen, 1985), informed by postmodern traditions using qualitative research methodology.

Kelly (1955) argues for epistemological constructivism, which proposes the notion that an individual may have personal constructions which are unique and

idiosyncratic, differ in organisation and fit with external contexts. This suggests that people may make sense of HV through personal constructions that align with their life experiences, cultural identification and the broader socio-cultural systems in which they are positioned.

From a social constructionist position, more emphasis is placed on social interpretation and the inter-subjective influences of family, culture and language (Hoffman, 1990). In relation to identity and sense of personhood, how an individual thinks of themselves is framed by legal, institutional, cultural, economic and social arrangements (Blackmore, 2010). A social constructionist position promotes the belief that the world can be understood through social artefacts historically situated among people through relationships (Gergen, 1985).

As social constructionism posits that there is no one absolute truth, it proposes that multiple meanings and multiple truths can co-exist (Gergen, 1985). As there are multiple meanings, social constructionism invests in the meanings attached to words. This research sits within a social constructionist framework in which there is no one truth. The emerging revisions in the conceptions of truth allow for psychology to be practiced with reflexive deliberation and intercultural dialogue in the postmodern context (Gergen, 2001). Research from a social constructionist perspective therefore moves beyond the dualistic and hierarchical processes of modernist traditions to evolve as a research process that is not static, but interactive (Anderson, 1997). Social constructionism promotes the co-construction of knowledge, such that the known reality is the social context between the knower and the known (Speed, 1991).

Within the social constructionist framework it is proposed that the construction of reality is according to the social groups in which we exist (Berger and Luckman, 1966). Questioning reality encourages the acceptance of different perspectives of the nature of reality, thus respecting an individual's construction of the world from their social and cultural context. With diversity of cultural communities in the UK there is a need to understand the human experience from diverse and non-Western perspectives, and not from a single eurocentric or ethnocentric reality. The analysis of culture is therefore an interpretive search for meaning (Geertz, 1973.)

Gergen (2001) defines language as the child of the cultural process in postmodernist traditions. Deconstructionism is one of the ideological shifts inherent in social constructionism (Hoffman, 1990). Deconstruction emphasizes the critical reading of texts to examine binary oppositions, contrast their differences and explore the relationship between them (Derrida, 2016). In critical psychology deconstruction questions how a 'problem' may be produced. This reflects the postmodern traditions of deconstructing a meaning, truth or label that exists, particularly in dominant discourses. Furthermore, alongside deconstructionism in a position of plurality, postmodernism promotes social criticism (Anderson, 1997). In relevance to the medical framework, postmodernist approaches support the deconstruction of psychiatric diagnoses and encourage contextualised thinking around the experience that has been diagnosed, as well as the meaning and expression of the experience and the language used to describe it. The process of deconstructing a diagnosis such as 'psychosis' may be seen to question the diagnostic validity, criticising the diagnosis as bound to dominant, Western, medical discourses. Postmodern thinking therefore acknowledges the inherent social, cultural, historical and political influences in 'psychosis' as a diagnosis and encourages deconstruction of the psychiatric category to improve understanding of human experience.

2.2.3 Employing Narrative Inquiry

What is Narrative Inquiry?

Narrative inquiry (NI) is concerned with the human means of making sense of the world (Murray, 2003), in a hermeneutic study (Labov, 1997), which highlights the interpretative nature of knowledge. Definitions of narratives vary from social linguistics in the context of language to whole life stories in anthropology, with psychology and sociology disciplines sitting in the middle of these definitions (Riessman, 2008). Social constructionism and postmodern traditions have influenced the development of narrative analysis (NA) (Smith, 2000).

This research employs the term NI to define its research methodology and also accepts the definitions of 'NA', 'accounts' and 'stories'. The terms may be used interchangeably reflecting their respective integrated and interwoven nature. This mirrors the power of language and meaning inherent in the social constructionist assumptions, and how words and meanings are co-constructed between the narrator and the listener.

Social interaction as a form of conversational narrative reflects the notion that we "are born into a storied world, and we live our lives through the creation and exchange of narratives" (Murray, 2003, p.113). Narratives may be defined as providing meaning, constructing knowledge or identity, organizing human action, altering the narrator's thinking and bringing emotional healing (Smith 2000). Attention is given to content, process and the reader's interpretation in NI, with further distinctions made between explication, explanation and exploration of a narrative (Czarniawska,, 2004). A narrative may be a sequence of events, with characters, formulated with a beginning, a middle and an end (Murray, 2003). Narratives employ narrative resources, which include the language resources of the narrator, characters, plot lines and genres, which allow conclusions to be drawn (Frank, 2012). Telling a narrative is a process of attributing meaning to events in life. People may re-story and re-author their experiences to create an alternative discourse, which can further challenge wider ideological and cultural societal discourses (White and Epston, 1989). Insight into one's subjective experience, self and identity may also be explored through the language of narratives (Smith, 2000).

A dilemma of qualitative research is presented between total objectivity and subjective awareness, such that researchers maintain a balance between subjective awareness and potential biases to best reflect the 'true' narratives of the participants (Ahern, 1999). The co-construction of a narrative may be influenced by the narrator's perception of what the listener needs or wants to hear (McCabe et al., 1991). Frank (2012) suggests a storyteller may be positioned by variables in the social and cultural world and by the stories they feel comfortable telling.

There is debate around what differentiates a narrative and a story, and how to distinguish whether a narrative is valuable. Not all narratives are stories, since the

former portray a technical account of events in sequential order (Tilly, 2006; Frank, 2012). It is contended that stories may be non-specialized, with a complicating event, a resolution and imagination (Frank, 2012).

A set of guiding principles outlined by Riessman (1993) define NI to be:

1. an interview schedule that encourages a story to be told
2. data from a number of informants
3. stories which are viewed as 'typical' of broader themes
4. detailed transcription
5. exemplar narratives from within the interviews
6. a report around written around the narrative text
7. assisting the reader to understand the meaning of experience

Justification for the use of Narrative Inquiry

In planning this research, different approaches in qualitative methodology were considered. This research did not aim to construct a new theory, thus Grounded Theory (Glaser and Strauss, 2009) method was dismissed. This study aimed to explore sense-making of HV beyond the conversational level, thus Discourse Analysis (Willig, 2013) was not considered. Interpretative Phenomenological Analysis ([IPA], Smith et al., 2009) is concerned with *what* people say about an experience, focusing on the content of speech in isolation of context, thus suitable for exploring the voice-hearing experience. However, in addition to story content, NI explores *how* narratives are constructed, considers *why* stories are told, attends to dialogic and performative aspects of the story and positions a story within its context, at both a micro and macro level (Riessman, 2008). Furthermore, NI theorises from the individual account rather than from component themes, may also categorise across multiple accounts (Riessman, 2008) and across the lifespan (McAdams, 1993). Therefore, for this study exploring the sense-making of African-Caribbean men who have heard voices, NI was

the most appropriate methodology. This allowed for an exploration beyond the experience of voice-hearing, but of its meaning-making within a cultural context, over time. NI was also chosen to reflect the social constructionist assumptions of this research due to its exploration of language, metaphor and emphasis upon the role of co-construction and researcher reflexivity (Riessman, 2008).

The choice of NI reflects the notion that humans live in a storied world and that stories are presences that surround us and have a symbiotic existence with us (Frank, 2012). Creating a narrative can be a means of making sense of the world, bringing meaning to one's life changes and establishing order from disorder (Murray, 2000). It is contended that people accept a culturally given plot line in narratives (Polkinghorne, 1988) which create a sense of self and personal identity. Identity is explored in narratives and can be determined by cultural ways of talking about and conceptualizing personhood (Neimeyer and Raskin (2000). Identity, personhood and cultural heritage are all relevant aspects of this research topic, explored in the contexts of HV.

Thinking about NI as a form of social action, it is suggested that the most effective way to change the world is to describe it (Latour, 2005). Thus, research to analyse the narratives of people who have heard voices has the potential to impact how wider society view voice-hearing, within a rich, personalised cultural context. Murray (2000) portrays NI as a call for support from others through the declaration of one's own account, both giving witness and searching for validation. This notion mirrors the peer support of the HVN and conveys how this research can have a beneficial impact in wider society.

Thematic analysis in NI examines the content of the account, such that what is told is a primary focus with significant attention to language as a resource, metaphors and the context-specific micro and macro systems of the narrator (Riessman, 2008). Analysing common thematic elements is relevant for this research as the accounts of African-Caribbean men who have heard voices had not yet been studied by the academic research community.

NI also supports the analysis of narratives beyond content and themes, positioning narratives in interviews as a public performance for ghostly audiences Langellier (2001). Ghostly audiences may be understood as listeners and readers of the narratives, who are not visibly present in the narrating of the story. The stories told for the purpose of ghostly audiences may be highlighted in the analysis in considering for whom was this story constructed, and for what purpose (Riessman, 2008). Furthermore, the notion of audience and ghostly audiences may impact what stories can and cannot be told in the narratives. For example, in this study, ghostly audiences may include the medical profession or other voice-hearers.

Therefore, understanding the themes spoken in the stories may portray wider contextual influences in the narratives. This may also include understanding dialogue and performative aspects of the narrative, the speaking out to ghostly audiences and the purpose of the narratives linked to wider socio-cultural contexts.

The contexts of Narrative Inquiry

All narratives are told within inherent contexts, and therefore narratives require positioning in a social and cultural context. Narrative resources are contextual, such that the world is made sense of through cultural resources (Smith, 2005) with debate as to whether narrative structures vary between cultures (McCabe, 1997). It is proposed that meaning is located within a social and cultural context, thus interpretation may change as it is influenced by history, culture and time (Anderson, 1997).

The broader historical, social and political contexts shape personal accounts. Williams (1984) argues that the individual explanations of 'illness' reinforce and maintain dominant societal discourses and structures. At a macro level, Murray (2000) argues that narratives that challenge dominant discourses in health can enhance the understanding of the power that maintains the master narratives, and the strategies needed to change them.

Thematic analysis in NI lends attention to contexts from the local micro level to the wider societal level. This research project was developed from perspectives in sociology, systemic theory and critical and community psychology with the view to challenge broader oppressive social structures that dominate the phenomenon of voice-hearing. Exploring the narrative accounts through a lens of hidden inequalities examines the inherent power at different levels of societal systems. This further portrays the wider contexts of social structures and power, and their relationship with social diversity that can be reflected in the co-construction of narrative accounts.

The importance of social diversity

The modernist discourse is criticised for ignoring the variations within this world and perpetuating universal metaphors for human description (Anderson, 1997). This research projects the assumptions of postmodernism and employs reflexivity to consider all aspects of the 'Social GRRRAAACCEEESSS' (Burnham, 2011). The approach of NI reflects upon the relationship between the participant and the researcher, which includes giving consideration to both visible and invisible similarities and differences respectively.

In the exploration of narratives from a BME group, who are over-represented in the 'psychosis' population yet under-represented in psychological therapy services and unheard in research, there is a risk in writing about a group or community that have historically been 'othered' (Fine, 2003). From a social-constructionist perspective, NI hears multiple truths and provides a platform for individual meanings to be represented in cultural narratives, thus influencing people's lives (Byrne-Armstrong, 2001). This transformative process has the potential to create social action by challenging dominant societal discourses, particularly for groups and communities that are discriminated against for being 'hard to reach'. NI can be a means of strengthening the marginalized and under-privileged (Murray, 2000).

2.3 Design

2.3.1 Consultation with experts by experience

In the development of this research project, consultation with experts by experience and service-users was employed throughout. Lead contacts of survivor networks and spirituality networks provided informal consultation on the research topic of HV. These conversations supported the broadening of a critical perspective of 'psychosis' and consequently guided the literature searching. This consultation also explored the practicalities of the project, such as recruitment and ethics, which benefited the development of the study.

The researcher[6] met with a service-user consultant as supported through the University of Hertfordshire DClinPsy Research Department. The meeting included discussions of the purpose and value of this research, practicalities of recruitment, the interview questions and schedule, and assessed the participant information for reader accessibility. The consultant provided lived experience from the perspective of self and as a parent to a young adult diagnosed with 'psychosis', which further informed systemic thinking around the family and the contexts around 'psychosis'.

Most relevant was consultation with the Founder of the HVN, Jacqui Dillon, via personal communication. Jacqui was extremely supportive of the project, and provided the researcher with knowledge and contacts of Project Workers and HVN Group Facilitators for research liaison. It was agreed that the research project would be advertised across the HVN via email dissemination to HVN members, across all social media and website.

The consultation process allowed for open discussion and reflection upon the language used by multiple people in various positions across different contexts. Furthermore, systemic issues were considered, such as how to reach out to African-

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[6] Researcher applies to the lead researcher of the research team who conducted this project

Caribbean men, the associated stigma of mental health services, and visible and invisible differences between the researcher and the client group.

2.3.2 Recruitment strategy

The researcher implemented a convenience sampling strategy, such that participants were recruited from within the HV community and local charities. Strong links were established with project workers and group facilitators of respective organisations as 'gate-keepers' to the HV community. The research information was disseminated across HVN as agreed, which further enabled snowballing recruitment. Snowball sampling may be defined as an approach to locate information-rich key informants (Patton, 1990) as relevant contacts and early sample members are asked to suggest others who may meet criteria for the study (Polit & Hungler 1997). Patton (1990) suggests that by asking relevant people who else to make contact with, the snowball gets bigger with recommendations, typically diverging across many possible sources; once names and sources are repeated, the recommendations converge.

In order to maintain visibility and presence within the HVN, the researcher connected with local HVN groups via email, telephone contact and face-to-face meetings. This personal approach created willingness to help by project workers and group facilitators, which consequently led to integration into the HV community. The researcher also presented the research proposal at both the HVN general meeting and to local HVN groups. This further supported the researcher to unite with staff from other charitable organisations and peer-led organisations, which extended research advertisement.

The staff members were instrumental in supporting the recruitment process, positioned as the 'gatekeepers' to the HV community, equipped with expert knowledge of potential participants for research.

2.3.3 Participants

For qualitative research, recommendations of sample size vary according to the chosen methodology. However, research suggests that a smaller sample size of four to six participants in qualitative methods allows for the collection of rich and meaningful data to be compared and contrasted (Smith, et al., 2009). Specifically for narrative methodology, Wells (2011) suggests that richness and complexity of data with sufficient depth for analysis may be captured with six to eight participants. Therefore, aiming to recruit up to six participants was appropriate to the time and scale of this study.

Participants were required to self-identify with the inclusion/exclusion criteria (stated below) and participate on a voluntary basis, thus, self-selecting. For the nature of the study, there were certain limits to the population sample:

Cultural identification

How an individual defines their culture may be influenced by subjective life experience and personal identity. Therefore, flexibility was maintained in understanding how one may self-identify, such that cultural heritage may be part of a wider identity. That is to say that 'Black British' may be a more dominant identifier of one's culture than second-generation 'African-Caribbean'.

Identifying as second-generation of a person who has migrated was a specific criteria of the sample in order to allow for exploration of the family history of migration and the potential socio-cultural influences of HV.

Age

The research was focused upon adults only, and therefore, participants were required to be 18 years old or over. Initially the research proposed a limited sample of 18-35 year olds, however, this was extended throughout the recruitment process.

Gender

The target population of this study was African-Caribbean men. As evidenced in the background literature, African-Caribbean men are over-represented in the 'psychosis population', more likely to be hospitalised, sectioned, and given a diagnosis of 'psychosis'. Researching African-Caribbean men only also maintained homogeneity in sample.

Language

It was a requirement that all participants be fluent English speakers. With the specifications around culture and the likelihood of participants being born in the UK, English was the first spoken language of all participants, and the shared language with the researcher.

Not currently an inpatient

As the project focused on community sampling, the participants were not a clinical sample (however, it is acknowledged that participants may have been engaged with community mental health services or GPs to manage the voice-hearing experience or any associated mental health difficulties). It was paramount that participants were not currently experiencing significant distress that necessitated acute psychiatric inpatient admission.

Not under the influence of alcohol or substance misuse

In order to elicit an account of voice-hearing under no influence of any intoxicants, it was necessary that participants were not under the influence of alcohol or substances.

Participants self-identified as meeting the following criteria:

Inclusion criteria:

- Experience of hearing voice(s) in the last two years / current voice-hearer
- Aged 18+ years
- Identify as living in an African-Caribbean culture in the UK
- Identify as second-generation from an African-Caribbean culture
- English speaking
- Not currently experiencing 'psychotic' experience that necessitates acute psychiatric inpatient admission

Exclusion criteria:

- If currently experiencing significant psychological distress
- No current substance misuse

All participants were known to supporting staff, who were knowledgeable about the individual's emotional and mental well-being, any potential risk and eligibility to take part in the research. The researcher was approached by individuals interested in taking part via supporting staff, and a phone call was facilitated between the researcher and participant for additional assessment of suitability for research.

2.4 Ethical Considerations

2.4.1 Process of ethical approval

A research ethics proposal was submitted to the University of Hertfordshire (School of Psychology) Ethics Committee and Secondary Registration with the Research Degrees Board. Research ethics was approved by the University of Hertfordshire on 17/09/2015 (Protocol number: LMS/PGT/UH/02003) (see Appendix C) and the recruitment commenced in October 2015.

2.4.2 Justification for non-NHS ethics

In the early development of the project NHS ethical approval was considered. In consultation with local NHS Trust 'psychosis intervention' teams a provisional recruitment strategy was outlined. However, the interest of this project was aimed at exploring social and cultural factors outside of a medical framework, thus a community population was preferred. Furthermore, it was decided that a clinical population may present forms of distress that on ethical grounds questions suitability for research. Other dilemmas of a clinical population also included escalated potential risks, the research being viewed as part of a medical system with influences of power, and the impact of this upon the stories told by participants. Therefore, NHS ethical approval was not submitted and participants were not recruited from the NHS.

2.4.3 Key ethical considerations

The researcher maintained ethical practice with the key principles of respect for the autonomy and dignity of persons, scientific value, social responsibility, maximising

benefit and minimising harm (BPS, 2014b). Scientific integrity and social responsibility of the researcher were maintained throughout. In accordance with the British Psychological Society Code of Human Research Ethics (2014b) the research adhered to all ethical guidelines and the following guiding principles:

Potential risks

Participants were made aware of potential risks of participating prior to the research interview with supporting participant information (see Appendix D) and open discussions with support staff and the researcher.

However, as the research involved a sensitive topic, there was the potential risk that some participants may have found the interview process distressing. It was the responsibility of the researcher to ensure that participants were protected from harm and not distressed by the research interview. It was paramount that the research interview did not elicit psychological distress or impact upon the participant's mental and emotional well-being.

To protect the researcher from risk, all interviews were conducted in meeting rooms of community centres where HVN and other community groups were conducted. Guidance in the 'Health and safety policy' (2013, School of Life and Medical Sciences, University of Hertfordshire, see Appendix E) on lone working was adhered to. The interviews were scheduled within working hours, in an interview room in close proximity to staff members and staff were reported to before and after the interview.

Valid consent

All participants were assessed as having capacity to give consent (DoH, 2005).

Before participating, all participants discussed the study with supporting staff, peers and group facilitators. Valid informed consent (see Appendix F) was obtained from all participants in written form and stored safely by the researcher. Obtaining valid

consent involved informing participants thoroughly of the details of the study, the time commitment expected, their right to decline information, and their opportunity to withdraw their data from the study up to a specified date. All participants had the opportunity to ask the researcher questions about the research prior to taking part. Contact details of the research team were available on all information materials about the study.

Confidentiality

Privacy and dignity of individuals and communities were maintained throughout the research. Anonymity and confidentiality of all data were maintained in accordance with ethical guidelines. All interview data, including identifiable information, was anonymised or deleted accordingly. A randomly assigned coded number was allocated to each participant and stored on a password protected document on a secure computer. All participants were assigned a pseudonym.

All data information is securely stored and archived at University of Hertfordshire for five years. Other data has been deleted and destroyed securely.

Giving advice

This research did not require giving advice. However, participants were offered a copy of 'Understanding Psychosis' (BPS, 2014a) as a resource about HV following the interview. Information about local HV groups was offered if not recruited via HVN.

Deception

At no point in the research did any deception occur. All information about the purpose and value of the research was truthful, clear and transparent and participants were made aware of what the research project involved. The researcher practiced with honesty at all times.

Debriefing

Following the interview all participants received a full verbal debriefing with the researcher. This provided the opportunity for the researcher to assess the participant's wellbeing and potential level of distress, and for the participant to ask any questions.

Managing distress in the interview

The safety and wellbeing of all participants was paramount during the interview. As a proactive strategy to manage potential distress, a break in the interview was offered to all participants and all interviews were conducted at a location known and familiar to the participant. Both the participant and the researcher maintained the right to stop, suspend or terminate the interview at any time. Participants were encouraged to contact the researcher, GP, HVN or any other appropriate person or organisation for support if they felt distressed following the interview.

Overall, it is advocated that participants may experience therapeutic benefit from talking about the voices and their experiences (Romme and Escher, 1989).

Ethical reflexivity

As the researcher identifies as a non-voice-hearer, their position in relation to voice-hearers and how that may or may not have impacted the research relationship was personally reflected upon. In accordance with Ahern's (1999) guide for reflexive bracketing the researcher maintained a reflexive journal to identify personal value systems, consider areas of role conflict, recognize potential lack of neutrality and re-frame blocks in the research process as transformative opportunities.

Acknowledging the inherent power of the researcher position, ethical dilemmas have considered the similarities and differences between the researcher and the participants across the 'Social GRRRAAACCEEESSS' (Burnham, 2011). Fine (2003) names Whiteness, middle-classness and education as powerful influences in the co-construction of narratives and discusses the impact of this upon the stories told.

2.5 Procedure

2.5.1 Recruitment process

The research recruitment phase was in October to December, 2015. (Full information of recruitment strategy is detailed in previous Section 2.3.2 Recruitment strategy).

2.5.2 Demographic information

Demographic information[7] of the participants is presented in Table 3.

Pseudonym	Age	Parental background	Self-described cultural identity	Given diagnosis
Alfred	Late 50s	West Indies	West Indian	Paranoid Schizophrenia
Bennett	Early 50s	NA	Black	NA
Carlton	Late 50s	Caribbean	African-Caribbean	Paranoid Schizophrenia
Deon	Late 30s	West Indies and Caribbean	Black British	Paranoid Schizophrenia
Eddie	NA	Caribbean	African-Caribbean	Psychosis

Table 3: representing the demographic data of research participants (NA = not available) as interpreted by the researcher from the narratives.

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[7] Demographic information was not recorded as part of the project protocol. However, from information elicited during the interview the participant demographics were co-constructed between the narrator and researcher. It was not known if the participants were currently involved with services, however, all participants were recruited via the HVN and community-based networks. Some of the narratives shared stories of engagement with clinical health services through the support of their General Practitioner and the use of medication as treatment for mental health difficulties.

2.5.3 The interview process

All interviews were arranged on a time and day convenient for the participant, and conducted in a service used by the participant, i.e. a local, familiar centre where the participant attends community groups.

The researcher verbally briefed the participant about the research and ethics, and provided a full participant information sheet. Upon agreement to participate, both the participant and the researcher signed the research consent form.

The process of the interviews was open and led by the participant, allowing the stories to be told and narratives to unfold. The researcher aimed to allow the participant's narrative to flow, therefore, there were minimal interruptions or re-direction by the researcher.

2.5.4 Collecting the stories

The methodology collected participant stories via qualitative research interviews, which reflected a natural and widely recognised form of interaction within Western culture as a medium for constructing and sharing life stories (Atkinson and Silverman, 1997).

The contemporary approach to narrative research emphasises the multiple people involved in creating the narrative (Andrews et al., 2013). Co-construction of narratives moves beyond the individual positivist assumptions, to include the researcher as an active role in the process (Andrews et al., 2013). The researcher was therefore not independent of the participant yet played a role as the stories were co-constructed between the two. Hunter (2010) emphasizes the usefulness of personal skills in trained therapists in NI, creating an atmosphere of trust and openness with the participant for the narrative to unfold.

Mishler (1986) proposes that stories may be co-constructed via relatively few open-ended questions. The interview schedule (see Appendix G) was carefully considered with open-ended and exploratory questions to address the main topic areas. Topic areas were informed by evidencing literature and current debates in HV and aimed to explore individual narratives around cultural identity, experience of voice-hearing and meaning-making of HV.

The interviews were semi-structured, allowing the participant to explore the stories in their own words (Fassinger, 2005). Flexibility was required throughout the interview, such that the interview schedule was a guide and not compulsory to follow verbatim. All interviews opened by asking the participant to say a bit about themselves as a person. Each participant responded to this question in a unique way and the interview then flowed as led by the participant's narrative. Thus, not all participants were asked the same questions in the same order. This supported the narratives to unfold as delivered by the participant, and conveys the co-constructive nature of collecting the stories.

Story-telling was encouraged in a process of open questions that allowed the narrator to share a reflective depth to their experience. This was supported by employing questions such as 'Can you tell me about...?', 'What do you mean by...?', 'Who first noticed...?', 'What was happening when...?', 'What things in your life...?', and 'How do you make sense of...?'. These examples of the questions employed in the construction of the interview portray how the story-telling process was supported to encourage narratives with meaning and sense-making and highlighted the temporal nature, systemic perspectives and turning points within the narratives.

2.5.5 Time considerations

The estimated duration of the interview was approximately 60 to 75 minutes. There was variation between participants, with the duration of the interviews ranging from approximately 45 minutes to 90 minutes. The proposed interview schedule was

completed with all participants. As the interview style was participant-led, timing was dictated by the narratives told.

2.5.6 Post-interview debrief

Upon completion of the interview, the researcher verbally delivered a full debrief about the research. The researcher checked-in with the participant about their emotional state to ensure that no distress had been caused by the interview, and that the participant was in the same state of well-being as before the interview. Systems of support were also discussed should the participant experience delayed distress following the interview, such as contact the GP or an appropriate helpline.

Participants were offered a copy of BPS (2014a) 'Understanding Psychosis' document. Arrangements for future contact were made if the participant requested to be contacted directly with the results of the study.

2.6 Analysis of the narratives

2.6.1 Transcribing their stories

All interviews were listened to in full twice by the researcher, with reflective writing alongside and following each listen. The first research interview was transcribed by the researcher and four interviews were transcribed by an external transcription service (confidentiality agreement signed by transcriber and researcher prior to transcription - see Appendix H). The interviews were transcribed verbatim, including conversational detail such as laughs and pauses (see Appendix I for example of transcript analysed by researcher). General observations were also recorded by the researcher in reflective journaling following the interview, such as contextual factors.

The transcripts were checked for accuracy with additional listening to the interview by the researcher. All transcripts were password protected and transferred to the transcription service via a password protected private file sharing database. All interview transcripts were anonymised.

2.6.2 The guiding framework of analysis

The narratives were analysed from a postmodern systemic perspective. Hunter (2010) defines the process of analysis and writing up as an interwoven process, which requires continual interrogation and reflection (Hunter, 2010). The researcher aimed to be immersed in the data which was approached by multiple readings and listening of the interviews. With each familiarisation of the data, attention was allocated to a specific aspect of the narrative (content/thematic; dialogue and performance; socio-cultural context). Reflexive notes were integrated throughout and the narrative interpretations were compared and contrasted. (See Appendix J for stages of analysis process).

Analysing content and themes

Thematic analysis of the narrative content examines *what* is said (Lieblich et al., 1998) Examining the content of the narrative emphasised language as the vehicle to the account and explored the function of the words and metaphors used in the speech to find analogous meaning to broader social contexts (Riessman, 2008).

'Big stories' and 'little stories' in narrative accounts were explored. Big stories portray life stories that are constructed over time with autobigraphical elements (Riessman, 2002). In contrast, small stories illuminate the local context of what is narrated in the interview (Bamberg and Georgakapoulou, 2008) and pay attention to the interaction between the participant and researcher in influencing what is told.

Reading for dialogue and performance

Analysing the dialogue and performance of a narrative considers what is said in relation to *whom, when, why* and *for what purpose* (Bamberg, 1997, 2004; Riessman, 2008). This mirrors the co-constructed nature of narratives and positions the accounts as composed and received in particular interactional, historical and institutional contexts (Riessman, 2008). Dialogue and performance pays attention to linguistics and speech within the local conversation to uncover structures of inequality and power in the narrative (Riessman, 2008).

In analysing the data, Frank's (2012) questions for dialogical narrative analysis (DNA) were also considered: what multiple voices can be heard; why is someone choosing to tell a story; how is the storyteller holding their own in the act of storytelling? Boje (2001) suggests a deconstructive stance in examining other voices not present in the narrative and questioning subjugated voices in the story. Voices may be situated in historical identities and internal politics and illuminate hidden discourses (Riessman, 2008).

Reading for context from a systemic perspective

In parallel to the social constructionist guiding framework, the narratives were analysed from different levels of positioning to portray the social cultural contexts of the micro, meso and macro systems. Murray (2000) defines the personal level as the lived experience of the narrator, the interpersonal level as the co-created dialogue, the positional level as the social positioning between the narrator and listener, and the societal level as the characteristics of wider communities and societies.

Comparing and contrasting the narrative accounts

After the analysis of each transcript, the narrative was summarised into a global impression (Lieblich et al., 1998) and individual accounts were written to describe the main themes of the narratives. Upon completion of all transcripts, each transcript was

re-read and re-listened to in order to distinguish similarities and differences in the accounts. The narratives were compared and contrasted which supported the analysis of the accounts into the main emerging storylines and sub-plots.

Re-presenting the narratives

Hunter (2010) describes a social constructionist approach to representing narratives which includes using participants' own words and language to define themes within the narratives. All narratives were represented with verbatim quotes of the personal accounts integrated into the researcher's interpretations (Riessman, 2003), which further maintained transparency of the analytical process. Ahern (1999) encourages post-analysis reflexivity to consider what stories have been narrated and for what purpose, critically questioning bias in the narrative accounts.

As this research sits within a social constructionist framework and advocates for multiple truths, it is acknowledged that the narratives presented are a reflection of the stories told by the participants, in co-construction with the researcher, situated in a particular time and context and subject to the researcher's interpretations (Wells, 2011). The narratives presented aim to answer the research questions proposed.

The individual narratives were re-presented in distinct sections including the researcher's interpretation of the narrator's story, the dialogue and performance of the narrative, and a section on 'Relational reflexivity and the local context of the narrative' for each participant in the analysis. This was to allow for a greater depth of researcher reflexivity and support the researcher to use the self in interpreting and understanding the interview context and interactional relationship with the narrator. Short quotes were used in the re-presentation of the participant's story to maintain transparency with the participant's use of language and for coherence in reading the story. Short quotes also supported the researcher to create a 'global impression' (Labov, 1997) with the words employed by the participants; thus the researcher's interpretation of the narrator's story. Although the interviewer's contribution to the narratives were omitted in the 'tidy up talk', the interactional context was acknowledged in writings of the local

context of each narrative. This decision was made in order to privilege the words of the narrator within the interpretation of each individual narrative, and thus the voice of the researcher was privileged through reflexivity.

2.6.3 Participant review of results

As the research findings reflect the researcher's interpretation of the narrative it was not appropriate for participants to review the analysis. Furthermore, it was deemed inappropriate for members of HVN or individuals with lived experience of voice-hearing to check the analysis for breach of confidentiality of the data. Therefore, in adherence to ethical guidelines to protect anonymity and confidentiality, participants, voice-hearers or HVN members did not review the results of the research. This decision is appropriate to the social constructionist framework of the study and its analysis.

The researcher was part of an academic peer group for NA which supported the discussion, reflection and analysis of the results. The analysis of the narratives was also reviewed by the supervisory research team.

2.6.4 Reflexivity and reflexive journaling

Following the interview, the researcher reflected immediately upon the interview experience by writing a reflective diary. Personal reflections included general observations that were not recorded on the audio equipment, notes regarding the environment and wider system, memorable language and meanings, dominant narratives and key themes, feedback from the participant, experience of the process, position of the self and emotional response. Thus, the researcher was engaged in reflexivity by looking inward and making oneself the object of relational reference

(Myerhoff and Ruby, 1992) to critically evaluate the approach, context and potential biases.

Researcher reflexivity was an ongoing process, such that reflexive journaling continued throughout all stages of the research process, including reflective writing following the interaction with HV groups and experts by experience. This promoted reflexive thinking about HV and enabled the researcher to challenge thinking about wider societal discourses. Reflexivity with the research team and narrative peer support group was of particular importance simultaneous to the analysis, to enhance the researcher's co-construction of the narratives and inform the research analysis. This was supportive of exploring the narratives through lenses of language, gender, social class, race and ethnicity (Denzin and Lincoln, 1998) of both the researcher and the participant.

Developing one's reflexive voice was an integral part of this research and facilitated the researcher to consider their own assumptions, positioning and context throughout the process. Furthermore, the researcher critically acknowledges the potential limits of fully knowing what shapes the research at the time of conducting it (Mauthner and Doucet, 2003) and is aware of reflexivity as an ongoing process.

2.7 Research validity

Finlay (2006) contends that the purpose of qualitative research needs to be compatible with the nature of the research question, its methodology, aims and assumptions. In order to achieve ethical, valid practice within this research, Yardley's (2008) framework for demonstrating validity in qualitative research was employed to ensure sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance of this study.

2.7.1 Commitment and rigour

The concept of rigour can be understood as internal validity, reliability and conceptual context and thus allows the reader to know the research can be trusted (Mårtensson and Mårtensson, 2007). It is proposed that rigour enhances quality and consistency of qualitative research and can be maintained with methods such as member-checking, peer debriefing, audit trail and reflexivity (McBrien, 2008). Reflexivity was employed throughout this research (see Section 2.6.4 Reflexivity and reflexive journaling) and the researcher engaged in peer debriefing in a narrative peer support group. Commitment and rigour were demonstrated in the recruitment of participants relevant to the research topic of HV and the research question, maintaining sensitivity to the context with perspectives of experts by experience (Yardley, 2008).

2.7.2 Transparency and coherence

Hiles, and Cermak, (2007) suggest key areas of transparency must exist in interpretation and data analysis, reflexivity, critical evaluation and dissemination. Methodological transparency in qualitative research eliminates inconsistencies and supports the reader to see the basic processes of data collection (Rubin and Rubin, 1995). The stages of analysis were consistent and transparent, sitting within a social constructionist framework and employed reflexivity throughout with critical evaluation of the research findings.

2.7.3 Impact and importance

Research relevance can be understood as a means to contribute to knowledge (Mårtensson and Mårtensson, 2007). Crocket (2004) recognises research as an act of

giving, that the purpose of the data serves the communities to whom the research will be addressed. In asking the questions 'for whom' and 'why' (Keen, 1991) the relevance of the research can be explored.

The research project was designed with an ethos of a community approach and was conducted in a pragmatic manner. The project is for both the scientific academic networks and for the HV community, and aims to bear impact and importance to the respective communities by contributing to knowledge and understanding of voice-hearing. The research results will be disseminated at both research and community level, with the submission of an article to a peer-reviewed journal and research feedback to local HV groups via the HVN.

Chapter 3. ANALYSIS

3.1 Overview

This chapter presents the narratives of the five participants as co-constructed with the researcher.

In reflection of the researcher's epistemological stance, the results are presented through a social constructionist lens, such that the researcher advocates for multiple truths. This recognizes the aspect of co-construction inherent in the narratives, acknowledges the context around the stories told (for the purpose of a research interview), and portrays the researcher's interpretation of the narratives.

The chapter is presented in two sections. The first presents the global impression (Lieblich et al., 1998) of each participant as a means of presenting the individual to the reader, providing a summary of the researcher's interpretation of the narrative, and offering contextual detail to support the sense-making process. Emerging storylines of all narratives are presented in the second section. This presents the dominant stories shared across the narratives in reflecting upon life stories over time, and illustrates the rhetorical power in the voice-hearers stories (Jones and Coffey, 2012). It is suggested that stories shared by groups may have greater influence and political power (Plummer, 2006) when heard by wider audiences. The narratives and storylines are considered within the wider socio-cultural and political systems, illustrating the context in which the narratives are created and reflecting the social constructionist perspective of this research.

This chapter privileges the narratives and storylines of the participants in the hope of re-presenting stories of individuals less heard, as interpreted by the researcher. The findings will be discussed in relation to existing theoretical literature in the final chapter.

Direct verbatim quotes[8] from the participants are presented in quotations, interwoven into the accounts. All participants have been allocated a pseudonym and identifying features have been anonymised.

3.2 Introduction to participants and 'global impressions' of individual narratives

Individual narratives are presented with attention to four aspects. Firstly, a summary of background information, such as demographic information, how they were recruited and where the interview was conducted. Secondly, a global impression of the individual's narrative guides the reader through the individual's cultural background, family context and meaning-making of mental health difficulties and HV. An account of dialogue and performative features are described for each narrative, and finally relational reflexivity and the local context of the individual narratives are detailed to mirror the atmosphere of the interview for the reader and further illuminate context of the narrative.

3.2.1 Alfred

Alfred was in his late 50s and identified his cultural background as West Indian. His parents migrated from Jamaica to London in the 'Windrush Era' of the 1950s. Alfred had authored several books, was a qualified Mentor and at the time of interview facilitated a HV group, from which he was recruited. The interview was conducted in a private meeting room in a local community centre, where the HV group takes place. There were no interruptions and one refreshment break during the interview.

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[8] "*Umms*", "*Ahhs*", "*Errs*" etc. and word repetitions have been removed from direct verbatim quotes to support the reader in ease of reading and make the sentence structure coherent. The removal of words are represented with [...]. Quotes are integrated into the account with quotations to show transparency in the data analysis and interpretation. The quotes are italicised to highlight the voice of the narrator.

The context of Alfred's cultural background conveyed a West Indian "*community*" who were "<u>*all very family-orientated*</u>[9]". Community connection was narrated within Alfred's childhood and reflected the social context of the families who migrated to England. Cultural pressure was portrayed as an inherent theme in Alfred's stories of childhood, which also reflected discourses of gender: "*particularly boys, we do tend to get <u>lost</u> [...] in trying to [...] <u>achieve</u> things that our parents might want*". The narrative was rich with the historical context of cultural migration and the associated issues experienced within the family through the pursuit of achievements for future generations. Alfred described parental pressure "*true of lots of West Indian families*" with high expectations, "*higher than they themselves could reach*". Alfred's narrative portrayed a dissonance between his father's expectation and his own personal values and perceived abilities. His father was characterised as the person he "*most wanted to live up to*", yet Alfred described feeling that he was "*not really capable of*" pleasing him since he identified as a "*different sort of person*". Through the process of trying to make his father proud, Alfred portrayed feeling that he acted outside of his own abilities, thus failing to achieve either.

Alfred's account detailed HV as several unfamiliar voices and his father's voice. The voices were positioned as critical of Alfred not realising his father's hopes and expectations as a son. In his early 20s, Alfred first heard a voice at a time of transition between higher education and employment, reflective of the conflict with his father's "*business-like*" expectations. The impact of HV upon Alfred was described as a "*disaster*", with emphasis and repetition of the word in the narrative; "*medically it was [...](p)[10] a <u>disaster</u>, emotionally it was (p) a <u>disaster</u>*". Alfred storied being unaware of what was happening, "*the tragedy is, I didn't know I was ill at the time [...] because I'm used to physical illnesses*". This was compounded with medical language to refer to HV as an "*illness*". The medical language employed by Alfred mirrored the diagnosis of 'Schizophrenia' and medical treatment he received. Cultural

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[9] Underlined words represent emphasis of the word in speech

[10] (p) represents a pause in speech

discrimination was portrayed in the narrative with Alfred's explanation that HV was understood as "*a bad thing*" and "*not always given a good reception*" in the West Indian culture. Alfred understood his family not talking about the mental health difficulties that he experienced as protective against cultural and community stigma and shame.

The master narrative of growth portrayed Alfred's evolution from "*living in complete silence*" to speaking out on multiple levels, which he experienced as "*freedom*". Alfred's recovery journey narrated a change in relationship with the voices; he described feelings of fear and experiences of criticism by the voices which shifted in the story when he gained control over the voices and transitioned to ask "*'what is this voice trying to tell me?'*". This self-reflection appeared to help Alfred view his experiences of HV as a message telling him that something had to "*change direction*". Alfred narrated the voice-hearing experience as a "*great time of growth*" which highlighted how the experience had encouraged him to look at "*life differently now*". The metaphor of a plant illustrated his personal journey:

> "*When I have a crisis, yes it's a crisis, but usually it generally means that something's (p) wanting to come through the ground, you know, like plants do, they need to push things out the way*."

HV was narrated as a life event that forced Alfred to change, grow and evolve. Such evolution mirrored Alfred's sense of personhood, perspective and identity as growing "*stronger*" and "*more versatile*". This journey of becoming "*more of myself*" was storied as transformative for Alfred, since he described that he was "*not gonna be able to exist*" without such acknowledgement of self. Alfred's narrative portrayed wider societal discourses around racism, positioned in the historical, political and social contexts of growing up in 1960s England. In making sense of his life experience, Alfred described feeling "*out of place*" which conveyed feelings of 'difference'. Alfred described social discrimination as "*Adultism*" which he defined as "*adults go on about... Black and White causing division, like power*". Racism was also re-framed as "*Peopleism*" in the narrative, in which Alfred accepted conflicts in cultural diversity.

The narrative was delivered in a slow pace, with a softly-spoken tone, with pauses throughout. Repetitive language accentuated points made, particularly around the impact of HV. Alfred performed knowledge in his account, asserting his identity as an author and HV group facilitator, and positioning his values as helping others by giving back into the HV community. Critical voices were also performed in the narrative, portraying racial discrimination by society and medical stigmatisation in the psychiatric system. Alfred also performed the voice of his younger self to reflect upon his own fears of discrimination and stigmatisation by wider society at the time of first experiencing mental health difficulties. The co-construction of the narrative utilised humour through jokes and shared laughter throughout, indicating a strong connection and rapport between Alfred and the researcher. As the narrative was co-constructed, Alfred invited the listener to feel proud of his journey, a story of self-discovery, overcoming adversity.

Relational reflexivity and the local context of the narrative

Alfred was the first participant that I interviewed. As we met through the HV group that he facilitated I had the opportunity to observe Alfred in his role as a group facilitator. During our first meeting I interpreted Alfred to be of a gentle nature, and I observed his interactions with others to be with warmth and compassion. I feel that these personal qualities were shared in our interview interaction together, creating an informal and relaxed atmosphere between us, and allowing the opportunity for Alfred to consider and reflect deeply about his experiences.

The interview with Alfred was the longest of all participants (approximately 90 minutes in duration), and appeared to be structured in two halves. There was a break at approximately 38 minutes whilst Alfred left the room to fetch some water. At this

point I wondered if Alfred felt ready to finish the interview and had said all he wanted too; I felt as though he was surprised that I had more questions. I interpreted Alfred's narrative in the first half of the interview as more free-flowing, more self-directed with less prompts, delivering the story which he wanted to tell, on the topics he wished to share, in the way he wanted to tell it; the second half of the interview felt more directed by questions from me. The second half of the interview began with stories of family secrets and shame associated with Alfred's mental health difficulties. As Alfred shared reflections on grappling with life, family dynamics, experiences of social isolation and his father's death the narrative shifted with the use of humour to stories of freedom, such as speaking out, authoring books and becoming more of 'himself'. I wondered whether this was a deliberate shift by Alfred in the narrative to move away from emotional pain of family difficulties to stories of success.

Alfred's stories appeared to identify his role as an 'educator' and someone who helps others, particularly through the tool of talking and in therapeutic writings of self-help books. I wondered whether stories of helping others were more prominent in Alfred's account due to his possible perception of me, as a Trainee Clinical Psychologist and as a Researcher. In the promotion of his books Alfred appeared to mock 'expert knowledge' of psychology disciplines in favour of knowledge of experts by experience, however, this humour was experienced with shared laughter. For me, this highlighted education as the most notable difference between us. Our respective levels of education were made visible in the narrative, and at various points in the narrative I felt this created both divergence and convergence between us.

The social action of Alfred's talk appeared to speak out to ghostly audiences in wider society, for example, to those who hold prejudice racial views, and to the medical professions with the hope of challenging respective discriminations. In Alfred's social position of educator I believe he was also speaking out to other voice-hearers to empower them in their journey of recovery and following their dreams, as he had done. Following the interview I felt 'filled with joy' and reflected upon how and why I felt humbled to hear Alfred's story. I reflected that the positive connection between us allowed a therapeutic rapport to build, and I felt appreciative of his time, effort and investment in sharing his story.

Bennett was in his early 50s and identified as Black. Bennett reported HV on three occasions in his life and received a diagnosis in his early 20s. Bennett was recruited via a local community group and did not attend the first interview arranged. The re-scheduled interview was facilitated at a local community group behind a screen in the lounge area. Bennett described feeling that this was private enough for confidential conversation. There was some background noise throughout and one interruption of a couple of minutes by a staff member.

Global impression

Bennett's master narrative of systems of power was employed to tell stories of social divisions and family life. Bennett positioned his family as something to be escaped. Competitive language and power were integrated into the account, describing his parents as "*difficult people*" who "*played against each other*" and brothers who tried to "*outdo*" him. Bennett's story shared minimal detail of family background and culture, however, a negative identity was characterized as he described his own "*sort of people*" as "*complicated and very troublesome*". Bennett's narrative conveyed his cultural identity as aligned with role models in Rastafarian music and politics, Bob Marley and Haile Selassie. He positioned them as having "*persevered and endured life*" against "*sufferings*" with messages of resilience against a "*failing system*". The failing system was defined by Bennett as "*The Establishment*". The establishment was positioned as a meta-group of people with multiple facets throughout the narrative: as the government, ruling classes, White people and medical coercion. Bennett proposed the notion of manipulation by the establishment, "*playing ourselves against each other and playing ourselves against ourself*". Bennett positioned himself as being held down by the establishment, which conveyed inherent issues of social adversity and inequalities in today's social and cultural systems. Bennett made sense of mental

health difficulties through an account of childhood trauma, in which he storied that a metal implant was put in his head:

"*They claimed I had an accident [...] and then no-one wants me to know the truth really so I guess I have to settle for what people told me. It's given me a scar on my on my forehead*."

The pronoun 'they' was co-constructed as the establishment, who Bennett storied as controlling his brain and seeing through his eyes. The narrative of the accident was spoken with a sense of uncertainty, which portrayed Bennett's lack of clarity and mirrored a narrative of trauma. He described being "*under a spell*" and "*wrestling*" with himself in not knowing "*what it was like to be a real person*". This story of trauma appeared to impact Bennett's sense of self and identity, creating conflict and confusion in understanding who he really was.

The three accounts of voice-hearing were narrated with a sense of confusion and mirrored Bennett's search for truth in his story-telling, positioning himself as someone who was trying to find the answers to life. Bennett's account used analogies of games and competitive language, such as "*mind games, word games, wrestling matches*" to explain his life experiences in discourses of power. Bennett employed game-like language when describing the rumination of his mind as an "*overplay*". The diagnosis given to Bennett was not named in his account, however he conveyed receiving a diagnosis as the realisation that "*it's all a mind game*". The voice of a GP was performed by Bennett mimicking himself as a "*puppet on a string*". Such self-mockery illustrated Bennett's sense of self as controlled, not an agent of his own actions, de-humanizing his identity.

De-humanising language was also present in Bennett's reflections on race and culture, suggesting that the ruling classes suppress others "*to be less than animals*". This mirrored discriminatory discourses in society diminishing a sense of value and personhood. Systemic elements of race and class were integrated in the narrative through depictions of social divisions.

Speaking out to ghostly audiences in wider society, such as health and social care professions and community groups, Bennett made a request to improve local community centres: "*instead of making it a loser's paradise, making it a winner's paradise*". This invited the audience to consider the broader societal discourses around mental health in the community. Connections with spirituality were portrayed in the narrative as Bennett drew upon notions of "*The Creator of the universe*" in existential understandings of his life. Bennett conveyed a strive for inner peace stating "*the most important part of a person is [...] their inner being, their spirit*". The sense of an inner being indicated an internal sanctuary for Bennett, protected from the power of discriminatory external systems. Bennett expressed his identity as the "*essence of me being the real me*", which indicated a part of him which he believed had not been controlled by the establishment.

Dialogue and performance

The delivery of the narrative conveyed Bennett as performing beliefs which through a medical lens may be characterised as 'delusions'. The words of the narrative were interpreted by the researcher with meaning yet the stories had lengthy tangents and multiple repetitions throughout. Humour was employed by Bennett at points in the narrative where the stories stopped abruptly, which may convey a forgetting of the story tangent or confusion. Bennett utilised metaphors in the narrative to describe systems of power, portray societal discriminations, and portray a sense of mistrust of mental health professionals. Bennett invited the reader to hear underlying messages about the equality of human beings and universal compassion, which appeared to be delivered in a scripture-like format in his stories.

The scene was set immediately in the narrative with the story of a critical incident as a child and themes of the establishment and power. Elements of mistrust and paranoia were perpetuated in some stories, and were also played out in the interactional context between Bennett and I. Prior to the interview, I interpreted some of Bennett's comments as suspicious of me, as an unfamiliar person, which he further explained to be the reason for his non-attendance to the first scheduled interview. This led to escalated anxieties in me, which I attributed to possible counter-transference between us. During the interview Bennett named social divides concretely, such as differences in race, culture and class. This made me wonder how and where I fit in relation to him and his ideas of the establishment, as a White, middle-class, mental health professional. I did not feel that the verbalised difference between us was spoken about with conflict in the narrative, yet the differences were very visible. As I interpreted Bennett's stories as attuned with debates of race and culture I felt confident enough to inquire directly about our visible and relational differences at the end of the interview. Bennett appeared to want to appease me by apologising for the non-attendance to the first interview, and then directed the narrative to validate why he sometimes has a fear of mental health professionals, thus not fully acknowledging my request to explore our visible differences.

The social action of the narrative appeared to be positioned in speaking out against the establishment and the 'ruling classes'; the narrative appeared to illuminate the importance of communities in the hope of moving away from social divisions, materialism and a hierarchical society. Mental health professionals and the psychiatric discipline were described as part of the establishment in the narrative, and were positioned as ghostly audiences.

At times, I experienced Bennett's stories as fragmented and chaotic, and I noticed a physical sensation of my head-hurting during the interview. I felt as though the account was a 'muddle' and I was left feeling 'muddled' in the interview transference. I observed myself resist the urge to formulate this 'muddle', which allowed me to be in a

less 'therapising' stance as researcher. However, in contrast, I was aware of my 'pulling' Bennett back into a story if I felt that it was unfinished, by repeating the questions that I had previously asked. This may have re-directed the narrative and highlights my active role in the co-construction of the narrative as researcher.

Following the end of the interview there was a prolonged goodbye, which left me with the sense that Bennett had a lot to say and wanted to say more. Despite my 'muddle' by the 'muddle' of the narrative, I felt an overwhelming sense of endearment towards Bennett and I appreciated his thoughtful and insightful reflections of power and social systems.

3.2.3 Carlton

Carlton was born in London in the 1960s and identified his cultural heritage as Caribbean. Carlton was recruited face-to-face when the researcher visited his local HVN group to facilitate a discussion group about HV. The interview was conducted in a private meeting room at the same location. There was one interruption of a few minutes during the interview.

Global impression

Carlton's cultural identity was characterised with the image of his younger self with "*hair locks'd up as a Rasta*". Carlton's family context spoke a narrative of an absent father; "*when I was born I didn't have my dad*", and Carlton identified as having a different father to his half-brothers. The value of parenting was conveyed through material affection, when Carlton described his step-father's parenting behaviour as "[he] *treated me good and used to buy things for me [...] and give me money*". This highlighted how he made sense of being cared for in childhood. The opening story

positioned Carlton as having had a "*good childhood*", which was contrasted with the confession that he had "*problems with the police*" when he was young:

> "*Taking drugs and all that. Smoking weed and [...] had a flat. I was in debt with my flat. [...] I was in debt with Lloyds bank [...] And I was ill.*"

Carlton storied social adversity, which was defined as drugs and financial difficulties with housing. He located the social difficulties in the time of being "*ill*" and first HV, which shifted the narrative from social adversity to a medical discourse. This reflected the dominant Westernised understanding of HV, and pathologised his experience as an illness. Social factors of "*college*" and "*working*" were narrated as overwhelming Carlton, "*a lot of stress was thrown on top of me*". The word "*explode*" was employed repeatedly in the account to explain his experience of both his internal and external world, which indicated helplessness and a loss of control at the time of mental health difficulties. The story of HV portrayed uncertainty and confusion as Carlton "*didn't know it was mental health or not*". Carlton described a common approach of increasing the use of recreational drugs to manage the distress of mental health difficulties and voice-hearing, as a form of escapism. An escalating vicious cycle was constructed as the cannabis was used to "*drown"* out the voices, yet made them "*worse*". This illustrated Carlton's vulnerabilities to smoking cannabis, a pattern of addiction, and the wider societal and cultural discourses associating cannabis with 'psychosis'.

Elements of violence and aggression were entwined throughout the narrative as Carlton described the voices as giving commands to harm others. The notion of risk was conveyed as Carlton narrated that he "*wanted to hit people, stab people*" as a consequence of being controlled by the voices. There appeared to be a lack of emotional content in the narratives of violence and aggression, which positioned the voices as responsible for the past violence.

The narrative indicated a transformational journey with the voices. Carlton's narrative positioned himself as no longer controlled by the voices but as having power over the voice-hearing. The theme of control was important for Carlton, shifting from a position of controlled to controlling in his relationship with the voices.

A subplot of help from others was illustrated throughout the narrative. Carlton's mother and her house were metaphors of safety in crises. In contrast, the mother's house was also storied as a scene of chaos involving violence, aggression, and the police. The police were characterised as helpful gatekeepers to hospital care, a counter-narrative to dominant stories of police involvement. Help from mental health services was positioned as a turning point in the narrative in supporting Carlton to gain housing and independence, which mirrored Western values.

Independence was characterised as enhancing Carlton's confidence and self-esteem. This was narrated more freely, in longer prose, demonstrating autonomy, agency and a sense of pride. Pride was also conveyed in Carlton's stories of attending college. Western values of education and employment were dominant in the account, reflecting Carlton's future hopes. Carlton positioned community groups as key influences in his recovery and independence, which portrayed the importance of social integration and peer-led community services.

Dialogue and performance

Carlton narrated in a slow pace with a flat tone and limited emotional expression. In the co-construction of the narrative the researcher was pulled into a position of short questions, converging to mirror narration style and language. This was felt by the researcher as 'clinical' in style, which aligned with a somewhat medicalised performance.

Relational reflexivity and the local context of the narrative

The structure of the narrative felt constrained by a medical framework as it appeared to fall into 'question-answer' mode, which mirrored a clinical interview. I wondered whether Carlton's past experience of interviews had been in psychiatric settings and

elicited 'factual' information, and thus he offered shorter responses which appeared less reflective. As I experienced Carlton as not 'forthcoming', I felt positioned as more active in the co-construction of the narrative, with increased prompts and more questions. At times there was a convergence in our language where my questions became closed and mirrored Carlton's short responses. I noticed that I started to 'play therapist' in a process of validation between us.

I experienced the interview as emotionally flat; I hypothesised that this may be due to long-term side effects of medication, or poor emotional literacy, or the relational context between us. Carlton repeatedly ended a sentence or story with "*know what I mean?*", which I interpreted as a rhetorical question in his phrasing as he hoped to find a shared understanding between us. I wondered whether this repeated phrase was an implicit meaning that no more detail would be shared on that particular point and thus the story was closed, and another question was required to prompt the narrative.

The longest story in the narrative was Carlton's description of hospitalisation, in which the length of turn-taking was observed to increase with longer prose. The whole account depicted a beginning and an end to Carlton's mental health difficulties and voice-hearing experience, illustrating a 'then and now' located in time, however, it appears to be missing a chronological gap in his life history. The interview was the shortest of all participants. This may have been due to the 'clinical' nature of the interview context, or it may have been due to an unexpected interruption by the service manager. I interpreted the interruption as rude, which left me feeling annoyed and like an 'imposter', undermined in my professional role. Following this interruption I noticed that I felt distracted and less 'with' Carlton in the interview connection.

The social action talk of the narrative speaks out to ghostly audiences in society not to judge people with mental health difficulties. The narrative also persuades other voice-hearers that recovery is possible, as Carlton positioned himself as someone who is developing new skills and establishing independence in his recovery journey. Upon multiple listenings to the audio I felt shocked by the medicalisation of the social difficulties in the narrative. The most powerful message that I learnt from the interview with Carlton was the power of psychiatric labels for people who receive a

diagnosis. Upon giving Carlton the BPS (2014a) 'Understanding Psychosis' document he stated, "*That's me, I'm a 'schizophrenic'*". I was struck by the power of the psychiatric label and how enmeshed it felt with his identity in that moment.

3.2.4 Deon

Deon was in his late 30s and identified as Black British. His parents migrated from the Caribbean to the UK in the 1960s. At the time of the interview, Deon was not employed, experiencing housing difficulties and no longer heard voices. Deon was recruited via a local community group. He was late for the interview, reporting to have over-slept due to medication side-effects. It was re-scheduled and facilitated in a private room of a community centre, with one brief interruption by a staff member.

Global impression

Deon depicted his childhood through the discourse of a family who had separated, identifying himself as growing up in a "*one-parent*" family with a father who "*wasn't really around*". His mother was positioned as primary caregiver in both childhood and in adult life as Deon was still living with his mother. The master narrative of loss in Deon's account was repeated in the storying of different family members. The bereavement of his partner was located as a turning point in the story as a trigger of HV, a life event that "*broke*" him and he "*got really messed up*". Deon's loss and grief was positioned within an escalating cycle of social withdrawal and mental distress; he did not "*talk to anyone about it*" for fear of what "*they think*", consequently he "*bottled it up inside*" and "*things got worse*". Deon storied the voice(s) as controlling him, making him carry "*weapons*" as he "*felt threatened by people*". This characterised Deon as experiencing 'paranoid' thoughts, not feeling safe in the world and unable to seek help.

HV appeared to be indescribable for Deon, "*just a funny feeling*". This conveyed his confusion of the experience, which led to the belief that he was "*going out of my mind*". The narrative of "*crazy*" was emphasised and reflected a wider societal stigmatisation around HV. Deon narrated the difficulties as "*spiralled out of control*" as they escalated "*from one problem to the next problem*" until he "*ended up in prison*". The sequence narrated a cycle of self-destruction following the bereavement: self-harm, using illegal drugs to "*block it out*", turning to crime to feed the addiction and ending in "*trouble*" with the police.

The forensic subplot was a turning point in Deon's narrative, such that prison provided his first contact with psychiatric care. A medical plot was thickened in the narrative with the diagnosis of 'Paranoid Schizophrenia' and Deon's use of language of "*illness*". Deon's identity was portrayed as enmeshed with the notion of being "*crazy*", internalising the diagnosis and the mental health difficulties to see himself through a lens prejudice and discrimination. The master narrative of loss was therefore mirrored in Deon's loss of identity to the diagnosis.

The story detailed further family losses in the death of his step-son due to a drug overdose and the imprisonment of his adolescent son. Both were narrated with a sense of sadness, tragedy and acceptance and reflected repeated generational family patterns. Deon implicitly narrated further loss of employment and independent living following rehabilitation from prison, which highlighted barriers to community reintegration.

Deon storied feeling punished for his past, such that "*they're not really that forgiving in this country*", positioning society as judgemental and discriminatory. Despite double discrimination by society Deon identified himself as "*recovered*" since he no longer heard voices. The subplot of positive recovery was located within meaningful relationships with his family, priest and GP. This demonstrated a transformational journey for Deon in his family relationships and relationships to help. Deon offered a narrative that talking was helpful for his recovery, a counter-narrative to the perception of talk in his cultural community. The rediscovery of strength and

resilience in family relationships was in contrast to the master narrative of loss, such that Deon had regained family connection.

Dialogue and performance

The story was narrated with humour and minimising language, which may be constructed as Deon's defence or coping strategy when talking about sensitive topics. At times the narrative required prompting and notable shifts were evident in the story sequence from past to present, possibly to avoid difficult feelings and protect the audience. The narrative was performed to ghostly audiences in wider society, such as to people who use drugs, voice-hearers, and to people bereaved with a personal message of 'look what happened to me'. This was further reflected in messages of double discrimination, to challenge stigma of people with a diagnosis and/or a criminal record. The co-construction of the narrative concluded with an overwhelming sense of hopelessness and being stuck, shifting affect from humour to sadness, which reflected the master narrative of loss.

Relational reflexivity and the local context of the narrative

In response to the opening question which was standardised across all interviews, Deon was the first participant to share a story of his hobbies, which created a sense of fun. I interpreted Deon's presentation as relaxed and laid-back as humour was employed early in the narrative to set the scene.

There appeared to be a shift early in the narrative with the storying of family bereavement. I noticed Deon's responses were shorter, as if to 'shut down' detail, and I felt I had to work harder to elicit more depth to the story. This was simultaneous to the sadness I experienced in response to his story, which was verbalised by the change in my tone to a 'therapist' voice. Short answers were employed in the storying of the

forensic plotline, yet the account was abruptly broken with humour as Deon re-directed to a story of psychiatric treatment. This shift in chronology in Deon's life experience created a gap in the timeline of the narrative, as if there had been episodes of prison and psychiatric treatment in his life, yet very little in between. Phrases such as "*stuff like that*" were interpreted as minimising and vague, which I experienced as Deon not wanting to share more detail, and consequently drew me into a position of high prompting.

I observed myself actively summarise the interview at various points in the narrative in order to maintain momentum. I felt an overwhelming sense of sadness during the interview, particularly in the storying of more family bereavement; I masked the emotions by drawing on therapeutic skills, to contain both of our emotional experiences. I felt the desire to acknowledge the adversities in life Deon had suffered and validate his emotional resilience. Humour was repeatedly employed as a tool by Deon to change the mood. I noticed that I ended the interview in the role of therapist, and wondered about my need to offer hope to Deon. I questioned what was my difficulty in sitting with a narrative ending that I interpreted as hopeless?

Differences of race and culture were not directly explored in the relational context, yet the greatest difference I felt between us was of our respective societal positions as bound by contexts of education and employment. I felt that there was a great metaphorical distance in our respective roles and positions in society in the context of a hierarchical systems of power; this was an uncomfortable feeling to sit with. However, I experienced a relational convergence in our emotional connection, a shared acknowledgement of 'stuckness' and hopelessness, experienced with sadness.

The social action talk of Deon's narrative made a plea to ghostly audiences in wider society to understand the person. This message is of particular importance to be heard by both the forensic and psychiatric systems, since Deon's narrative positions him as discriminated against by both. Social acceptance was interpreted as Deon's personal request of ghostly audiences. Following the interview, the sense of sadness remained with me for days. However, re-reading and re-listening to the transcripts was less

emotionally intense, which conveyed the strength of the emotional connection with Deon during the interview.

3.2.5 Eddie

Eddie was born in the UK and identified as an African-Caribbean man, with his parents originating in the Caribbean. Eddie was married with children and employed as a Volunteer Assistant in a local third sector organisation from where he was recruited. The interview was facilitated at his workplace, in a private meeting room, without interruption.

Global impression

Eddie positioned himself as a survivor of childhood neglect in the context of strict parenting traditional of the Caribbean culture. Parental separation and enmeshed family relationships were portrayed with Eddie's parents teaching him "*to be dependent upon others*". The notion of dependency may suggest wider discourses of social class and reflect how Eddie identified the social position of his family whilst growing up. Swear words and pronouns such as 'they' and 'them' rather than 'we' were used in Eddie's family stories, which highlighted his disrespect of his parents, and indicated personal and relational separation. The impact of Eddie's upbringing and not being "*around people that can reason*" was named as the causal factor for the mental health difficulties he experienced. Mental health difficulties were "*frowned upon*" within the African-Caribbean community, illustrated with the cultural myth that "*they think that if you're around it you'll catch it*". Eddie re-enacted his father's voice in the story to perform hear'say of cultural myths and stigmas attached to mental health.

The difficulties of Eddie's adolescence were physically embodied in the narrative, with "*tension*" "*building up*" that made Eddie "*rigid*" and "*ready to explode*". Medical

language was utilised to narrate the escalation of "*anxiety*" and "*depression*" to HV. The voices were storied in multiple presentation, male and female, familiar and unfamiliar, with an overwhelming feeling that made Eddie lose himself. A sense of confusion was illustrated in the account, echoing dominant narratives of HV as indescribable. Conflicting roles within Eddie's voice-hearing were presented through familiar people, positioned as either attacking or an ally. This was mirrored with the account of religious and spiritual dichotomies of voice-hearing, which portrayed conflicting demands between the "*Devil*" and "*God figures*". Themes of violence and aggression were attached to the 'Devil' voices and were conveyed as integrated into Eddie's sense of self:

> "*I couldn't control the aggression. It [...] had become a part of me [...] and eventually I killed somebody and ended up [...] in hospital and I got sectioned off*".

Discourses of gang crime reflected the local urban social-cultural context. However, Eddie provided a counter-narrative for his forensic history, demonstrating shame and guilt about the past, identifying himself as "*more sensitive*" than people who "*lived a life through crime and actually enjoyed what they did*".

Eddie's journey through the forensic system signified a turning point in both his life, and in his relationship with the voices. Accessing psychological support in the forensic psychiatric system was characterised as normalising that he was "*not crazy*". This indicated Eddie maintaining metaphorical distance between the diagnosis and his identity. Eddie's identity-now was characterised as independent, a counter-narrative to the values of dependency taught by his parents. The recovery from mental health difficulties and HV were positioned as turning points in Eddie's life in establishing his own independence and identity.

The narrative of re-affirming his "*belief in Christ*" offered another turning point in Eddie's voice-hearing experience. A "*hallucination*" characterised "*the Christ people*" offering support and praise by "*clapping hands*" when Eddie was "*doing something good*". This storied HV as transformative and made Eddie feel comforted, which illustrated a powerful affiliation with religion. His mental well-being was depicted in a

religious metaphor, with his world view described as shifting from darkness to light. Eddie's connection with the Church was further characterised in his reciprocal relationship with the vicar, such that they "*support each other*". Community acceptance and integration was storied through the Church, positioning the Church as another family and part of his identity as a "*Christian*".

At the core of Eddie's recovery story were positive personal and social relationships, described as the "*nurture*" and "*support*" that gave him the strength to "*take control*" of his life because "*being involved in positive relationships is a healing process itself*". There was an essence of a wounded healer in Eddie's narrative, as he portrayed surviving adversity and reaching out to help others. In this position Eddie invited the audience to identify him as an advocate and role model of mental well-being. Eddie defined talking as a "*catharsis*" through a "*social intervention*", not a clinical one. This reflected the importance of community-based interventions in health and social care. The story of survival also invited ghostly audiences in the health care and forensic systems to challenge prejudices:

> "*I'm stigmatised because I've had a mental health experience and people like the Home Office [...] psychiatrists would always try to keep me back because of that. Because of the way they approach like diagnosis and [...] they feel that I'm never going to transpire to do anything [...] other than cope with my mental health issues.*"

Eddie's narrative reflected upon overcoming double discrimination and societal stigma of mental health difficulties and a criminal record. The story spoke of Eddie's journey of re-building himself, his transition back into the community, and his hopes of further inspiring others with similar experiences.

Dialogue and performance

The narrative was co-constructed in a manner that was felt by the narrator as therapeutic in its process. Eddie performed the dialogue with deep reflections on his

life history, with strong emphasis on the concept of family and nurturing one's identity. Eddie claimed ownership over his transformational journey, echoing Western values of independence, liberty and hard work to his personal achievement of recovery. Discriminatory societal discourses attached to mental health and offenders were challenged in this narrative, as Eddie models positive community reintegration. The interview elicited inspiration and feelings of hope in the researcher.

Relational reflexivity and the local context of the narrative

The scene was set by Eddie with the characterisation of his identity as a 'family man', which I interpreted as an important value and a core theme throughout his narrative. I felt that the rapport and trust was established early in the interaction between us. This was conveyed through the disclosure of Eddie's forensic history, without prompt, which may indicate the trust he felt in me. I felt surprised, shocked and curious by the crime, which created a dilemma as interviewer in the narrative - I wanted to explore the story in more depth but resisted the urge to ask questions and allowed the narrative to flow in a more 'natural' delivery by the narrator, devoid of interruptions. Throughout listening to the forensic subplots my mind wandered to Deon; I noticed that Eddie's account mirrored Deon's in the psychiatric and forensic subplots, particularly in that prison was their first contact with mental health treatment. I felt overwhelmed by their difference in current stages of recovery. I desperately wanted to metaphorically place Deon on the same position as Eddie on the 'recovery continuum'.

In the interactional context, I interpreted Eddie and I as aligned in our beliefs about therapeutic recovery and our shared positioning of talking as a catharsis. My role as Trainee Clinical Psychologist may have encouraged Eddie to share stories which characterised him as a client, a therapist, and someone who values psychological support. This may have contributed to Eddie performing his identity as a model client who had employed his learning from therapeutic conversations to move from 'rock bottom' to 'being the change he wanted to see'. This led me to reflect upon the

different stages and directions of recovery, from 'self-sabotage' to community reintegration, and wondered what empowers an individual to grow and maintain emotional resilience in the process.

The public performance of Eddie's story appeared to speak out to ghostly audiences on multiple levels: to the systems of psychiatry and the Criminal Justice System that confine the rehabilitation of people with labels of diagnoses and offender categories; and to individuals who had experienced similar journeys of adversity and institutionalisation. The social action message was interpreted as challenging discriminations and societal prejudices to show that an individual can live a different and reformed life, rather than as an identity shrouded by medical and criminal discourses. Eddie also employed messages of persuasion to reach out Black communities and mental health professionals working with diverse communities against the dominant discourses of the 'hard to reach' label in the hope of challenging the stigmas and cultural myths associated to mental health difficulties.

Following the interview I experienced an 'after-glow'. The description of positive relationships as a healing process has stayed with me since our interaction. I reflected on Eddie's journey of recovery and felt inspired and hopeful that positive community rehabilitation is possible for all in a world where recovery exists, social relations matter and community reintegration can be successful.

3.3. Emerging storylines

This section of the results presents the collective emerging storylines of all five participants in their meaning-making of mental health difficulties and HV. The analysis defines four main storylines shared from the narratives: 'Storylines of the changing understandings of hearing voices over time', 'Recovery: Reformation, Redemption and Restoration', 'Storylines of family life and understandings of culture and race', and 'From Silence to Freedom: Speaking Out and Reaching Out'. Each storyline will be presented with emerging subplots within the storylines.

3.3.1 Storylines of the changing understandings of hearing voices over time

The collective storyline of "the changing understandings of hearing voices over time" describes four subplots: "I just thought I was going crazy"; "Every time I would hear the voices I want to block it out"; "What is this voice trying to tell me?" and "I was actually ill but I don't know exactly what caused it".

"I just thought I was going crazy"

Storylines of HV as 'crazy' emerged from all narrators highlighted with the words used repeatedly and alongside 'madness'. The notion of 'crazy' presented itself through narrators' performance of their confusion in the voice-hearing experience; as well within a cultural context through their fear and shame of mental health difficulties and in the prejudices dominant in wider society.

The theme of 'not knowing' throughout the content of the narratives reflected uncertainty in the experience of HV:

Carlton: *"I didn't know it was mental health or not, didn't know what it was at the time. Cos I was trying to figure out what it was"*

Deon: *"I didn't know what was going on I was confused"*

"I just thought I was going crazy"

Alfred: *"I didn't know I was ill at the time"*

"if you don't know anything about them, about what's going on then it's quite scary"

The experience of voice-hearing was co-constructed as indescribable, "*a funny feeling*" (Deon) that made the narrators feel "*uncomfortable*" (Eddie) and question their thoughts and reality, "*I'm not sure whether what I'm thinking is crazy*" (Eddie). Uncertainty in the stories highlighted a difficulty in distinguishing between one's own thoughts and the external voices. Uncertainty may also indicate the voice-hearers' fear of mental health difficulties, reflective of dominant prejudices and discriminatory discourses around mental health difficulties, 'psychosis' and HV in wider society and the media. Alfred's account was co-constructed with the legal and political discourses of mental health in the early 1980s, when he first heard voices:

"*People in those days [...] didn't talk about mental illness as much as they did now, and [...] it was [...] very derogatory*" (Alfred)

This reflects a separation of mental and physical distress through a medical discourse and suggests that ignorance around mental health created a sense of discrimination at a macro-level. The use of 'they' to 'other' non-voice-hearers in Carlton's story performed the attitudes of wider society as perpetuating beliefs that HV means 'crazy':

"*They think you're crazy or you've lost it or something like that. But you haven't. It's just that the voices are talking to you*." (Carlton)

This offers a counter-narrative against societal stigma that someone can hear voices and not be 'crazy'. This is in contrast to Deon's account of the diagnosis affirming the belief that he had an "*illness*" which means "*being crazy*". The internalized diagnosis reflects the power of a label and its impact upon an individual's sense of identity. This echoes the wider societal discourses around what it means to hear voices, the Western prejudices of being 'crazy', and the lack of education around the experience, which consequently maintains stigma.

The confusion performed in the accounts when trying to narrate the voice-hearing experience mirrored a dissociation from time and place in the context of heightened distress, thus creating difficulty in remembering or distinguishing the experience. Confusion in Bennett's talk and his performance was associated with his beliefs about his own 'madness':

"*My madness is a bit worse than that because I've been saying that um that [...]
the police um are getting paid protection money via the Mafia and vice versa and
that [...]the real Queen was [...] the Queen's sister who they pushed into the
mental asylum.* [laughter]." (Bennett)

In contrast to other narratives which reflect upon the notion of 'crazy' as a past identity
or belief, Bennett demonstrated an identity and attachment to 'madness', with the use
of the pronoun 'my' when sharing his beliefs with the audience. The laughter in the
narrative created a sense of self-mockery, which may be understood as Bennett
humouring himself, or a sense of self-doubt and self-criticism. Bennett's idea of
madness is associated with his experience of "*class wars*":

Bennett: "*Well I guess it's about class wars, but for me it started when I
was an infant [...] when I was little they saw that I was going to
be a genius and they [...] looked at my parents and they thought
oh no they could not afford that to happen so they thought
they'll beat me up to make sure that I don't get far. Because my
parents they're not very great people really when it comes to
using their brain really. Because maybe like I says earlier they
were being played against each other in the relationship, why I
wanted to get away. But maybe [...] it was external factors that,
I guess maybe for Black people they were always [...] put under
a spell to [...] be a curse to ourselves.*"

Bennett positioned the notion of 'madness' within a social structure framework,
highlighting differences in race and social classes and identifying himself as
controlled by the "*ruling classes*" (Bennett). This highlights social adversity through
marginalisation and exclusion, suggesting that he suffers from 'madness' due to "*class
wars*" (Bennett). The dominant message in Bennett's account conveyed madness as
bound to discriminatory social structures of oppression and control, using 'madness' to
"*outclass other people*" (Bennett).

Stories of social withdrawal and self-harm were shared across the narratives as a means of managing the distress of mental health difficulties and HV. Common techniques of self-managing the voices were detailed in the narratives, which reflected the escalating distress of the mental health difficulties and HV to the point of crises.

Eddie: *"Going into myself I was trying my best actually [to] overcome it, but it was making me worse, but I didn't realise that at the time."*

Deon: *"Every time I would hear the voices I want to [...] block it out, [...] and harm myself, to try and get rid of it"*

                        "at first I tried to do things [...] like burning myself, cutting myself, things like that. I was trying to block it out, yeah. And that's when the drugs came in afterwards."

The stories narrated self-harm and drugs as an escape in the short-term that worsened the voices in the long-term.

Carlton: *"It's mostly at night time I used to hear it. And I say it's used a lot of weed at the time, kill it off, drown me drowning it out."*

Researcher: *"And did that help?"*

Carlton: *"No. Just made it worse."*

Carlton positioned the cannabis as negatively contributing to the mental health difficulties he experienced. The metaphor of a vicious cycle with "*a lot of things going into one [...] from one problem to the next problem*" (Deon) portrayed the circular and inter-connected nature of the difficulties.

Self-harm and suicide attempts were storied with accounts of trauma and desperation which described heightened mental health difficulties and a loss of hope in oneself. The cycle of distress was narrated with a crisis point by Alfred who "*cut*" himself and

"*attempted suicide*" (Alfred). For Alfred the crisis point was the first contact with psychiatric care, thus also a turning point. This reflects a common occurrence in Western society that help may not be sought by many individuals in distress until the point of crisis. Particularly for young African-Caribbean men, this may be representative of fear of services, shame of the distress, and not knowing where to get help.

Illicit drugs were characterised in two accounts as a helpful means of escapism, both from the voices and from the difficult life situations of the narrators. Substance misuse was storied within the context of an addiction cycle, the use of cannabis and crack cocaine following similar patterns of escalated dependency and equal deterioration of mental and emotional well-being.

"What is this voice trying to tell me?"

All the narratives co-constructed a relationship between the voice-hearer and the voice, and as part of the sense-making process questioned the message of the voice.

The shared master narratives echoed stories of power and dominance by the voices. The narrators invited the audience to recognise the control by and criticism of the voices, and consequently their negative and debilitating impact upon the individuals' lives.

Alfred: "*it was like people putting you down all the time*", "*quite critical*", "*just saying you're not good enough*"

Bennett: "*a voice called me, said that I was stupid*"

All narratives co-constructed the voice-hearing experience as multiple voices in presentation, however, the accounts varied as to whether the voices were constructed as familiar to the voice-hearer. The voices were unfamiliar to Bennett, Carlton and Deon, whereas for Alfred and Eddie some of the voices reminded them of a familiar person. Alfred made sense of hearing his father's voice in the context of their

relationship and family values. Alfred identified as a "*different sort of person*" to his father and self-portrayed as having "*no ability*" (Alfred) to make his father proud. The self-perceived failings of Alfred reflected the gendered and cultural expectations of achievement within an African-Caribbean family in the 1960s and the self-criticism for not meeting these expectations. The self-criticism was storied as the personification of Alfred's father's voice in the voice-hearing experience. Familiar voices were characterised as two sisters in Eddie's narrative, an ally and an attacker.

The nature of voice-hearing was described with an organic metaphor in some of the narratives, such as a "*growing thing*" (Alfred), which suggested an internal experience which overwhelmed the individual. This was reflected in Carlton's account of the voices making him reach a crisis point which caused everything to "*explode in*" (Carlton) him. The voices were conveyed as having a life and identity of their own, both separate to the individual and enmeshed within their lives, which made it difficult to separate the experience from the person. The command of the voices were characterised as instructing the individual to "*do negative things*" (Carlton).

The stories of voice-hearing were attached with the emotional experience of the voices as feeling "*threatened*" (Deon) and "*frightened*" (Eddie) with the consequence of social withdrawal. The voices were portrayed as inciting fear in the voice-hearer, which made Deon carry "*weapons*" (Deon) for a sense of safety against people. Themes of violence were integrated into Carlton's and Eddie's narratives, both identifying as powerless to an uncontrollable aggression as commanded by the voices.

In contrast to the dominant stories of the voices as critical and controlling, Eddie offered a counter-narrative of voice-hearing as a comfort. Eddie storied an experience of voice-hearing as a "*hallucination*" of "*Christ people*" "*clapping hands*" which was portrayed as "*very comforting*" (Eddie). This was located within a religious discourse and framed in the timing of Eddie "*reaffirming*" his "*belief in Christ*" (Eddie) offering a personal message of encouragement and empowerment.

The empowerment was also heard in Alfred's narrative as he invited the audience to inquire about the personal message of the voice:

Alfred: "*'what is this voice trying to tell me?' and sometimes it's trying to tell you not to do something or to do something or change direction.*"

The metaphor of voice-hearing as a plant symbolising growth is observed in the positive message "*to protect itself or to build up itself*" (Alfred), such that HV may serve a functional purpose for an individual in a particular context and time.

"I was actually ill but I don't know exactly what caused it"

Similarities may be observed in the narratives as social difficulties and life experiences of adversity were co-constructed as triggers of mental distress and voice-hearing, yet labelled within a medical framework of 'illness'. Medical stories were thickened with the use of language referring to mental-health difficulties and HV as an "*illness*"; medical language to define mental health difficulties and HV was in contrast to the master narratives of social adversity shared by participants. Carlton named "*drugs*", "*debt*" and "*stress*" (Carlton) as overwhelming factors that made him "*ill*", which highlighted the attribution of social difficulties to a biological explanation. Deon's trigger of mental health difficulties was contextualised to the bereavement of his partner which "*broke*" him and led to HV and taking drugs, making things "*really messed up*" (Deon). Bennett narrated 'madness' in the context of societal pressures, power and prejudices and storied a traumatic event in childhood as a trigger of being 'mad'. Eddie reflected that childhood adversity, such as family neglect, contributed to the development of mental health difficulties in adolescence. Alfred storied academic and employment pressures as a personal struggle around the time of first experiencing mental health difficulties and HV. He positioned himself as "*disconnected*" as he found it "*more and more difficult to cope in the classroom*" (Alfred), which demonstrated social disintegration as a consequence of difficulties in the learning environment. Despite such reflections and awareness, Alfred maintained uncertainty in his account, "*I was actually ill but I don't know exactly what caused it*" (Alfred). This may be constructed as a conflict of social-cultural difficulties diagnosed as

something biological, since Alfred offers explanations of personal and social adversity at the time of mental health difficulties, yet defines them with an identity of being 'ill'.

Wider societal discourses of 'schizophrenia' were performed in Alfred's account, which highlighted prejudices towards the diagnosis, "*the Western model was saying [...] "that's it*", "*you're gonna get locked up and not let out again*" (Alfred). Alfred's narrative suggested a fear of the consequences of mental health difficulties and a possible diagnosis, such that he may lose his sense of self, identity and freedom. This was portrayed as a turning point in driving Alfred's ambition to question his life choices. Alfred performed the voice of his younger self in the narrative with the reflective question ""*there's got to be more to life than this?*"" (Alfred). Alternatives to the medical model were offered in Alfred's story, with emphasis upon literature as a source of information beyond psychiatric services:

> "*I read that book it talked about.... being positive, going after things, [...] rising above difficult situations... I started to get onto reading a lot around personal development and psychology and things like that, looking for other ways rather than just the medical model.*" (Alfred)

Psychology may be constructed as providing hope and direction for Alfred's journey of self-discovery, redirecting his life choices. A counter-narrative to medical understandings of HV was co-constructed with Eddie:

> "*Lots of people in the world who hear voices so that I've gathered [...] Whether they've had a mental health history and recovered from it [or] whether they have heard voices but they've been able to cope with it from the outs... [...]maybe lost their voice [...] getting on in the community and doing things [...] and they're happy people. [...] hearing voices doesn't have to be [...]a negative thing*" (Eddie)

This statement may speak to ghostly audiences in society with the hope of challenging discrimination of mental health difficulties and HV, normalising the experience of voice-hearing, and validating individual recovery in the community.

3.3.2 Storylines of Recovery: Reformation, redemption and restoration

The collective storylines of recovery depicted four subplots: "Reformation: Prison as a turning point", "The Church provides redemption", "Restoring one's sense of self" and "*I've got to be able to reflect... to know where I'm going*".

Reformation: Prison as a turning point

Storylines of reformation as part of recovery depicted prison as a turning point in the experience of mental health difficulties and voice-hearing and, consequently, the narrators' lives. Crime was positioned within an escalating cycle of escapism and destruction, of both self and others. For Deon, burglary supported a drug addiction to escape the voices; for Eddie, robbery was a financial solution to escape the family home. Deon invited the reader to feel the sense of chaos in his life, only understanding that "*this is real*" (Deon) upon being caught by the police:

Deon: "*I was going along taking the drugs and doing the crime [...] I was untouchable*"

"*was just doing things [...] like thinking not of the consequences*"

Eddie: "*...first it was theft. [...] when things got really bad I kind of went on um a thieving spree. I robbed [...] a shop [...] ended up in prison [...] then when I come out of prison I kind of got totally aggressive*"

Both accounts offered a story of escalation, the crime conveyed as addictive or uncontrollable. Eddie's story further reflected a gang culture inherent in London boroughs of socio-economic deprivation, pursuing a "*vendetta*" with a "*small crew*" (Eddie) after leaving prison. Through Eddie's journey of reformation, shame and guilt were performed as he reflected on criminal acts that consequently made him feel "*hurt*" and "*depressed*" (Eddie). This provided a counter-narrative to stories of gang-crime. Following the second time in prison, Eddie portrayed a reformed identity and positioned himself as separate to other offenders who had a "*completely different mentality*" self-characterising as "*much more sensitive*" (Eddie).

Eddie: "*...from prison I got sectioned um ended up back in the community after coming out of hospital and reoffending and going back into hospital. That's in the second time in hospital that I learnt my lesson [...] and become more of the person that I've always wanted to be*"

The experience of prison was narrated differently by Deon and Eddie. Deon offered concrete words to describe the scene inside illustrating prison as "*very scary*" and "*horrible*" with "*boredom*" and "*tension*" (Deon), whereas Eddie depicted the experience as a learning process. The narratives indicated a contrast in the therapeutic support received in the prison services: Deon "*saw a psychiatrist*" and received "*medication*" (Deon); Eddie was "s*ectioned*", transferred to a "*medium secure unit*" and saw a "*psychologist*" (Eddie) as well as taking medication. This recognises the need for psychological talking therapies within the prison system and reflects the therapeutic impact upon one's recovery and rehabilitation back into the community. The stories of recovery shared by Eddie and Deon highlighted differences in how they position their own recovery journey. Nonetheless, both narratives highlighted prison as a turning point as their first contact with mental health professionals. This may raise questions about access to services, the invisibility of particular groups in talking therapies and the need for early community-based psychological intervention for people experiencing mental health difficulties.

The stories of reformation also conveyed double discrimination experienced by Deon and Eddie. The narratives both portrayed awareness of the stigma attached to a

criminal record and diagnoses, demonstrating the impact of labelling by society and their barriers to recovery. Eddie positioned systems as preventing him from progressing with judgements that he is "*never going to transpire to do anything*" (Eddie). Eddie rejected the societal prejudices and demonstrated a non-acceptance of the labels as part of his identity. In contrast, Deon's narrative portrayed hopelessness as he narrated that he "*can't really look at my future in a good way really. Cos I've got a criminal record now um, I'm on medication*" (Deon).

Despite prison representing a period of transformation and reform for both Eddie and Deon, the double-binds of discrimination may be constructed as maintaining differing impacts upon their identities and sense of recovery.

The Church provides redemption

Smaller stories of faith and religion were inherent in Deon and Eddie's accounts, narrated as a process of redemption, being saved and learning from one's past. The Church was positioned as a protective factor, helping them overcome difficult life events and supporting their re-engagement with the community. Deon's account conveyed himself as actively engaged in attending church, which he found helpful for him and his family. The reader was invited to view the church as a protection at a time of family bereavement.

> Deon: "*the priest came over and um he blessed the house and stuff like that. He blessed the room. Um he put some like holy water around the place and [...] gives like closure [...] of what's happened.*"

Similarly, Eddie's view of the church was narrated as a different kind of "*family*" to the one he grew up with, where people were characterised as "*really respectful*" and "*kind of encouraging*":

> Eddie: "*they're all so different, but we all come together as a community and we're like a family*"

Eddie also narrated his association with the church in relation to his experience of voice-hearing and being "*sent*" voices related to "*God figures*":

> Eddie: "*the Christ people would come up [....] an hallucination, like when you're doing something good clapping hands and I would see it.. I would never see the face but I would see [...] hands clapping*"
>
> "*some would describe it as a vision or some would describe it as a hallucination or whatever. But that was very positive and actually it was very comforting*"

Bennett offered a counter-narrative to the church as protective, and positioned religion within his dominant narrative of power games and influences of the establishment:

> Bennett: "*...it's all about playing church [...] I don't go church any more, it's all about [...] spying on those who are more genuine than those who aren't and making sure that they trap them so that don't get too far* [*laughter*]."

With the metaphor of a game to illustrate religion, Bennett indicated his mistrust of religion as being "*about stopping people from knowing what the true religion is*" and instead identified his connection with "*spirituality*" (Bennett). This reflected Bennett's search for truth in trying to make sense of his world and how such ideas perpetuated his mistrust of systems such as the church and the establishment. Bennett's reference to Haile Selassie may be constructed as his faith in the Rastafari movement, which perceives Haile Selassie as the incarnation of God who will lead humanity into eternal peace, righteousness and prosperity (Sullivan, 2005). Bennett's narrative of his faith conveyed gratitude to "*The Creator*" (Bennett) and conveyed spiritual beliefs reflective of his identity within his cultural context.

The stories of recovery shared similarities in the co-construction of restoring one's sense of self. The experience of mental health difficulties and HV was narrated as impacting one's identity, thus a transformational journey in the face of adversity was co-constructed through various aspects of self-awareness, independence and employment.

Alfred narrated the restoration of his identity through the acknowledgement that he was not going to be the person that his father wanted him to be. The acknowledgement was storied as a turning point with voice-hearing that he "*couldn't deny then, that I had to change, otherwise I was not gonna be able to exist*" (Alfred). The story of survival conveyed Alfred's acceptance of HV as a "*great time of growth*", from which he had "*grown stronger*" and "*versatile*" (Alfred). HV was positioned as a life-changing event:

> "*...it's a period of growth, so I've gotta change direction and I've learnt that I'm one of these people that gets on and who does set themselves on a path and doesn't like to change and usually it has to, is forced to change my life, [...] that's where I am today.*" (Alfred)

Thus, HV was characterised as forcing him to move, explore and change his sense of personhood, awakening him to discover his identity and future directions. Restoration of identity was also storied by Eddie through strength and growth as from the experience of mental health difficulties and HV he identified as different to his family members, "*more resilient*", "*more thoughtful*" and "*more understanding of others*" (Eddie).

The concept of recovery was narrated as growing as a different person after surviving mental distress and HV. Eddie defined recovery as "*being adaptable enough to change depending upon circumstances in your life*". Medication was named as contributing to Eddie's recovery, however, it was his "*hard work*" that was most celebrated for keeping him "*well*" (Eddie). Bennett narrated his recovery story with

gratitude that he did not lose "*the essence of me being the real me*" (Bennett), which reflected his sense of a core 'true' identity.

For Carlton, the restoration of identity was nurtured through independence, developing life skills and self-worth by relearning to look after himself. Western values of employment and education were echoed in the narratives, which represented different levels of social positioning and recovery between the narrators. Deon identified as being "*recovered now*" (Deon) yet recognised the challenge of unemployment. This portrayed a sense of boredom in his life as he demonstrated the desire to learn a trade. Deon's account indicated that employment would contribute to his sense of restoration and self-worth. Western values were mirrored in Alfred's account, which characterised his ideal 'recovered' self as "*settled down*" with a "*a good job*" and "*reasonable health*" (Alfred), reflective of Western dominant discourses of happiness and success.

The story of recovery resonated with Alfred's critical question: "*Why put your dreams on hold?*" (Alfred). Alfred validated his answer with his identity in education and employment and recognised that following his "*own dreams*" (Alfred) is the key to his recovery and identity.

" I've got to be able to reflect... to know where I'm going"

Similarities in the narrative also drew upon the notion that talking was a positive experience and an integral part of restoring identity. The co-construction of the narrative was evident when the narrator was invited by the researcher to reflect upon the interview process. However, powerful messages were also shared in participant reflections beyond the research interview.

Carlton had not "*talked to no-one about that for a long time*" with concerns that "*not everybody wants to hear [...] what you went through* " (Carlton)

Eddie described talking as helping him to establish his identity and direction:

"*...allowing me to actually reflect on my journey which is always a good thing. There's parts that are [...] uncomfortable to talk about but then they're part of my history so I've got to be able to reflect on them to be able to know where I'm going.*" (Eddie)

The message of talking was further enhanced by Bennett's statement that "*they think it's all about a one-to-one but it's not it's all about the community*" (Bennett), which highlighted the importance of social connection in one's recovery. The interview was therefore positioned as a platform for talking, the opportunity to reflect and share about how one makes sense of HV.

3.3.3 Storylines of family life and understandings of culture and race

The collective storyline of "family life and understandings of culture and race" details three subplots: 'Family life: "The adults creating the problem that was being passed down"', "Culturally... Hearing voices is a bad thing" and "Experiences of racism: *"It's not about colour, it's about learning*".

Family life: "The adults creating the problem that was being passed down"

The context of family history of migration was shared through stories of cultural differences and generational conflicts within the narratives. Parental expectations, parenting style and absent fathers were also storied through a cultural lens.

Alfred characterised the West Indian culture as a "*community*" which was "*very family-orientated*" (Alfred), which reflected the social movement of friends and relatives to England in the 1960s. Alfred employed examples of education to demonstrate the different ways of doing things between the countries of migration, which explained how his parents who migrated became "*lost in the way things were*

done here" (Alfred). Difficulties in acculturation was described with a sense of loss and storied as being socially positioned in the "*lower classes*" with a stigmatised identity of a "*trouble-maker*" (Alfred). Thus, Alfred recognised the different levels of resources in the country of origin and consequential shift in social class through migration, which required social adaption. It may be hypothesised that African-Caribbean families who migrated may have been trying to exert a sense of worth and social standing in the face of social adversity through the achievements of their children. Pressure to achieve was storied with a gendered discourse of "*high hopes*" (Alfred) such that male children were highlighted as trying to please the parents, creating conflict in the discrepancy between parental ideals and child desires. This mirrored the story of the American Dream, migrating for the opportunity of prosperity and upward social mobility. The cultural expectation of migration was therefore narrated as not meeting social reality in the parents' generation.

Bennett described family conflicts with parents who were "*played against each other*" and younger brothers who tried to "*outdo*" (Bennett) him. The notion of escapism was illustrated by Bennett as he "*wanted some breathing space*" because he "*couldn't stand the home life*" (Bennett). Narratives of strict parenting were echoed in several accounts. Cultural discourses around the Caribbean way of life described traditional parenting as "*very strict*" (Eddie) with the expectation of the children to model the same norms and values. Generational and cultural conflicts in the narrative reflected the difference in wider cultural and societal discourses of the countries of migration, which portrayed a difference in the values and norms inherent in each respective culture.

Shared narratives of separated families were co-constructed with Carlton, Deon and Eddie who each detailed their families with an 'absent father'. The stories differed in their continued relationships with family members, which may have reflected differences in their upbringing in the context of a parental separation and single-parent family. The stories of an absent father were contrasted with Carlton's and Deon's metaphors of their mothers' house as a place of safety. A gendered discourse may consider the impact of the lack of a father figure in family life and question who a young African-Caribbean male may seek as role model when growing up. Eddie

positioned upbringing as a key factor in how one is able to cope with the experience of mental health difficulties and HV in later life.

"Culturally... Hearing voices is a bad thing"

Similarities in the narratives highlighted cultural myths and fears attached to mental health difficulties and the experience of voice-hearing. The Black community were storied as frowning upon mental health difficulties for fear of contamination (Eddie). Deon conveyed fearing the judgements of others and how they might view him differently if he talked about his mental health difficulties. Shame was implicitly storied in the narratives, with family and members of the wider cultural community not understanding the experience of mental health difficulties or HV. Eddie recounted his father telling him to "*snap out of it*" (Eddie) and withdrawing from him; Alfred re-enacted his father's voice in the account telling him not to talk about the mental health difficulties and HV; Carlton employed the example of the hospitalisation of Frank Bruno to convey his fear and shame of his similar experience; and Deon spoke of community hearsay and suspicion as he distanced himself when feeling distressed. Acknowledging that HV was "*not always given a good reception in our culture*" (Alfred), Alfred offered an alternative explanation of his parents' silence as protective of both him and them within the community context. The secrecy and shame surrounding mental health difficulties and HV may be reflective of cultural sense-making of the experience, and the myths attached to mental health. Such prejudices reflect a limited awareness of mental health difficulties and demonstrate the need for mental health education across diverse communities.

From a systemic perspective, social class may be constructed as creating differences in how one's experience of mental distress is managed. Alfred employed the notion of class divisions to narrate "*if you are in a higher class, it is easier to hide your illness*" (Alfred), and contextualised the example to workplace hierarchy. This may reflect the vulnerability of individuals living in places of socio-economic deprivation as more

exposed to and affected by mental health difficulties with less protection than those of higher classes.

Alfred's account voiced the societal prejudices he suffered at the time of experiencing mental health difficulties, reflecting wider societal discourses of stigma and discrimination:

Alfred: *"people say "yeah you go to a hospital and you'll never get out""... "it's just a <u>general attitude</u> of like "ah you've got a mental illness, that's it" ... ""you can't have a job cos you're mentally ill"""*

Such attitudes were storied as maintaining double discriminations that prevent community reintegration and make the person "*go around in circles*" (Alfred). Alfred's experience of other people's prejudice attitudes towards mental health difficulties may have been bound to the historical, political and socio-cultural contexts at the time of first HV in early adulthood.). Bennett also conveyed reflections on social prejudices and described feeling that nowhere was safe, his attitude was characterised as his only place of safety and protection against the experience of mental health difficulties and wider social discrimination.

Experiences of racism: "It's not about colour, it's about learning"

Issues of racism were illustrated in some of the narratives. Alfred shared reflections on being 'othered', and identified as feeling "*out of place*" (Alfred). In the context of childhood in the 1960s/1970s Alfred's account conveyed power divides between Black and White people, which he experienced as "*Adultism*" with the prejudice "*'Blacks you go back'*" (Alfred). Social divisions and racial divides depicted Alfred as socially isolated at school, performing his younger self as questioning whether he would have "*any <u>friends</u>*". Alfred referred to racism in adulthood as "*People-ism*", which he defined to be "*some jostling just cos we are all different and we all get on differently*" (Alfred).

Deon's account offered insight into the experience of a Black man in forensic and psychiatric systems. There were contradictions in Deon's narrative, such that he reported not to have experienced racism, only observed it experienced by others; however, he disclosed having suffered name-calling of "*racist words*" (Deon) when in prison. This highlighted the cultural context of a Black male in the forensic and psychiatric services and how racial abuse may be tolerated as the norm:

> "*so Black people get kind of stigmatised by the police [...] when they don't know what's wrong with the person. They get treated differently and [...] get man-handled, get beaten up sometimes*" (Deon)

Bennett claimed "*every race of people have the same sort of problems*" and offered a positive message that "*we are brothers and sisters, don't matter what colour people are*" (Bennett). This invited the reader to understand that "*it's not about colour, [...] it's about learning, for people learning to think properly and to respect um nature*" (Bennett). This highlights the need for greater education about racial, ethnic and cultural diversity at all levels across society, including in education, in communities, and at the policy-level, in order to prevent racism and institutional racism.

3.3.4 From "complete silence" to "freedom": Storylines of speaking out and reaching out

The collective storyline of "From "complete silence" to "freedom"" is composed of two main subplots of "Speaking out" and "Reaching out and helping others".

Speaking out

The narratives of all participants voiced personal messages against wider societal discriminatory discourses around HV. The researcher asked the question "*If you could*

give a message to the world about mental health, or about HV, what would that message be?" which may be viewed as priming the participants to speak out a personal belief. However, all participants offered similar responses which encouraged people with similar experiences to speak out against mental health discrimination and maintain an individual and personal sense of identity. Examples from Carlton, Deon and Eddie illustrate speaking to ghostly audiences in wider society with the message not to judge HV and mental health difficulties:

Carlton: "*Because when people got mental health problems and people don't understand about mental health, they wanna judge it and all that. Don't judge mental health how it is because you don't know how people got there and what they went through, cos it's a lot you go through when you have mental health*"

Deon: "*...always think before anyone judges anyone they should understand the person more before they start judging someone and putting their opinion across*"

"*to understand the person more, yeah and don't judge anyone before you know what the person's about.*"

Eddie: "*...you can't really judge somebody who hears voices, for hearing voices til you know, know a bit about their background [...] get to know that person. And that's the way you'll find out why that person hears voices.*"

"*Don't judge them and say that person got unresolved issues, cos that person may have unresolved issues. But they may be really unresolved issues they may be real issues.*"

All three narratives advocated against discrimination of mental health and HV and made a plea for an individual to be understood within the context of their personal life experiences. This echoed Longden's (2013) critical question that it is not 'What's *wrong* with you?' but 'What's *happened* to you?'. This provides a counter-narrative to the stigma of a diagnosis, which may be a limited way of understanding human experience.

In the narratives against societal judgement, maintaining a sense of personal identity was encouraged with the notion of self-acceptance to 'be yourself'. Alfred and Eddie echoed this phrase in the same wording, encouraging people to look beyond the diagnosis, reflect upon one's own ambitions and stay true to oneself:

Eddie: "*just be yourself. Be yourself around people*"

"*know where you're going, where you want to be, who the person that you want to be. And work on it. Takes hard work*"

Alfred: "*Yeah, be yourself. Yeah. Be yourself, at all times. That's probably the best thing. [...] my life probably would've been different if I... got more in touch with who I was as a teenager*"

Bennett echoed messages of non-judgement through the inspirations of Bob Marley, "*life is about healing, it's not about being destructive*" (Bennett). Identity and personal values were reflected within a community framework in Bennett's narrative as he suggested that "*we all are a part of the problem or part of the solution*" (Bennett). This conveyed the need for social connection, such that everyone will "*need that one person to [...]be a better community*" (Bennett).

Writing a book was a turning point for Alfred in speaking out about his experience of mental health difficulties and HV in "*permanent form*", a transformative process from "*complete silence*" to "*freedom*" (Alfred). Similarly, Eddie also storied speaking out in public, sharing a narrative of contributing to a mental health awareness film for BME groups as part of a national charity campaign. This demonstrated how speaking out can raise awareness of mental health and HV and, consequently, help others.

Community connection and the process of reaching out to help others was an integral part of the recovery journey for Alfred and Eddie. The notion of sharing portrayed social relationships, particularly highlighting the importance of peer support, helping those with similar lived experience. In narrating about their respective roles in the third sector, Alfred and Eddie demonstrated their personal values of sharing both their knowledge and personal journeys in the support of others:

Alfred: "*...it's about supporting people...*"

...."*I like seeing people grow*"

"*...discovering things for yourself, it's not good to keep them to yourself...*"

...."*I don't want to keep it, what's the use of that, I may as well share it with other people, share and use it*"

Eddie: "*I might be able to help others to be able to get as far as what I've come* "

"*It kind of inspires me to help others to get where I'm getting who maybe had similar experiences to me*"

The stories of reaching out to help others positioned both Alfred and Eddie as survivors of mental health, advocates of peer support and social connection, and positive role models of recovery. This acknowledged a selfless act with the concept that having helped themselves, they were now ready to help others through their transformative journey of recovery.

Chapter 4 - DISCUSSION

This research aimed to explore the narratives of second-generation African-Caribbean men who have heard voices and their meaning-making of mental health difficulties and HV, with an appreciation of cultural context. This chapter presents a summary of the findings, as a result of the emerging stories co-constructed in narrative analysis, and discusses the findings in relation to existing theory and research. The clinical relevance of this research will be considered, with discussion of practical implications and service provision. The strengths and weaknesses of this study are evaluated in methodological considerations, with suggestions for future research. Learning from the research is shared in personal reflections to conclude the chapter.

4.1 Summary of findings and theoretical links

The research question was "How do second-generation African-Caribbean men narrate their experiences of HV?". There were four main narratives interpreted in this study: 'Storylines of the changing understandings of hearing voices over time', 'Recovery: Reformation, Redemption and Restoration', 'Storylines of family life and understandings of culture and race', and 'From Silence to Freedom: Speaking Out and Reaching Out'. In order to orient the reader through the research findings, the narratives will be discussed in relation to each component of the research aim exploring the narratives and meaning-making of HV, and how HV is understood within a cultural context. The discussion will compare and contrast the findings in light of existing theory and other research.

4.1.1 What are the narratives of African Caribbean men who have heard voices?

Voice-hearing was narrated with unique accounts that shared common stories between the narrators. 'Storylines of the changing understandings of hearing voices over time' were narrated with wider societal discourses of prejudices against mental health difficulties with the use of stigmatising terminologies of "crazy" and "madness" to label the experience of voice-hearing, further reflecting historical discriminatory discourses. The notion of "madness" in the narratives depicted individuals as losing their sense of self and disconnecting from reality at the time of heightened distress. Blurred distinctions between the narrator's thoughts and the voice(s) were storied, echoing research defining key elements in the voice-hearing experience (Holt and Tickle, 2014).

The stories narrated made sense of mental health difficulties and HV through a dominant psychiatric framework, which was observed in the narrators' use of medical language. Cultural meanings attached to diagnoses within a Western context positioned HV as an 'illness', confirming and perpetuating broader societal discourses. This confirms research suggesting that a voice-hearer may perceive HV as a 'generic mental illness' (Jones et al., 2003) influenced by the loading of clinical terminology (Woods et al., 2015). This highlights the impact of medical language and diagnoses upon an individual's frame of reference and sense-making of HV.

Alternatives to psychiatric stories were offered through the narration of social adversity in the subplot "*I was actually ill but I don't know exactly what caused it*". This storied social adversity as a precipitant of becoming 'ill', with a diagnosis of 'psychosis'. Social adversity was explicitly storied as bereavement, difficulties in education and employment, substance misuse and offending behaviour, some of which were identified triggers of mental distress with the formation of voice-hearing. This supports previous research with voice-hearers' explanations of HV due to stress, trauma and attachment difficulties (Holt and Tickle, 2015; Andrews et al., 2008) and voice-hearing as a coping strategy for trauma (Goldsmith, 2012). Family difficulties

and traumatic early life experiences were shared in all narratives, highlighting the subplot 'Family life*: "The adults creating the problem that was being passed down"'.* This finding supports the notion that 'psychosis'/voice-hearing may be a logical response to ontological insecurity in childhood to manage family tensions (Laing and Esterton, 1964).

Moving beyond stories of 'illness' and family conflict, all narratives shared storylines of recovery interpreted as 'Recovery: Reformation, Redemption and Restoration'. Reformation in prison was identified as part of the recovery process by two narrators. However, the forensic stories highlighted wider systemic issues around young Black men, mental health services and the Criminal Justice System. Keating and Robertson (2004) describe individuals of African-Caribbean communities as characterised by higher rates of sectioning and hospitalisation, police involvement, excessive admissions to court, over-diagnosing of 'schizophrenia' and the over-use of psychotropic medication. This is supported by research highlighting an over-representation of Black people in medium and high secure security settings Fernando, et al. (1988). The narratives detailed that prison was the first point of contact for psychiatric treatment and psychological support; this may reflect a component of race relations and a social distance between Black communities and mental health services experienced as a 'circle of fear' (Keating and Robertson, 2004). This is supported by the estimate that Black people are eight-tines over-represented in prison compared to White people (Hood, 1992). The forensic stories shared by two narrators mirror a common route of a 'revolving door' through the psychiatric system; for some people this process can also be characterised by violence and police arrests (Boast and Chesterman, 1995). The narratives portray that mental health difficulties may increase the risk of violent offending, medical remand, prison and admission to a secure hospital, with the stigmatised label of 'non-compliance' (Boast and Chesterman, 1995). The narratives therefore highlight the tangled institutional processes of psychiatry and the Criminal Justice System which can disadvantage Black people (Boast and Chesterman, 1995).

Positive journeys of recovery were shared across all narratives in the storying of mental health difficulties and HV. The stories provided a counter-narrative to mental

health difficulties and HV as 'ill' which supports the notion that constructive stories free oneself from the dominance of problem-saturated stories (Neimeyer, 2000). Storylines of overcoming 'illness' highlight recovery as a struggle through adversity to find unique ways of surviving, learning and moving on (Basset and Stickley, 2010). Recovery stories are celebrated for "decoding the meaning in madness [and] can lead to understanding and addressing emotional injustices that have occurred in the past" (May, 2007, p301). The accounts shared stories of addressing injustices of the past through social action in order to make sense of the mental health difficulties experienced. Stories of social action were re-presented in the storyline 'From Silence to Freedom: Speaking Out and Reaching Out', supporting research that highlights voice-hearers taking a lead in their own recovery (Goldsmith, 2012). This supports Becker's (1997) proposal that the Western conception of the self may be impacted in suffering, yet restored with positive narratives of a recovery journey. The concept of recovery as on a continuum suggests that individual meaning of what it is to be 'recovered' may vary, depending upon an individual's context and experience. Thus, the narrators' sense of their own recovery may be different to how recovery may be viewed by wider society. This portrays the various social and cultural barriers to recovery that were characterised within the accounts, illustrating the stigma and discrimination of moving on from a diagnosis of 'psychosis'.

In reflection of the narratives that I have interpreted, it may be that my position as a researcher and a Trainee Clinical Psychologist primed more medical stories conveyed in the use of psychiatric language by the participants. The participants view of me as a mental health professional may have encouraged 'clinical' stories to be told and 'silenced' or 'limited' alternative stories. My position may have impacted the storying of positive experiences of hearing voices or whether in fact the participants still identified as a current voice-hearer, for their fear of my potential judgement or bias. Both the co-construction and my interpretation of the narratives reflect wider societal discourses of a western context, since this is the context in which the research was located. I have a personal interest in strengthening positive narratives of individuals

which may have attuned my listening to stories of recovery and consequently may have further impacted my interpretation of the narratives.

Meaning-making of voice-hearing was illustrated within the rich details of the accounts. The findings demonstrate the narrators' storying of strong emotions associated with voice-hearing, such as anger, fear and confusion, which supports evidencing literature describing the emotional experience attached to HV (Romme and Escher, 1989; Woods et al., 2015). Coping strategies for managing voice-hearing were narrated as a means to cope with HV, which consolidates research that highlights voice-hearers attempts to block out voices (Kalhovde et al., 2014).

The voices were detailed in two of the accounts as personally known, representing a family member or ex-partner. The familiarity of the voices in the narratives mirror research that found voices to have characterful qualities (Woods et al., 2015) with an identity and power (Holt and Tickle, 2014), and characterised as socially aligned (Leudar and Thomas, 2000; Nyani and David, 1996). The narratives socially positioned the voices with power and control; such social attributions of the voices in relation to the voice-hearer conveyed a lower social ranking and marginalisation of the voice-hearer in the voice-hearing experience (Birchwood et al., 2000). The narratives offered insights into a shift in power with the voices, which may be understood cognitively as a change in individual beliefs about omnipotence and control over the voice(s) (Birchwood and Chadwick, 1997), or reflect research that suggests voices can change over time (Woods et al., 2015).

Changes in relationship with the voices over time were also highlighted in two narratives detailing positive experiences of the voice(s). This supports research suggesting that the voices may serve an adaptive or protective function, perhaps representing a companion or friend (Benjamin, 1989). The voices as adaptive was performed in one narrative with the purpose of encouraging the narrator to question

his life choices and change direction. This reflects research findings that individuals who hear voices may search for personal meaning in voice-hearing (Holt and Tickle, 2015; Jones and Coffey, 2012) and explore the function of HV to understand the voices (Fenekou and Georgaca, 2010) as part of their recovery journey (Longden, 2013).

Different stages of recovery and relationship with the voices were also narrated through contextualising voice-hearing either as a regular occurrence or located to specific episodes and past life events. The latter supports the notion that voice-hearing may not persist once difficulties are resolved or integrated (Escher et al., 1998). This reflects the psycho-social and cultural understandings of HV, highlighting social adversity as an influencing factor.

As an alternative to voice-hearing with mental distress and social adversity, a spiritual connection of HV was storied in one account, which supports research that highlights spirituality as an explanation for HV (Holt and Tickle, 2015) and a positive spiritual perspective of some voice-hearers (Jones et al., 2003). However, Fenekou and Georgaca (2010) found that individuals who heard voices with a supernatural character gave biological explanations for the voices' origin. This illustrates the power of the biomedical discourse and the dominant medical framework in which voice-hearing sits in Western societies despite a spiritual character of some voices.

In consideration of identity, the narrators varied in identification with their respective diagnosis, some suggesting it no longer applied to them locating the diagnosis to place and time within their story, others integrating the diagnosis into their view of self. This confirms research that positions meaning-making of voice-hearing as influencing the perspective of personal relevance (Jones et al., 2003), and impacting one's view of self (Holt and Tickle, 2015) and identity (Jones and Coffey, 2012). The identities and personalities performed in the narratives may have aimed to demonstrate coherence, unity and purpose in life (Smith, 2000). Peters et al. (1998) suggest a biomedical framework in Western societies supports the creation of a self-protective narrative, relieving feelings of guilt and shame. However, guilt and shame of mental health difficulties and HV were implicitly spoken in some participants' stories, and reflected

both uncertainty and confusion of the distress suffered and its impact upon self and others.

In reflection, I acknowledge my limitations in identifying as a 'non-voice-hearer'. This may have created a metaphorical gap between me and the narrator in the stories that were told and in my understandings of the phenomenon of voice-hearing. I have wondered whether an experience can ever be fully understood if not experienced personally? This portrays a contention between an expert by education and expert by experience; nonetheless, I have aimed to re-present the stories of voice-hearers in a meaningful and sensitive manner. The narratives I interpreted echo familiar stories from my previous clinical work experience with people who have a diagnosis of 'psychosis' and HV. Despite stories being told within a psychiatric framework, I have paid attention to the dichotomy between social adversity and the medicalisation of mental health difficulties which may reflect a bias in my interpretations since I positioned myself and this research within a social constructionist and non-medical stance.

4.1.3 Cultural meaning-making of hearing voices: How are the narratives of hearing voices understood within a cultural context?

The 'Storylines of family life and understandings of culture and race' presented narratives which echoed stories of cultural heritage told through the plots of family systems, community relationships and cultural myths of mental health difficulties and HV. HV was characterised as a "bad thing" within the context of some of the participants' African-Caribbean culture. This message was performed in various stories across several narratives, including the secrecy and shame by family members, the fear of telling others, social rejection in conversations about mental health difficulties and HV, hearsay and gossip in the community, lost relationships, and the myth that "mental health is catching". This supports the notion that Black

communities may fear mental health issues and services for fear of prejudice, misunderstanding, misconceptions and racism, which consequently delays help-seeking (Keating and Robertson, 2004). Stories of racism were performed with creative analytical repertoires (Larsen, 2004), such as "Adultism" and "Peopleism" which minimised impact of racist experiences for the audience.

Discrimination was further storied in the cultural meaning-making of HV, which conveyed the stigma of mental health difficulties and HV in the local cultural community as impacting upon an individual's identity, supporting research that highlights the influences of stigma attached to mental health difficulties and HV on social relationships (Holt and Tickle, 2015). The narratives shared varying influences of the cultural understandings of mental distress and voice-hearing upon individual sense of personhood which mirrors the suggestion that the self as 'mentally ill' carries cultural implications, which may include sanctions to liberty (Jones and Coffey, 2012).

Cultural understandings of mental health difficulties were also narrated through stories of conflicts with parents in traditional African-Caribbean upbringing. This was co-constructed in the narratives as parenting styles and parental expectations that consequently led to generational and cultural conflicts within the family. This may portray how personal goals may exceed opportunity for families with a history of migration living in inner-city urban areas (Bagley, 1971) due to challenging socio-economic factors such as higher unemployment, poorer housing conditions and lower income (Harrison, et al., 1988). Such cultural conflicts and difficult relationships in families with a history of migration may be understood as a contributing factor of distress for second-generation individuals within a particular socio-cultural context (Harrison et al., 1997).

As a researcher, I was open to giving up a position of certainty, familiarity and sameness (Khan, 2002) in order to be more neutral, open and curious in enabling and facilitating different frames of narratives to be told. This included identifying both visible and invisible differences as a White, female researcher who did not hear

voices. In reflection, I acknowledge that my interpretations of the narratives are created from a place of difference, such that I am writing about a culture that I do not personally belong to or identify with. This positions the narrators as educators of African-Caribbean culture as I am positioned as an 'outsider' to their African-Caribbean culture. In our interactions I interpreted a shared understanding that the narrators may have grown up and lived life experiences that I may not have shared, such as racism. This conveys how my Whiteness may have impacted the stories told, since the narratives were a creation of a co-construction in cross-cultural work and interpreted by me. The cultural difference between us may have prevented me from exploring in more depth the participants ideas about racism and whether it is linked to mental health. I feel that I tentatively approached this in the interviews, yet I perceived the narrators as re-directed or dismissing the topic of racism (for example, by stating that racism was something that they had observed experienced by others yet not experienced personally). In reflection, the topic of racism may have been too sensitive for us to explore from a place of cultural difference, or the narratives may have been constrained by the 'circles of fear' (Keating and Robertson, 2004) that shadow mental health services. Keating and Robertson (2004) contend that it may be too difficult for service users to talk with professionals about race and culture. The point of difference between myself and the participants may also have transcended beyond culture and race to additional socio-economic factors including social class, employment, and education as features of diversity. Our point of sameness in identifying as British must also be acknowledged. In creating a space to explore cultural differences on relational processes and the impact on how we interact, what we understand and how we interpret may prevent polarizaion in cross-cultural work (Anane-Ageyi, et al., 2002). Therefore, I acknowledge that my interpretations of the narratives in this research are impacted by my position as a female, White, Trainee Clinical Psychologist. From this research, it may be suggested that a Black perspective and a White perspective can add to and enhance one another (Anane-Ageyi, et al., 2002).

To summarise the findings, the narratives mirror the personal testimonies of voice-hearers (Markwood, 2005; Bellamy, 2000; Bayley, 1996) in the meaning-making of

HV and the associated issues of distress, identity, social adversity, societal stigma, unemployment and self-acceptance contextualised within a Western discourse. Therefore, the findings of this study echo the new emerging literature of voice-hearers' perspective and meaning-making of HV and additionally provide new findings which illuminate the narratives and cultural context of African-Caribbean men who have heard voices.

In reflection of my interpretation of all the findings, I contend that relationships are socially embedded and thus the narratives re-presented in this research sit within certain socio-political contexts, including age, race, gender and culture (Khan, 2002). In the storying of cultures, Khan (2002) posits that the interplay between individuals, their cultural values, experience in social communication, and cultural sameness and difference may constrain or liberate the process (Khan, 2002). I acknowledge that the narratives of Alfred, Deon and Eddie are more visible in my re-presentation of the findings, which may be a reflection of the interview process. In the social constructionist framework of this research I have employed postmodern thinking and the use of self to maintain vigilance of my own assumptions, biases and culture from a stance of curiosity and respect in an attempt to understand both the micro and macro socio-cultural processes of this research (Khan, 2002).

4.2 Clinical relevance and implications for service provision

In this study, the narratives of African-Caribbean men who have heard voices highlight experiences of social adversity in a cultural context and the impact of receiving a diagnosis of 'psychosis'. Therefore, whether mental health difficulties and HV are understood as a diagnosable experience or not, it is important to consider the usefulness of the findings of this research for service provision of health and social care in NHS clinical settings as well as in the wider community, such as in third sector organisations.

4.2.1 Danger of a single story: Understanding hearing voices beyond a diagnosis

The findings of this research highlight the meaning-making of HV, reflective of both dominant medical discourses and social adversity within personal frames of reference. "The danger of a single story" (Adichie, 2009) raises question about the stereotypes in the stories that we tell. In relation to voice-hearing, contradictory arguments suggest that a diagnosis of 'psychosis' may be viewed as a labelling process which may be de-humanizing (Jones and Coffey, 2012), or alternatively may provide an answer to unexplained experiences, and consequently empower people to reconstruct their lives (McIntosh, 1996). Nonetheless, if voice-hearing is understood within one framework alone, and storied in a single way, then how it is understood across all societal levels and disciplines will potentially be maintained within a diagnostic category. As the findings suggest, the language of a diagnosis may perpetuate discourses of mental distress and voice-hearing as an 'illness'. It is therefore contended that understanding voice-hearing experience within a singular framework may be limiting (Jones et al., 2003). Thus, based on the findings of this study, it is recommended that clinicians working with voice-hearers look beyond the label of a diagnosis and privilege the silenced stories that support the meaning-making of the voice-hearing experience.

In a critique of mental health systems Bayley (1996) claims the person behind the diagnosis is often forgotten. This is supported with the notion that psychiatric services understand voice-hearing with symptomology devoid of meaning (Boyle, 1992). Middleton and Uys (2009) criticise mental health services as working with institutional custom rather than person-centred care, which suggests the services operate with repeated customs and patterns overlooking the individual. This critique advocates the need to understand the individual behind the symptomology within their context, life history and personal perspectives. The findings of this study illustrate cultural background and family history of migration as key elements in understanding the individual's life story over time. This means understanding mental health difficulties and voice-hearing in the context of individual's life, making sense of the

distress in a way that is meaningful, accessible and relevant to the individual. The findings of this study suggest that clinicians may gain a greater depth of insight into an individual's distress by paying attention to and explicitly exploring cultural context through family background and associated issues of cultural or generational conflict in the family.

Therefore, in order to challenge the cultural weight of a diagnosis and contest the dominant narratives privileged by more powerful groups (Jones and Coffey, 2012) the findings of this study support that sense-making of voice-hearing be on a continuum (Lawrence et al., 2010; BPS, 2014a), with additional attention to cultural context. This may be beneficial to both voice-hearers and clinicians alike, by widening multiple perspectives in the sense-making of voice-hearing with a less-pathologising approach that challenges associated stigma. Beyond clinical practice this may also serve to shape wider societal discourses in moving dominant thinking away from discriminatory labels of the voice-hearing experience.

4.2.2 Formulation-based approaches and Narrative therapies

This study highlights the importance of understanding an individual's cultural context within voice-hearing experience. It is therefore recommended that clinicians employ constructive approaches in care to avoid viewing an individual as a set of symptoms (Bayley, 1996) through interventions such as a social-constructionist based formulation to share the narrative of a story that is "constructed rather than discovered" (Harper and Spellman, 2006). Clinicians may employ social-constructionist formulations to permit the use of shared language in naming and making-sense of mental health difficulties and voice-hearing, furthermore acknowledging that what is storyed as an 'authentic' 'reality' may be the 'reality' of the voice-hearing experience (Goldsmith, 2012; Bayley, 1996).

Personal meaning of experience is viewed as an important factor in this narrative. (BPS, 2011). The findings support the notion that how an individual constructs the

meaning of their voice(s) is within the socio-cultural context of their life history and understanding this meaning-making is an integral part of the therapeutic process. Thus, clinicians may explore the cultural meaning-making of voice-hearing and create space for alternative discourses to be shared in therapeutic work. For example, clinicians may explore cultural context of mental health difficulties and voice-hearing through social-constructionist formulations, in meaning-making through aspects of the 'Social GRRRAAACCEEESSS' (Burnham, 2011) in therapeutic work, and in narrative therapies (White and Epston, 1990) such as the Tree of Life (Ncube, 2006). This may support the meaning-making of mental health difficulties and voice-hearing in the context of a person's rich social history in relation to the cultural and political systems in which the individual is embedded. Narrative approaches draw on therapeutic principles to enhance an individual's sense of identity and may provide support for meaning-making of voice-hearing within a cultural context, moving away from narrating HV within dominant medical discourses. Akinyela (2002) suggests four guiding principles of narrative practice as storytelling and witnessing to create meaning, interpretation of meaning, a non-expert stance to resist imposition of meaning, and alternative stories to build upon testimonies of hope. Narrative approaches also seek to raise the voice of the individual in narrating their own experience in their own language as a form of meaning-making. This is echoed beyond the clinical setting in the survivor movement (Longden, 2013) at the centre of the recovery approach. Storylines of recovery in this research therefore suggest that clinicians and services may benefit from identifying the strengths and resilience of the individual as a survivor of adversity.

The survivor movement was reflected in the storylines of 'Recovery' and 'Speaking out and reaching out'. These findings suggest that clinicians may act as collaborators rather than in an 'expert' position, in supporting the individual to be empowered as the agent of change to lead their own recovery journey. This may seek to re-address power differentials in clinical work and negotiate both visible and invisible similarities and differences in the therapeutic relationship. This is supported by Fernando's (1995) call for power relations to be addressed in therapeutic settings and Mason's (1993) suggestion that such power differentials may be more equally

acknowledged through 'collaboration' rather than 'partnership' work. Furthermore, re-balancing power and illuminating the voice of the expert by experience with personal accounts may help to educate wider society, personal and professional alike, by providing alternatives to current medical discourses around mental health difficulties and voice-hearing. The inclusion of peer support interventions as a necessary element of recovery in health care (for example, as a recommendation in NICE Guidelines and NHS service provision) may also acknowledge that the support of experts by experience can be more powerful than experts by profession in some aspects of sense-making of voice-hearing.

4.2.3. Consideration of cultural context: Diversity in therapeutic work and cross-cultural working

The findings of this research highlight the invisibility of African-Caribbean men in systems of early intervention support, and their need to receive help prior to the escalation of difficulties to a severe crisis point, particularly in early adulthood. Health and social care services may need to reconsider the accessibility of their services, and reach out to young, African-Caribbean men whilst overcoming potential issues of fear, stigma and shame of mental health difficulties in the local cultural community. Culturally-matched services with culturally-appropriate resources and staff may support the establishment of trust, including peer mentors of lived experience from the same cultural group to promote identification and relatedness in experience. Educational interventions to promote awareness of mental health difficulties may serve to break barriers to help-seeking. This may be achieved through interventions in schools and colleges to inform adolescents and young adults about mental well-being, or community-based approaches, as led by mentors within the African-Caribbean community. The use of social media avenues by services may also serve to make contact with broader audiences by reaching-out to more people within the community. Establishing dialogue and partnerships with community-based groups may help to break the 'circles of fear' (Keating and Robertson, 2004).

Nolte (2007) advocates for the active engagement of clinicians with the risks, challenges and rewards in cross-cultural work. In working with an African-Caribbean community this may mean clinicians have to take risks in negotiating cultural myths, build rapport against the challenges of perceived fear and mistrust, and find ways to help that mirror the needs of the individual's cultural context. Awareness of the individual's cultural context and lived reality through validation and acceptance may support African-Caribbean men who experience mental health difficulties to feel heard and understood. Akinyela (2002) advocates for a post-colonial therapy which critically understands a culture is never fixed nor homogenous, acknowledges the effects of everyday racism and invites a counter-hegemonic cultural practices based on stories, history and experience in the understanding of the individual's life.

Clinicians should be encouraged to celebrate and value the expertise of the service-user (Basset and Stickley, 2010), with openness and curiosity in understanding how the individual makes sense of mental health difficulties and voice-hearing and the cultural context within which the meaning is derived. This may require training about voice-hearing by voice-hearers to clinicians to improve the understanding of the meaning-making of voice-hearing, and further challenge dominant discourses attached to HV in NHS services. In promoting the voice of experts by experience, clinicians may consequently support people who have heard voices to speak out in proudly adopting the identity of voice-hearer (Romme and Escher, 1993), as the findings indicate this to be advantageous for recovery.

In order to prevent polarization in cross-cultural working it is recommended that clinicians reflect upon their own beliefs and stereotypes (Thomas, 2002), acknowledge explicit differences in "cultural naiveté" and explore the impact and meaning of difference to keep focus on the shared common goal (Dyche and Zayas, 1995). This may also involve taking a stance of openness and acceptance in a credulous approach by looking through the lens of diverse cultures, different to one's own. Patel and Fatimilehin (2005) suggest that in order to transform clinical psychology, the profession and practitioners must acknowledge the extent of racism inherent in the discipline's theories, approaches, practices and services and critique our own racism, and listen to the views of Black and minority ethnic service users. Services are

recommended to incorporate regular reflective thinking spaces for staff, using models such as Kolb's (1974) 'Experiential Learning Cycle' for practice and development in reflexive learning to enhance cross-cultural practice.

As the findings highlight cultural myths and stigmas attached to mental health difficulties and voice-hearing within the African-Caribbean community, it can be recommended that clinicians at all levels receive adequate training and support in negotiating the myths of 'barriers to engagement'. Promoting education and awareness to clinicians of the needs of diverse cultural communities may advance culturally-appropriate care at the level of service provision. Specific training on the needs of African-Caribbean communities and voice-hearers, delivered by experts by experience may advance learning about culturally-specific issues and needs in relation to HV. Services and professional disciplines may also benefit from examining current cultural frameworks, and interrogating historical and contextual specificity of distress (Patel, 2011), particularly at the policy level of health care. This may shape knowledge and understanding beyond the clinical context to challenge ignorance, stigma and discrimination of mental health difficulties and HV.

In light of the findings a community model might be usefully employed to explore the wider cultural issues experienced by an individual within the context of the wider socio-political system. The subplot '"*I was actually ill but I don't know exactly what caused it*"' echoes the claim that material conditions are reduced to psychological ones, with social difficulties engendering psychological difficulties (Smail, 2004). This supports the suggestion that recovery from emotional distress will be possible only when linked with experiences of inequality and injustice (Harper and Speed, 2012). More community-based services may be achieved through partnership work with statutory and voluntary to address social inequality in housing, unemployment and education (Keating and Robertson, 2004).

4.3. Methodological considerations

It is paramount to critically evaluate all aspects of the study, demonstrating transparency in the research process. Strengths and limitations of this study are considered through researcher reflexivity.

4.3.1 Strengths

A main strength of this study is its originality in research topic. The focus of the study explored a new growing area of research in exploring the first-person account and meaning-making of the voice-hearing experience, contributing to the literature understanding HV. Exploring the meaning-making of HV with African-Caribbean men has not yet been researched, therefore the study is original and novel in topic area, participant group and cultural context. Furthermore, African-Caribbean men appear to be historically overlooked in scientific and academic literature, stigmatised as a 'hard-to-reach' group. Previous HV research may have conducted studies 'on' or 'about' African-Caribbean men rather than 'with' (i.e. quantitative HV research with a clinical focus in a medical framework, rather than qualitative research exploring personal accounts and meaning-making of HV). The cultural context of this study therefore reaches out to Black individuals of diverse communities and illuminates the stories of their experiences of mental health difficulties and HV. The illustration of life stories provides rich detail to make meaning of the participants' voice-hearing experiences with attention to cultural context. This offers alternative narratives to the dominant discourses in society which may stigmatise and mislabel voice-hearers, and further challenge misconceptions around the over-representation of Black men in the 'psychosis' population. Consequently, this may seek to sensitise clinicians and wider society alike to African-Caribbean men who have heard, or hear voices.

The use of NA in this research may be viewed as a strength of the study, instrumental in researching *how* participants make-meaning of voice-hearing and focusing upon the

psychological and social processes in meaning-making (Weatherhead, 2011; Wells, 2011). The analytical process employed criteria of transparency and coherence, commitment and rigour and sensitivity to context (Yardley, 2008) to optimise impact and importance of this research in cultural meaning-making of voice-hearing. A positive aspect of NA in this study is that it illuminated the contextual significance in the individual's account (Crowe and Alavi, 1999) in relation to HV. A strength of understanding how participants narrate mental health difficulties and voice-hearing highlights life stories over time and portrays the resources of the voice-hearer with rhetorical power and speaking out for social action (Jones and Coffey, 2012). In this research, counter-narratives to medical discourses were offered, promoting the storying of transformative identities through survival and growth to overcome adversity. This is in contrast to wider societal discriminations attached to mental health difficulties and HV.

The process of the research may also be viewed as a strength of this study. The researcher maintained a community approach throughout the research process. This was actioned predominantly in the recruitment process, observed by the immersion of the lead researcher within a HV community. This strengthened rapport, trust and working relationships with people of lived experience, often via face-to-face interaction. The research process was enriched with multiple and varied opportunities to experience and understand the HV community. The researcher was able to bear witness to the sense-making of voice-hearing with a diverse range of individuals through the invitation into the world of experts by experience, allowing greater depth of researcher reflexivity.

4.3.2 Limitations

To critically appraise the research, there are some limitations inherent in this study. Within the target population, the study aimed to recruit individuals who had a voice-hearing experience in the last two years. However, the co-constructed narratives and

researcher interpretations suggest that some of the participants may not have heard voices for a longer time period than was specified for recruitment to the study. This was conveyed in emerging stories told in the narratives which were interpreted as locating the experience of voice-hearing to several years in the past. For example, voice-hearing was located within a sequence of escalating distress in stories of being 'ill' in the past, yet voice-hearing was not characterised in recent stories of recovery (excluding one account in which recent voice-hearing was linked to affiliations with religion and understood by the narrator to serve a protective function). Therefore, the researcher interpreted the narratives as mainly sharing accounts of voice-hearing experiences of the past, with the narrators reflecting on the voices as a historical event in their story rather than as a recent or current experience. This may have influenced the narratives in how they reflected on the voice-hearing experience and the meaning made of it. Consistency may have been maintained if all participants identified as 'current' or 'recent' voice-hearers within the specified time period.

The recruitment criteria specified a diagnosis of 'psychosis', and may have primed 'medical' frameworks in the narratives of voice-hearing, despite participants sampled from non-NHS settings. However, the narrating of voice-hearing through a medical lens and the positioning of HV as an 'illness' may be reflective of dominant discourses in wider society. Participants' previous experience of interviews may have been limited to clinical settings with mental health professionals, which may have impacted the stories told, how they were performed and the narratives co-constructed.

Further demographic data may have been obtained in this research, such as age, age of first HV, current status of voice-hearing, services received, frequency of contact with services, length of time received services, current/previous involvement in groups, employment status (Holt and Tickle, 2015). However, the conscious decision made not to obtain demographic detail was to avoid a formality that may have mirrored clinical settings, and have potentially influenced the stories told. All participants were involved in community groups (HVN) or networks. This may have biased the findings such that the participants represent a subset of voice-hearers, who may be more reflective and skilled in thinking and narrating about HV, thus not generalisable to all voice-hearers (Hartigan et al., 2014). Furthermore, the study researched a small

number of participants, which limits the generalisabiltiy of the narratives to wider groups of voice-hearers in society.

The researcher maintains awareness of the critiques of NA. It is argued that all narratives are incomplete since experience and subjectivity cannot fully make their way into language (Andrews, et al., 2008). Riessman (1993) contends that narratives are an interpretation and are therefore a context-dependent co-construction. This highlights the pluralistic nature of NA (Bruner, 1990), such that the narratives told may change with audience, time and wider contexts. It is acknowledged that as NA increases audibility of some stories, in the same moment other stories are neglected. Frank (2012, p.50) encourages appreciation for the analysis, stating that the "dialogue always continues". This conveys the importance of reflection and relational meaning in NA, since narratives are located within a certain context at the time of being told.

In acknowledging that appraisals of voice-hearing may change over time and thus impact the narratives co-constructed, multiple interviews over a period of time may have offered the opportunity to explore the sense-making of HV over an extended period, however, time constraints of this study did not permit. The structure of the interview may be viewed as a limitation of the research. An interview guide was employed flexibly to prompt topic areas, however, this may have privileged some stories whilst silencing others. Nonetheless, in-depth interviews revealed the nature of voice-hearing, the context and situations in which voice-hearing emerge, providing insights into cultural frames and sense-making of HV and participants' social worlds (Miller and Glassner, 2011).

There were greater visible differences between the researcher and participants than similarities (Burnham et al., 2008). Such relational differences may have influenced the accounts co-constructed and how stories were performed. In the context of NA, it was also important to consider what was not narrated and what was left unsaid. Invisible perceived influences of relational power between the researcher and participant may have impacted emotional storying, such as shame. Thus, the researcher's role, position, cultural context and own personal life experiences may

have influenced the stories told as an active person in the co-construction of the narratives.

Furthermore, it is suggested that trained clinicians face challenges in researcher roles (Mishler, 1986) and may conflict in skills between therapist and researcher (Johnson and Clarke, 2003). At times the researcher felt caught between a dichotomy of two modes of working, a 'push-pull' of wearing a clinician's hat in a researcher role, and therefore faced dilemmas in the narrative which may have influenced the co-constructive process. The researcher enlisted several techniques to reflect upon and counteract potential limitations throughout the research process, including reflexive journaling, a narrative peer support group and research supervisory team.

4.4. Suggestions for future research

This research explored the cultural sense-making of African-Caribbean men who have heard voices. Future research may consider replicating this study with African-Caribbean females, or voice-hearers of diverse cultural backgrounds to further understand the cultural sense-making of HV (such as Asian or Minority Ethnic). This study also focused specifically on the context of second-generation individuals of families who migrated. Alternatively, future studies may examine the cultural sense-making of first or third generation individuals, with the possibility of comparing and contrasting the accounts of voice-hearing to research generational and cultural influences. In the context of migration, research with refugees and asylum seekers who hear voices may also explore the impact of acculturation and cultural adjustment on mental health and voice-hearing. Looking beyond the specific context of this study, future research may investigate diverse cultural contexts, replicating this study in different cultures at an international level. Eastern cultures may provide alternative narratives of voice-hearing, highlighting alternative sense-making to Westernised discourses.

In continuing research on the meaning-making of voice-hearing, a different aspect of HV may be the explicit focus of future studies, such as one's relationship with the voice(s) over time. It is suggested that seeking meaning from the voice(s) is the phase before the voice-hearer stabilises permanent ways to manage the voice(s) (Romme and Escher, 1989). Therefore, this research may be repeated with multiple interviews over time, to explore changes in the relationship with the voice(s) and respective meaning-making in the narratives. The narratives in this study included stories of how other people made sense of the individual's voice-hearing experience. Future studies may research the meaning-making of an individual's wider systems to explore how different people such as family members, friends, partners, peers, cultural community and professionals make sense of HV.

Thinking around the individual in different contexts, future research may consider alternative recruitment of voice-hearers from diverse settings within the community. For example, further community outreach may include connecting with local church groups and networks beyond the health and social care setting. A non-clinical sample of voice-hearers may be researched, such as via spirituality networks or individuals who identify as not engaged with clinical services. The sense-making of voice-hearing may also be explored in acute settings, such as voice-hearers within the NHS context and in the prison services.

Although a larger sample may be used in future research, this study employed a suitable number of participants for rich, detailed stories and sense-making of HV. More research from the narrative perspective would be helpful to illuminate the stories of those in diverse cultural communities who may otherwise be unheard, marginalised, excluded or over-looked. This may be of particular importance for those who are over-represented in the 'psychosis' population yet their voices less visible in the scientific research community. Inevitably, this may allow a widening of perspectives to build alternative narratives that challenge dominant discriminatory discourses of HV. Investing research into more accounts of the first person perspective and meaning-making of HV may promote the voice of expert by experience.

4.5. Personal reflections

It is suggested that no one is helped if there is a distinction between 'pathological' and 'normal' (Gergen, 2001). At various points in this research I have critically questioned the usefulness of a diagnosis. For some, it may provide an explanation; for others, it is a stigmatising label that carries discriminatory weight. All narratives in this study storied voice-hearing as triggered by specific traumatic events and social adversity in early adulthood, which consequently led to long-term medication and a diagnosis of 'psychosis'. The stories also shared accounts of overcoming adversity. Therefore, I critically question, if one has 'recovered', why does a diagnosis persist? Once given a diagnosis, why is it a label for life?

In initial research phases I experienced reservation and hesitation from community groups, which may have been indicative of suspicion and mistrust of mental health services. This made me consider my role and identity as a White, female, non-voice-hearer, Trainee Clinical Psychologist researching HV, and the perceptions of the local community in what I may hold by appearance or professional title. It was therefore of paramount importance for me to consider power relations throughout this research.

In initial contact with HV groups I noticed my tentativeness in the language I used, my own anxieties and fears around using the 'wrong' words. I was aware of collaborative language to share meaning and respect identity at both the individual and group level. Throughout community engagement I noticed a low proportion of African-Caribbean men engaged in therapeutic and social support. I reflected upon wider systemic issues at the macro-level and was confronted with the label 'hard-to-reach' which I strongly disagree with. I believe that every individual is 'reachable', it is a matter of finding the 'push where it moves'. In reflection I considered African-Caribbean men to be 'under-served' and 'under-resourced' by services in meeting their needs in a culturally-appropriate fit.

As I submerged myself within the HV community where possible, I was allowed the privilege of sharing experiences with voice-hearers. I was able to bear witness to HV peer support groups who retrospectively anchored (Flick, 1995) and connected shared

meanings of voice-hearing, thus allowing their community to build social representations of the phenomenon (Murray, 2000). Such social representations reflected the socio-cultural beliefs and assumptions of the HV community at the ideological level (Murray, 2000) with the hope of challenging wider dominant discourses of HV. I noticed the power of a story enabling others to tell their story. Through respect and curiosity I learnt the privileged position of a researcher as entrusted to tell someone else's story. In the HV communities I noticed the plea of voice-hearers to be heard, for clinicians not to 'talk around the issue' of HV but to *understand* it. This led me to question whether one can ever fully understand a lived experience if one has not lived the experience? I have learnt that there are strengths in both positions of 'expert by experience' and 'expert by education' (Basset and Stickley, 2010), thus it is beneficial to unite the respective skills in the sense-making of HV.

In the process of analysis I visualised and reconnected with the relational 'felt sense' of the interviews that nurtured more thoughtful, emotional and reflective representations of the narratives. In the write-up process I was struck by my attachment to the stories. This was conveyed through feelings of loss when the detailed stories were condensed and constrained by word limits. I reflected upon what makes a narrative 'valid', and the difference in a narrative as a plot with causal chains of actions and events that form a meaningful structure (Czarniawska, 2004), and the muddle and chaos of one participant's story as an anomaly.

The research interviews elicited 'intimate' moments of self-disclosure by participants which was contained in the interview space with sensitivity. This illustrates the research interview as a distinct social relationship which invites a sense of 'intimacy' (Birch and Miller, 2000) through talking as a therapeutic tool. The privilege I experienced in being entrusted with such personal stories has empowered me to give back to the HV community, ensuring that the end of this project does not signify the end of its meaning. My hope is that the stories may continue in the dissemination of the research and their messages be heard by the academic discipline, the local community and wider society.

Conclusion

In conclusion, it may be viewed that how one constructs voice-hearing influences the nature of the experience (Goldsmith, 2012). Meaning-making in HV may be understood as a "quest for voice-hearers to arrive at explanations that are congruent with their understandings of themselves and their place within the social world" (Jones and Coffey, 2012, p14.) These findings conclude the need for fundamental revision in our concepts of language in understanding personal distress (Smail, 2004), specifically voice-hearing.

The narratives in this research have shared stories of cultural sense-making of mental health difficulties and HV, recovery, diversity and speaking out; authoring such stories conveys personally significant and elaborate frames for understanding and coping with mental health difficulties and HV (Geekie, 2013).

For me, this research process has been a journey through complex hidden life stories that yield a deeper understanding and appreciation of mental health difficulties and HV beyond a diagnosis, within a cultural context. From this study I will take forward the notion that I understand voice-hearing on a continuum, within a cultural context, with the voice-hearer's meaning-making at the heart of understanding the phenomenon, informing my future clinical practice and research with the voices of experts by experience.

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APPENDICES

Appendix A - Mind map for literature searching
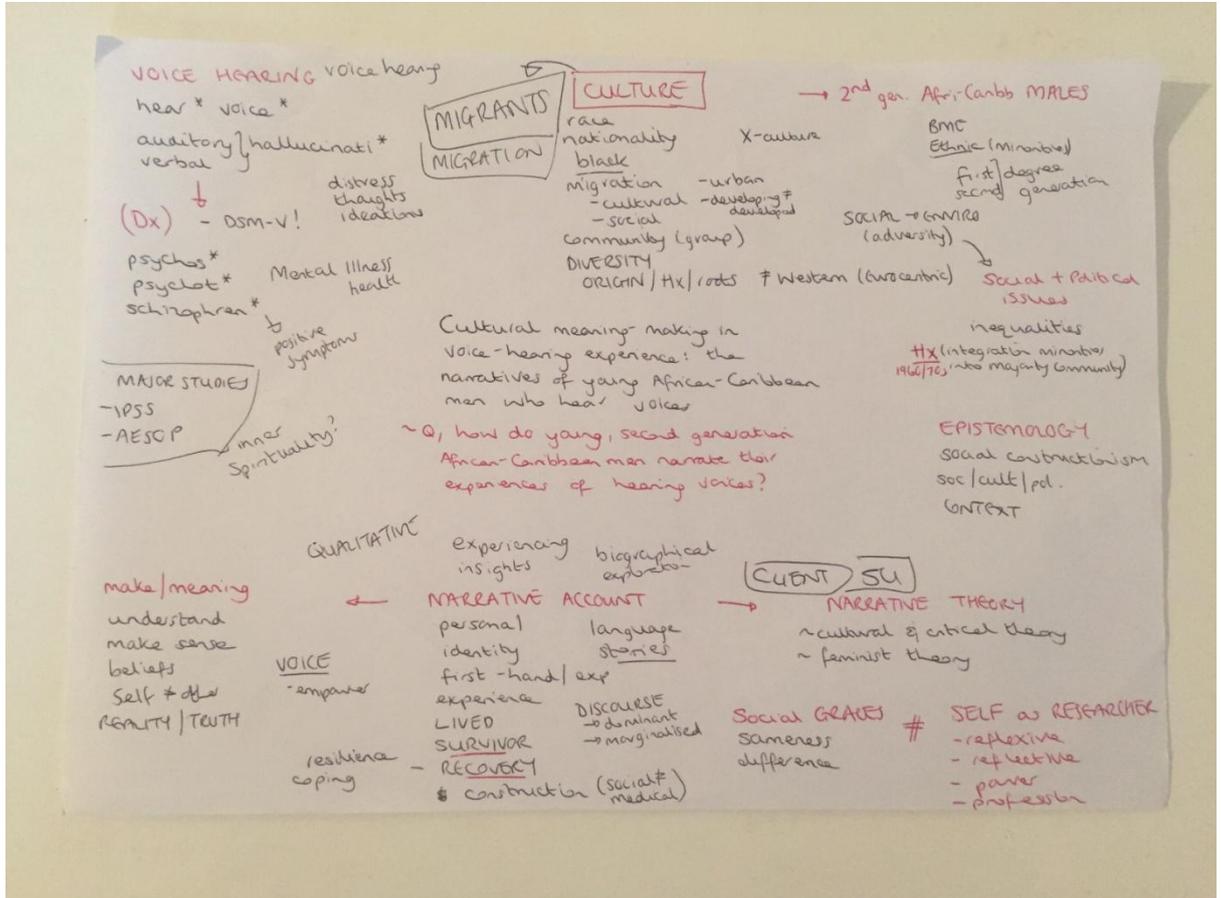
Appendix B - Initial systematic review

Searching:

Utilising the search terms in Table 1, four key databases were searched for the review: PubMed; PsycNet/PsycARTICLES; Scopus; PsycINFO. The databases were selected in accordance to the access permitted to the researcher and sourced peer reviewed articles only.

Terms:

Domain	Search terms
TITLE	"African" or "African-Caribbean" or "Afro-Caribbean" or "Caribbean" or "Black British"
TITLE	"psychoses" or "psychosis" or "psychotic" or "schizophrenia" or "hearing voice" or "auditory hallucinations"
ALL FIELDS	"UK" or "England"

Table 1: Key search terms

Exclusion:

Exclusions were applied to repetitions, dissertation abstracts, comments and authors' replies. Further exclusions applied to non-relevant research, such as 'psychosis' in pregnancy and birth, suicidal behaviour, neurological illness, clinical outcome measures and clinical trials. In all papers sourced and reviewed a medical framework was dominant, with research such as incident rates, symptom-focused HV, genetic factors, hospital admissions, psychiatric treatments, with a distinct lack of reference to context or social-cultural factors. Therefore, articles were excluded if they uncritically accepted the illness model of HV, and articles were fully-screened if they considered a multiplicity of perspectives of HV, such as cross-cultural understandings, trauma-model, or spirituality. Table 2 details the exclusion process.

Database	Total articles	Repetitions excluded	Title screen	Abstract screen	Whole article	Comments
PubMed	31	-	7 excl.; 24 remain	8 excl.; 16 remain	12	4 exclude No access
PsycNet/ PsycARTICLES	0	-	-	-	-	
Scopus	25	22 reps; 3 include	3	3	-	3 exclude (abstract access only)
PsycINFO	56	27 reps; 29 include	21 excl.; 8 remain	5 excl.; 3 remain	1	2 exclude No access
Cumulative total	112	63	35	21	**13**	**11**

Table 2: Total no. of articles per database per screen stage

Appendix C - Ethical approval

UNIVERSITY OF HERTFORDSHIRE
HEALTH & HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION

TO   Stephanie Minchin

CC   Dr Pieter Nel

FROM   Dr Kim Goode Alternate Chair, on behalf of the Heath and Human Sciences
ECDA Chairman

DATE   17/09/15

Protocol number: **LMS/PGT/UH/02003**

Title of study: Cultural meaning-making in voice-hearing experience: what are the narratives of young African-Caribbean men who hear voices?

Your application for ethics approval has been accepted and approved by the ECDA for your School.

This approval is valid:

From: 17/09/15

To: 01/07/16

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

UNIVERSITY OF HERTFORDSHIRE

**ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')**

Amended from 'FORM EC6: PARTICIPANT INFORMATION SHEET'

Cultural meaning-making in voice-hearing experience: the narratives of African-Caribbean men who hear voices

Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulations governing the conduct of studies involving human participants can be accessed via this link:

http://sitem.herts.ac.uk/secreg/upr/RE01.htm

Thank you for reading this.

What is the purpose of this study?

The aim of this research is to emphasise individual lived experience of African-Caribbean men who identify as second-generation of people who migrated to the UK, their narrative of psychosis and their meaning-making of hearing voices, with an appreciation of cultural context.

The purpose is to explore multiple perspectives and cultural contexts of people living with the experience of hearing voices in order to enhance understanding of the experience.

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect any treatment/care that you may receive (should this be relevant).

Before you take part you may wish to seek advice from someone independent e.g. family member, a friend, someone who has similar experiences to you or a trusted professional.

Are there any age or other restrictions that may prevent me from participating?

You are eligible to take part in the research if you are between the ages of 18 to 35 years old and if you currently hear a voice(s) of have had the experience of a hearing voice(s) in the last two years. The research requires you to identify as second-generation of a person who has migrated from an African-Caribbean culture and identify as living in an African-Caribbean culture in the UK. People who are fluent speakers of English are preferred.

You are not eligible to take part if you are currently experiencing psychological distress (e.g. related to hearing voice(s)) or if you are currently using substances or alcohol.

What if I am interested in taking part? ....

If you are interested in taking part you can discuss this with someone independent, or contact me by telephone/email (contact details below). We can then discuss any further questions you may have about the study. Once we have spoken you can decide whether you would like to take part in the study.

If you decide to take part in the study you will need to read, sign and return the consent form within 7 days.

If you change your mind at any time during the study you can withdraw at any time, without giving a reason. If you decide to withdraw from the study at a later time, your data will be destroyed and this will not affect your ay services you received or may require in future. You can withdraw your data from the study up to 3 months after taking part in the study.

How long will my part in the study take?

If you decide to take part in this study, you will be involved in it for one interview and and 1 follow-up meeting with me, the researcher.

What will happen to me if I take part?

Once you have agreed to consent to take part in the study, the first thing to happen will be to arrange an interview, face-to-face with me, the researcher. It is anticipated the interview will last for approximately 60-75 minutes.

You will be given the opportunity for one follow-up meeting, either face-to-face or on the telephone, with me, the researcher. We can discuss your experience of the interview and also allow you to hear back a summary of the interview, review my understanding and meaning-making, and provide an opportunity for questions and de-briefing.

Where will the interview happen?

The interview will happen at a place and time convenient to you e.g. a quiet space, in a comfortable environment, at local group, or at a local health centre. We can decide this together.

What are the possible disadvantages, risks or side effects of taking part?

The possible disadvantages, risks or side effects to all participants have been considered, and are to be maintained at a minimum.

However, it is possible that you may find the interview process distressing, for example, talking about some difficult experiences that you may have had. In order to protect your welfare, we will take all measures to ensure that you are in the same state as before the interview.

For after care and support, information about relevant local support groups, third sector organisations and charities will be provided to all participants.

The safety and wellbeing of all participants will be paramount during the interview. If you start to feel distressed or upset during the interview, you may stop completing the interview. Following the interview, if you feel distressed at any point, you can contact the researcher, GP, Hearing Voices Network or any other appropriate person or organisation for support.

What are the possible benefits of taking part?

The benefits of taking part in the research are to improve society's understanding of what it is like to be a African-Caribbean man who hears a voice(s). It is an opportunity to have your experience heard and understood as well as to represent other people who share similar experiences to you. This will be helpful not only for researchers and professionals of scientific and academic communities, but also for people in wider society such.

How will my taking part in this study be kept confidential?

All data information is to strictly confidential and is to be anonymised, which means that no names or identifying features will be kept with any of the study information. A randomly assigned coded number will be given to each participant and stored on a password protected document on a secure computer.

Some direct quotes from the interview transcripts may be used in the study write-up (thesis and journal article) however, quotes will not contain identifying features or names.

Once the study is complete, all data information is securely stored and archived at University of Hertfordshire for 5 years. Other data is deleted and destroyed securely.

What will happen to the data collected within this study?

After all the data is collected, it will be analysed and the study findings will be written in a thesis for doctoral-level research. An article will then be written and submitted to a relevant academic psychology journal for publication. There will be no identifying features or names written in the thesis or academic journal. There may be some direct quotes cited from the interview, however, anonymity and confidentiality is maintained.

Will I be reimbursed for my time and effort for taking part?

Although participation in the study is not paid and travel cannot be reimbursed, you will be asked if you would like to be offered a token of appreciation for your time and effort, such as a voucher for a supermarket/book.

Who has reviewed this study?

This study has been reviewed and approved by the University of Hertfordshire (School of Psychology) Ethics Committee and secondary registration has been approved by the Research Degrees Board at the University of Hertfordshire.

This study has also been reviewed and approved by National Research Ethics Service (NHS ethics).

The UH protocol number is LMS/PGT/UH/02003.

What happens after the study?

After the study, there is no further requirement of you.

After the study all the data will be discarded appropriately.

If you are interested, you will be able to request a copy of the final published article.

Who is organising and funding the research?

The research is organised and funded by Cambridge & Peterborough Foundation Trust which commissions the doctorate-level Clinical Psychology training (DClinPsy) programme at the University of Hertfordshire.

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, in writing, by phone or by email:

XXXX

XXXX Principal Supervisor XXXX

Room 1F414, Health Research Building, College Lane Campus, Hatfield AL10 9AB

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix E - Guidance in the 'Health and safety policy'

(2013, School of Life & Medical Sciences, University of Hertfordshire)

UH School of Life & Medical Science - Health & safety policy (2013, p.10)

17 LONE WORKING

Lone working is not the most desirable of working practices but it is essential in some areas and at

certain times. The general guidelines are that lone workers should have somebody else within

shouting distance to provide aid if necessary, using a lone worker alarm, a mobile phone or reporting

to someone else by telephone at regular intervals e.g. Security. **The actual procedure to be used**

will be part of the risk assessment for that activity.

If lone working is carried out outside of normal working hours, then the *out of hours* procedures must

also be followed.

Appendix F - Consent form

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

('ETHICS COMMITTEE')

FORM EC3

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

………
…….

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..………
……

hereby freely agree to take part in the study entitled *[insert name of stu*dy *here]*

………
……..

1   I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, and any plans for follow-up studies that might involve further approaches to participants. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2   I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place. I understand that anonymised verbatim quotes from my interview may be included in the research report of the above named study.

4 I have been given information about the risks of my suffering harm or adverse effects. I have been told about the aftercare and support that will be offered to me in the event of this happening, and I have been assured that all such aftercare or support would be provided at no cost to myself.

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

6 I understand that my participation in this study may reveal findings that could indicate that I might require medical advice. In that event, I will be informed and advised to consult my GP. If, during the study, evidence comes to light that I may have a pre-existing medical condition that may put others at risk, I understand that the University will refer me to the appropriate authorities and that I will not be allowed to take any further part in the study.

7 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

8 I have been told that I may at some time in the future be contacted again in connection with this or another study.

9 I have been given the opportunity to ask questions about the study. I have also been provided with researcher contact details and other relevant sources of information if I have any further questions following my involvement in the study.

Signature of participant……………………………….....Date………………………….

Signature of (principal)
investigator……………………………………………Date……………………

Name of (principal) investigator *[in BLOCK CAPITALS please]*

………XXXX……………………………………

Appendix G - Interview schedule

Main areas	Prompts	Domains
General background	Current life situation e.g. date of birth, location, BME status, employment, living circumstance, where lived most of the time, country of origin, how many years in UK, reason for migrating to UK	
Cultural identity	What does it mean to be a young African-Caribbean man who hears voice(s)?	Personal identity
Cultural background	How is hearing voice(s) understood in your parents country of origin/cultural background?	Cultural context
Experience of hearing voice(s)	• nature of the voices • frequency of voices • how cope with voices • how interpret the voices • how interact with voices	Voices Construction of voice-hearing experience (self)
Other people's experience and sense-making	e.g. family, friends, local community, work colleagues, professionals	Construction of voice-hearing experience (others)
Western view of 'psychosis'	Medicalisation	Construction of voice-

	Diagnosis Same/different understanding?	hearing experience (society)
Strengths	Have you ever experienced anything positive or protective from hearing voice(s) Spirituality Religion	Coping strategies
Access to services	Has your understanding of hearing voices impacted your access to services and/or treatment offered (if any?)	
Future	How do you see your future? If there was someone out in the community who was hearing a voice, would you tell them?	Recovery Resilience Positive message/peer support

Is there anything that I have not asked you in this interview that you would like to tell me about, or you think is important for me to know?

Interview end - what happens next?

- Confirm SM contact details in case participant wants to get in touch, etc.

- Agree whether ongoing contact e.g. email, notification of study publication/how to access

- Provide information e.g. local support groups, third sector volunteer organisations

- Arrangements for giving/emailing voucher of choice

- Check well-being of participant - same state now as when started interview

THANK YOU! V. GRATEFUL!

Appendix H - Transcription agreement

University of Hertfordshire

Appendix 8: Transcription Agreement

University of Hertfordshire

Doctorate in Clinical Psychology
University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:
Stephanie Minchin ('the discloser')
And
Lesley Beadsley, alltypes-secretarial services ('the recipient')

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.
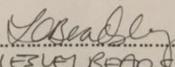
Signed:.....................................
Name:.....LESLEY BEADSLEY.
Date:.....8/12/15.

Major Research Proposal: African-Caribbean men and hearing voices   Student No: 13088961
1.

Appendix I - Excerpt of interview transcription and analysis

Dialogue and Performance	Interview Transcript	Content, Themes, Stories, Plots	Context e.g. social, political, cultural
	I: There we go, that's recording... OK... So, just before we start talking about your experiences of hearing voices, it would be really, really good to hear a bit about.. you as a person. So could you tell me a bit about yourself?		
Repetition in identity - shy	P1. Erm... Well... I started life off being very quiet and erm (I - Mmm).. very... shy, I'm still shy and quiet... but, umm (p.)... I kinda've... like... fell into a, a... a job, everyone says I gotta get a job, so I got a job in a solicitor's office... and er... from there I seemed to blossom a bit...and err... decided to go off and do a degree in law.. and... er... that's when I became ill. (I - Ok) um... which at the time seemed like a disaster cos I was at what was known as then in those days was known as polytechnics, I was at a polytechnic, it seemed to be a disaster because it was sort of like, I was just starting to get up, you know, climbing up a big hill and get b- then getting b- a bit better ?? not the whole world crushing to meet you in, in the rush, you know...and um... but medically it was like (p) a, a disaster, emotionally it was (p) a disaster, but... in the.... now looking back at it, it's actually, it was a, a great time of growth (I - Mmm) and er (p)... that has helped me to sort of, look at err my life differently now. When I have a crisis, yes it's a crisis, but usually it generally means that something's (p) wanting to come through the ground, you know, like plants do, they need to push things out the way (I - Yeah) and erm... I think that's where that came, but I think that's like reflection rather than, you know, pre-knowledge (I - Yeah) as it were, if there's such a word. Ummmm. So, I feel.. that because.. of the illness... and I've had other upsets afterwards... that each time I've grown stronger, I've grown.. more.. versatile.... erm... and... yeah, a lot stronger, so yeah that's me really, so I see it now... I see... I don't know, I don't think I'd enjoy my, err, another stay in hospital, but the way I look at it is err it is err it's that it's a period of, it's a	Personal identity *Follow expectation - Q who says to get a job? - good start, achieve *Ill in context of not coping, high pressure with edu/employ *struggle to achieve? sense of nearly making it. METAPHOR urban rat race? *different levels of disaster *positive reflection in hindsight *change in perspective *Nature metaphor - grow, evolve, learn, change *because of event, impact sense of personhood *fixed idea of who/what got to	Identity Ill Life event Personal growth Identity Life changing event
Pauses throughout			
Rep. "disaster" strong word, fixed word			
Rep. crisis			
Rep. growth			

| Rep. abroad | period of growth, so I've gotta change direction (I - Yeah) and I've learnt that I'm one of these people that gets on and who does set themselves on a path and doesn't like to change and usually it has to, is *forced* to change my life, you know, umm, so that's, that's me, that's where I am, that's where I am today.

I: I see... So in some sense that's a big summary of.. how that, how that experience of what you say 'becoming ill' changed your life, but upon reflection has been a big personal growth (P1 - Yeah).. ok. And *now*, do you, could you tell, tell me a bit about who you are as a person, so things that you like, things that you don't like (P1 - Ermm) your family set-up...

P1: Err , my family's all abroad (I - Hm-mm) umm my dad died this year...

I: I'm sorry to hear that.

P1: Err, thanks... Umm... Err.. My family's all abroad. I've got sisters, a mum, two nieces, all abroad; I've got a couple of cousins over here.

I: And abroad, err, you mean? Where's, where's abroad?

P1: West Indies... (I - West Indies? OK) err, um, I've lost my trail of thought (I - Sorry) yeah, so they err, so my family are all abroad. So I'm basically here *on my own*. I was *born* here ummm and I grew up (p) in the.. *Eastern* side of London... ummm...

I: Mmmm whereabouts?

P1: Ummm... *XXXX*. I was born I *XXXX* actually, but did most of my growing up in *XXXX* (*Name of London boroughs*) (I - Ok). Ummm. So, I have um (p) yeah s-so that's me really, it's just-, sort of things I like, I like music, that's very (I - Hmmm).... I like listening to people,... I like working | be; takes something to happen to move, change, explore. Awaken to sense of who he really is/wants to be

*sense of loneliness - only person in family here

*very basic list of family, sense of detachment for family relations, low connectedness

*connections found in new networks caring for/helping others | Identity

Family

Social |

	with people to do things... ummm... yeah things like that.. I can't really think of anything else really (P1 laughs).		
	I: So you said that you were born here but now most of your family is abroad, can you tell me a bit more about that?	*family history *social movement (why did family move here? better life, new prospects?)	Family Cultural context Community
Rep. died	P1: Well my parents, my parents were born in XXXX (Name of country) and.. um (p) er th-they came over to this country in the 50s, I suppose they call it the Windrush era, (I - Ok) ummm.. They came over in the 50s, and I was born, not long after they were over here and ummm (p). So, basically, we had a, a community of, you know, their friends and relatives that used to be here, a lot of them have died now, or passed on, umm, well that's the same thing and a lot of them have died now or they have gone to other parts of the world, ummm (p). So they've kind of... so there was always this like, my mum always used to cook an extra big pot of food, just in case anybody would pop by (I - Great) and she'd be good to hand them out, so that's the sort of community we had. And ummm (p) my experience of it as a kid was, you know, there wasn't so much nurseries then and so my mum was looking after us, and to help her, her income, she would, well family income, she would um look after other people's kids as well, and... so I used to help with that, well me and my sisters used to help with the looking after the other kids as well, keeping an eye on them and stuff like that, so we were all very family-orientated (I - Lovely) But err.... Umm... So, that's it. (p) Umm. School was, school was ok. I didn't have... any problems, hardly had any, apart from when I first went to school, I had a few fights, but that was largely because of me, being the err, err, being a bit rough, rougher than I should've been...	*nurturing, fond memory, community spirit *need for extra money - lower classes, financially struggling? *big community *minimise? self-blame? difficulty fitting in? why rough?	Alone / isolation Community Family School
Emphasis of all (vs. solo now)	I: What do you mean by that? P1: Getting into fights (laughs)	*father as guide, moral figure, source of protection	

	I: (laughs) *All* because of you or....?		Bullying
		*sense of being used, if so, then not his fault, was this a way of forming friends at school, pleasing peers?	
	P1: Well I , I used to, I, my my ==dad took me aside one day== and said, you know, I shouldn't be getting into ==all these fights== (I- Mmm) and he said well, it's because, and I explained what happened is... Well, you're getting into these fights but they are not your fights, and ==they're not *my* fights==, and they ==were for someone and said someone's gonna threaten to hit me a==nd said OK I'll get *X (P1's name)* onto them, and it's only infant school stuff, but you know what I mean, it ==taught me a very, at a very early age,== not to get into other people's fights and not to be the one that's like, because ==you get *used* sometimes== (I - Ok), cos, as you are probably aware, you get used and if someone wants to do something to somebody and ==they call you in so you hit them and you go in there== (I - Right) and fighting it, it just isn't (p) when you look, when I look back I can see that my ==Dad was right==, that was that was what was happening, so I got a good telling off about the age of 7, and ummm (p). Just cos I'd just left infants school (I - Mmm) and joining um, and don't know what they call it these days with all this year things, but it was infants school (I - Yeah) and primary school and, you know junior school in my day, and that was that (p). So ummm (sigh).... so yeah that was fine.	*vulnerability as child - do what others say, another person's pawn/class clown?	Importance of father figure
		*sense of not being clever - academic failing, failure to father? against parents' expectations/hopes, especially as only son	
Lots of description - high energy in describing job	And growing up through the, through the secondary school... I was um, ==I used to work pretty hard but never get very far,== as ==I'm not very, not a bright person as such, ummm, at least not in that way== (p) and err. (p) so,.. yeah, that's it really. On leaving school, I left with a few um O-levels, and then ==couldn't get a job==, and then got a job in a solicitor's office, as a Junior Clerk (I - Yeah, and um), or as an Office Junior, I should say.	*joy in roles/responsibilities, job satisfaction, sense of importance in job	Employment
Praised self then back-tracked,	I: OK, great, can you tell me a bit about that job? P1: Well it was *great*, I *enjoyed* it, a lot of it used to be ==travelling around==	*discovery of a path that would've pleased father	Turning point

acknowledge limitations Tragedy = shakespearean Rep. scary	London, um delivering papers, barristers briefs, and used to meet the barristers, ummmm and then I got promoted and I got to go and sort of take notes at the back of the court, um (p). I err, I helped with the um filing of papers and issuing (*rits?*) and all, doing all that backup stuff, procedural stuff, (I - Yeah) I was involved in, and er yeah, it was quite good... then I, and I decided, that um, I've really got a... *taste* for this, this is supposed to be what I meant to do, that's when I went off to Polytechnic and studied a Law degree (I - Ok) which I was doing really quite, when I started off, I was doing quite well, you know, I mean I wasn't *brilliant*, but I was alright for a starter, for a beginner, and um.... that err.... that point I err....I got, I got... ill. And... The tragedy is, I didn't know I was ill at the time, you know. Because I'm used to physical illnesses (I - Right) because people in those days don't well, don't um, they didn't talk about mental illness as much as they did now, and if it was it was in a sort of like very deragotory or ummm you know you're gonna get locked up and not let out again that sort of thing, which if you don't have anything to, if you don't know anything about them, about what's going on then it's quite scary, and it was scary, scary at the time, and I was um..... fortunately, I got... I went into hospital for six months but it was, and it was two years before, that was in 1981, and errr, it was two years before, the.. ummm.... two years before the errr, Community Care Act came in, came in, you know where they treated people in the community as opposed to big Edwardian hospitals, or Victorian hospitals, so ummm, so, I... I think all that helped for my getting out much easier, I mean, I don't *know* that cos I've got no evidence but I think with the times and saying that it probably did it help it was banking on giving the... **(???)** (I - Ok) and I know people *did* get out so (P1 laughs), so people did get out and umm it was um.... you know it's just it was, it was just a sign of the times that err that people used to errr, whenever when, *before* I went in whenever um people talked about... err mental illness and people say "yeah you go to a hospital and you'll never get out", and that's the big worry (I - Right) because when I was *in* hospital I, it used to be the big um, you know,	*not knowing *separate MH and physical H *stigma & discrimination *fear MH *long stay in hospital *positioned within context of legal/political discourse (link with views of society & how treat people who HV) *uncertainty, not knowing *trapping, contained, imposing *machine, lemmings, de-humanizing, loss of control, loss of indiv. self - fear *uncertainty of future - fear if forever	Societal discourse Hx context 1981 Socio-political discourse Societal context

enclosed um hospitals you know big, big, it had like massive grounds but the thing is you used to walk all on the inside and you would see old people in chains, I mean chains and chains of old people, and when I say chains I mean daisy chains like one holding their hands and one holding the back walking along, keeping them all together and you used to, errr you used to see them and when, and you just wonder, or I just wonder like what the future like, would that be me in the future, at times, had that kind of, so for.... For me anyway, there was a real fear of not getting out... I: So you said that when you went to Polytechnic that was when it first started (P1 - Mmm) and it first happened, and at the time you didn't really realise, so I am wondering who first noticed what was going on? P1: Oh right, umm, well I, I, I attempted suicide and err I *believe* it was the neighbours who... gave a call for help, you know called for help, called the police, etc., and they took me to hospital because I cut myself, and umm... although it's *hazy* for me to, to do this part, because I can't really remember this part exactly, and it was such a, it was traumatic, but anyway,.. anyway, I went down and the police came and an ambulance, I think the ambulance took me away or, *no* the neighbours took me in the back of the car, their car to the hospital and the police came and everything, just to see what happened... I: Ok so you've got some kind of memory of what would've happened after... P1: It's very grey... I: And do you know, or do you have any memory of what was happening up to that point, or what made you want to self harm, or attempt suicide? P1: Ummmm, I was very depressed, I didn't *know* I was depressed, I didn't	*suicide attempt is what it took for self and others to notice *SH - low memory *police & neighbours - at what point did family help? *dep - no model of dep. to understand the experience - reflection of MH at that time, low awareness, no education, stigmatised, secret, shameful	Critical incident Trauma Not know/understand the experience Critical event

Medical lang.	know about that kind of depression, never been that ==sort of low== before and to my knowledge I hadn't seen anyone that low before... and... ummm, I just woke up, feeling very... *down,* and err I went to get a knife and that's when the landlord saw, saw me and.... he called up, he called the neighbour, so they came, but I'm not sure how that worked, I'm not sure how that worked... I: Yeah, it sounds really difficult P1: It, it *is*, because it was a ==life-changing event==, but it was very, and yeah... I: And at the time when you were feeling low, can you reflect on, perhaps, what things were making you feel that way? What things in your life were making you feel depressed? P1: Mmmm, I don't, ==I don't know,== I was in, I think I was, I was in a ==bad space==...... Ummm, I think it was partly because ==I had fallen out with a friend==, which, cos I, I'd umm... yeah I'd fallen out with a friend, there...... although that ==wasn't his fault, or, or even mine==, it was just like, and even after what happened what was going on cos I was gradually becoming more and more... ==disconnected== (I - Right) and ummm, I was just, like.... I was more and more, finding it ==more and more difficult to cope in the classroom==, in the lecture hall, because I was hearing voices, although again, I think they were.... umm...... so that was that really. ==I was actually ill but I don't know exactly what caused it.== I: And do you remember the first experience you had of hearing voices? P1: Not exactly. ==No, I don't know, I don't remember,== I know I've had them, I was experiencing them before but I don't remember the first time, cos I'm pretty sure that when I, ==on the day I almost attempted suicide I was hearing voices== then, and... but, I'm sure I had heard something similar before but I	*not knowing *why? whose fault? Loss of important rel *social disintegration *academic failings/struggle *ill *social context triggers unknown *now knowing/remembering *disconnect from reality *multiple *critical *paranoia *course of HV not as a switch	Loss of social networks Loss of reality Academic challenge Nature of HV

	don't know exactly when cos my <mark>time... frame, of my mind, is not together</mark> on that. (I - Sure, ok). But, it's not, would've been that <mark>same year '81, it was January '81,</mark> but it's that time which I, when it definitely first started I can't say. I: So that feels like a, a main event, a very traumatic main event, and um, do you have a memory of what the voices were saying; so you said voices, so there were more than one, more than one voice? P1: Yeah, it was <mark>more than one voice,</mark> um but there's, it was more like, it was more like, it was <mark>like people putting you down all the time</mark> (I - Ok) and stuff like that, and <mark>today I would say I had a bit of paranoia</mark> as well, although that wasn't diagnosed, I'm pretty sure at the time, I didn't get that until 10 years later... So it's, it's <mark>something that, it's a *growing* thing I think,</mark> it's not something that.... It's difficult for me to pinpoint things like that, to me I see it all as one, one all pieced together I: Ok, so say that the voice would be, the voices would put you down, so was that quite critical?	but growing (does growing suggest organic in nature, like HV has life of its own, a place in reality?) *core belief/NAT *neg. thoughts develop to HV *no identified trigger, why at that time?	HV
Reps please him, not capable of, different	P1: Yeeeaaahhhh, it was quite critical, umm.... You know, just saying <mark>you're not good enough,</mark> and, things like that in so many words. But, umm... I mean, even, even before I would get thoughts <mark>along those lines, and they would just pass,</mark> but for some, but <mark>for some reason at that particular time, it didn't pass.</mark> I: OK, and were the voices voices that you recognised, or where they were unfamiliar? P1: Some of the voices were <mark>familiar,</mark> one of them was my <mark>Dad's voice,</mark> but most of them were unfamiliar.	*father as iconic figure, role model, want to make proud, privilege, pleasing other not self *inherent failings? acting outside of one's own abilities, wants & desires *awakening & discovery of the self *idea of only possible option is to change i.e. alternative to suffering & emot. pain	Father Identity Critical incident leads to awakening, realisation
Some mix of			

past/present tense re father Rep no ability Change in dialogue to praise father, what learnt from him - why at that point in narrative (e.g. protect against own inadequacies, too difficult to talk about?)	I: And how do you make sense of that, it being your Dad's voice? P1: Well my Dad was the person I always most wanted to live up to, so it was always, always that thing, ummmm, don't know.... I told him, I actually told him that he's the person I most admire, and um sometimes when you're trying to... please someone.... ummm you're doing something you're not really capable of. You're, I'm, I'm, I'm trying to please him, but I'm, that I'm not really capable of doing whatever that's doing, that's not me, I'm a different sort of person (I - Ok), and I have to acknowledge, once I start to acknowledge, that I'm a, a different sort of a person, yeah, umm... it, it, it became easier for me. And part of that acknowledgement came, came in that, err being ill... by being ill. Um, I had, I couldn't deny then, that I had to change, otherwise I was not gonna be able to exist (I - Right) so I had to become more of myself I: So it sounds like before you were trying to please your father and that wasn't working (P1 - Yeah). In what way do you see that you were different? So what would your father may have wanted? P1: Well, my Dad was a more technical person, although he's very creative as well, but he's more technical and I've got no technical ability whatsoever, so err, and he's ummm, very good at maths, and engineering, and again I had no ability in that, along those lines, ummmm. I just used to like his approach to life, really, apart from that, he was very, ummm.... I've never known him to shout, you know. And that's something my parents, my parents...... Most of other... p-, p- ummmm... My people, most other, most other, um... My peers at the time I was growing up, they talked about their Dads shouting and that, but I never heard my Dad shouting, I can't think of any time, he never shouted at me, and I never saw him shouting at any of my sisters, but he always got his *point* across, umm... In a *direct* way, but it was always.... you know, it was you knew where you were without all the adults shouting n screaming at each other.	*values held in family - technical vs. creative - gendered, stereotyped expectation of trade & achievement *how did he get his point across? assertive, strict? *expectation in life *migrating with promise of better life, modernity, high prospects for next generations, like American Dream *age of responsibility? transition to adolescents, what does this mean, within cultural context & family?	Family norms Cultural expectation Cultural migration - values & hopes of family Academic pressure Culture, family, gender

Rep & emphasis modern & lost	I: So you said there is something about , er, one of the voices being your father's voice, and feelings of perhaps not being good enough, how do you make sense of that? P1: Well, my Dad high, high hopes for us...and I think you'll find there is probably true of lots of West Indian families, particularly those who had just come over from Barbados, their parents, um.... A lot of their expectations are quite high, in fact sometimes, their expectation is higher than they themselves, possibly higher than they themselves could reach, or, or, or likely to reach, and... there's umm... a lot of pressure that way sometimes... er, to do... to do well, to please them. Particularly for the age of (sighs) eleven really, of eleven upwards, eleven onwards, eleven downwards, and then the pressure goes on from about thirteen, that's what I found anyway. (I - Mmmm) Umm cos you're thinking about O-levels, or what are they're called GCSEs these days, ummm, and things like that, so err, so start thinking about wanting you to do well, umm.... Often, you're somewhere in the line of things, ummm particularly boys, we do tend to get *lost*, in trying to, in trying to umm *achieve* things that our parents might want and you got other distractions, (I - Ok) you know... It's quite interesting really.... Cos I used to um.... one of the interesting things, one of the reasons that happened say in the 70s, so that's when I was at like secondary school, like 60s and 70s, ummm, the reason there was that was, cos many of the West Indian um, cos I went to a, apart from primary school, I went to an all boys school, so we'd come over, or they would come over from the West Indies with their parents, and because they couldn't relate to what was going on in a British school, cos it was a completely different way of doing things, umm, in the sense that, like for instance, when we, for maths, maths is a way of showing that, cos er we did um what they called SNP perhaps **???** I can't even remember what that stands for, which is we did things like matrices and... um.... matrices, and um, I can't remember my maths now,	*why boys? *conflict self vs. parents *Q was this different way of doing things unexpected by parents? children caught between tradition/new *e.g. Maths *low resource in country of origin - sense of being 'behind'? *academic inadequacies *Q were parents trying to exert their own worth and social position in face of social adversity through the achievements of children?	Hx context of cultural migration and education systems Class Stigma Socio-political context & discourse

Rep school?	Pythagorus we did that ok and that would've been , would've been, we both would've done that, but ummm, <mark>binary and things like that to do with computers and all that sort of stuff, whereas like, if you came from the West Indies, well they wouldn't have access to all that,</mark> so we were mainly strict arithmetic, um and things like that but <mark>when they came to England, that wasn't enough,</mark> what what they had then, so... although sometimes they would be very good at, if they did the traditional maths, they would probably be very good, but <mark>when they did the more *modern* maths,</mark> the sort of thing we did at our school, it wasn't the same at every school, modern maths, it was, it was more um, <mark>difficult to understand, yeah. It's just a way of doing.</mark> So, um, sometimes, not just maths, but they often got *lost*... in the, lost... <mark>lost in the way things were done here, so they would end up in the lower classes. So already, they would be the people in the lower classes who might be a bit more like trouble-makers and things and you had to defend yourself to survive. So you didn't get into more trouble, or that's it.</mark>	*differences in edu. system also have impact in later life i.e. job prospects *adjustments to norms, values, ways of life	Colonialisation Hx context School / peers Racism
Use of humour		*what does Adultism mean - positive re-frame? why? denial, disbelief? avoid? not want to accept victim of racism? location of blame in adults.	
Perform other voice (radio)	I: And what else, and what other challenges do you think there might have been for parents of families coming over from the West Indies?		Socio-political discourse
	P1: Ummmm....	*child memory	
Perform younger self	I: In terms of the British way being a bit different from what they were used to?		POWER Political discourse of discrimination
		*stigma & discrimination	
	P1: Ummm.... Well, look it was <mark>*all* different actually,</mark> ummmm... Even the weather was different, you know (P1 & I shared laughter) Ummm... but.... it was, it was a, I imagined about the, the maths, cos it is highlighting differences quite easily in the education systems. Umm... but... I mean, <mark>if *I* went over *there*, I would find it, I would struggle, to, do things, the way they, they way they do, they way they did their thing so.</mark> Although, funnily enough, it's based <mark>on the same *principles*</mark>, cos Barbados was like a, a, an island, that was, British, so, you know, the education system was British,	*political message by someone in power *picture of home-life struggles against social adversity *social isolation, rejection, loneliness, outsider, different, sense of other, not belonging?	Atmosphere in society

	so, maybe it was just the school that I was out, I just noticed that, at the school, about the differences there, so.... cos of ummm....	innocence/naivety as child, vulnerable
	One of the things that went on at um... One of the things I found difficult dealing with at um at school, at school was um, not at school, at the school, some people experienced racism, you know, black, white, etc., and um, I don't think,. I don't believe, I don't believe I have ever experienced any racism... What I experienced is what I call 'Adultism'... adults who are being	*feeling in atmosphere - tension? spoken/unspoken? *reaction - what happened-impact on child, family, community?	School context
Performing younger self	R: Ok, ok, what's that? (shared laughter)	*juxtaposition in story - school 'ok' vs. difficult (how accept?) *Adultism - blame adults - indicative of X-cultural clash, p born here, knows no different, more acceptance than elders, maybe protected from full extent of discrimination as a child?	Adults as metaphor - representative of the societal narrative
	P1: I'm only joking around, um it was more like the adults go on about... black and white causing division, like power, and like people being like.... like I would be on the.... at home, I would be at home having breakfast getting ready to go to school and it would he would be going on about 'blacks you go back' and you know. It should be, at that time, in the 70s and 80s, and that was quite, he was quite, one of the most famous MPs, he was an MP as well, so all that.		
			Societal discourses - high prejudices
	So, imagine if you're a kid, and you're a, you're eating your cornflakes and you're thinking, well I, I know I thought, I used to think sometimes, "well, don't know if I should go into school today, cos I, cos I don't know if there will be anybody there that's err, I don't think I'm gonna have any friends", you know. Cos... um... because of that feeling that was going on... and... the way parents... would... sometimes... react to that, quite angrily, you know...	*very public *fear *like knowing that trouble can come your way too easily (lower class/'trouble makers') *extreme example. have to be aware, adjust, avoid social situations, sense of easy target, highlighting vulnerability	
	I: Angrily, in the way parents would...?		
	P1: Angr-, angrily, I can't say the word, in an angry way (I - Yes, yeah, yeah) Not... offensive, cos we were kids you know but just a bit upset about it I suppose (I - Yeah). Ummmm... So that made, sometimes it made life at		Sense of different - other, not belong
Reps never Perform younger self	school difficult. Although, see I can remember my er fellow classmates because none of them ever brought it up with me anyway at school, they never, brought up any racism or things, and there's never err, we just	*strong sense of difference, managed with acceptance	Strength & skills as different - Q

Perform BOOKS - what's the message, purpose, value, intention here? (relational power, acceptance, validation, sense of worth, identity as facilitator & author) *this was following on from Q re feeling 'out of place' - Q why not answered, too hard/sensitive? re-directed to strengths? change in narrative? *p take control	accepted the way we all were, as far as I know. So it was really the adults creating the problem, that was being passed down to err... I: Yea, but so you said your friends never brought it up with you but there were sometimes when you felt like "I' don't know if I'll go to school today because I might not have any friends"...? P1: Cos you hear this, it's like, it can be, you *hear* that and it's on the radio and you're um, you know, it's sort of, well you know, like telling the *whole country*, the whole country that's it, you know, and you're thinking, well, you know, "Am I gonna be out of place every time I walk into..."... like if you knew there's trouble, was a bar full of trouble, a bar full of Hells Angels (I - Right) and um.... and you were passing by, you wouldn't go in there unless you, unless you, well you might do (shared laughter) you wouldn't normally go in there unless, unless you, unless you *had* to (I - Mmmm)... yeah? You'd probably *avoid* it, well most people would. I: So is the experience of feeling out of place quite a common one that you've had throughout life? P1: Yeah, I feel, I, I feel even now, I kinda feel out of place, but um... well... But I'm gradually coming to terms with that... yeah. I: In what ways do you feel that you're out of place? P1: Well, it's.... I've come to realise that I've got different talents (I - Mmmm) and different abilities and some of the things, I mean... when I run, or facilitate the hearing voices group that's something different I would *never* have done that, you know what I mean, in a million years, I would never have said "well I will do that"... and so, so by being, having, having gone through what I've gone through I managed to use it to help others so I, it's been quite *useful* (I - Hmm-mmm). Now I've written, a couple of	recognised? HVN Lived exp - expert Identity Recovery BME service-user
	*acknowledgement of strengths & skills. But 'different' to what/who's expectations? (father. other families in community? peers? boys?) *juxtaposition with early life expectations, (career pathway/dreams, different to job prospects encouraged by father) *giving back - selfless - using own hardship/reflections to support others (part of a healing process for himself?)	

of interview - I had no intentions of going!	books... ummmm... well, one I contrib- one book I contributed to it, and that was um, now I've, I've it <mark>here with me, to show you</mark>.... I: Ok, lovely, yes, yes do... P1: I thought I'd bring it along *P1 takes books from bag, puts them on table to show I.* P1: That's the first book I did, the one contributed to ...	*why did he think I was going? Want interview to end? Said enough? *feedback by me - very impressed, in that moment felt proud of his achievement, very humbled, wanted him to know it is an amazing achievement	Recovery Future
Performing books, showing quotes - need for validation? sharing positive feedback. Sense of pride.	*P1 hands book to I.* I: Ok so it's a book called **'*XXXX (Book title)*'.** P1: I wrote two chapters in there. I: Two chapters? Great. *I reviews the contents pages of book.* I: Oh here you are, um **'*XXXX*'** and **'*XXXX*' (*2 Book chapters written by P1*)**... I might try and get that out of the local library, they would both be interesting reads. Thank you for sharing that with me *X (P1 name)*. Ok, so in some sense, you've... P1: And, <mark>before you go</mark>, the other one I wrote which I wrote last year, it came out last year, it's this one. *P1 hands I another book.* I: **'*XXXX*' (*Book title*)**. Wow. So you've been able to <mark>take forward your</mark>	*BME - lived experience, connection, advocate, represent *supporting others recovery	BME Turning point

| experience by reflecting on it and, and empowering others, and providing support to others, yeah.

P1: So I actually do *XXXX (Job Title)* now.

I: Oh you do?

P1: Yeah. I used to do it here, for um, for *XXXX (Mental health charity)*, before, before, a few years back, to work with people who are experiencing mental health from the BME community... and um... as soon as I developed that, I, I continued to develop at *XXXX (Mental health charity)*, it used to be called *XXXX (Mental health charity)* in those days (yes, yeah), and that's when I did, there's actually about three people in there who's actually all um...

P1 and I referring to the book. | | |

Appendix J - Stages of analysis

This demonstrates the process of analysis, which supports the interview transcript excerpt (Appendix I). Examples of reflection are integrated throughout in note form as extracts from my reflexive journal.

1. Reflections immediately following interview

Post-interview feeling - "fills me with joy" - really good feeling, very grounding, very appreciative that he shared his experiences and reflections with me

Post interview feedback from participant - he "enjoyed it" and "relaxed" and "not too many Qs"

I experienced the interview process as connected with a good sense of trust and rapport, demonstrated with humour and laughter throughout. I noticed myself smiling during the interview which conveyed a feeling of being relaxed. This may have been because we had met before when I visited the HV group he facilitates. I was made to feel very welcomed by him. he came across as very supportive and understanding of the project

During the interview I noticed that he shivered, reported to feel cold and his body language closed. At this point in the interview we were speaking about the bereavement of his father and more recent experiences of HV.

Self as non-therapist was a different and difficult position to hold. I *wanted* to be more validating, I struggled not to 'therapise', I *wanted* to ask more questions. There were so many tangents/branches to explore but I also had to hold back and allow him to tell his *story, how* he wanted want to.

I experienced the interview schedule as a guide and not a Bible, and felt more relaxed when less attached to the questions as prompts. This made me learn to be more free from the interview schedule and be more fully present with the participant, connected in the moment.

Literature as a source of importance for him, performing his strengths and skills. Books represent an avenue of self-development for him, sharing the message in an avenue for social connection and helping others.

Job is the very thing that made him 'ill' - is there an unmet need in goal and ambition? once he gets a good job, will he be 'recovered'? (maybe that is why there is so much pride and joy in HV facilitator/author, it is part of his healing process?) - peace and acceptance once achieved job (that his father would have wanted him to have had, please him) - own business, whose goal is this, fathers?

Conflicts: silence vs. freedom

Cultural identity: identify as West Indies - in prose spoke about "they" / "them", indicates a sense of detachment? also not really know what culture say about HV

if non-HV, how be different?: rich, £, something about fulfilling father's dreams & ideals

Identity & personhood: sense of isolation & loneliness - in pursuit of happiness

HV as "ill" (concept; language)

- no positive aspect or protective element to HV experience (although recognition that relationship with HV has now changed).
- difficulty in identifying/clarifying what else was going on at the time of HV triggers - hazy memory, blur, long time ago but dates as memorable.
- language conforms to illness narrative - conformity to societal discourse
- medical language as the historical language to MH exps, as dictated by psychiatry and medicine
- BUT indefinite concept of HV as ill forever
- KEY Q if a p is no longer HV (or no longer meets DSM criteria) are they still diagnosable? are they still a label? consider meaning of this and impact upon identity, processing of exp, and transition back into community, and on future directions in terms of life goals/achievements

Process

Before the interview I was anxious as it was my first one, and throughout the interview I wondered whether I was asking the 'right' questions. After the interview I felt very appreciative of his story, (his effort, investment, time) and privileged to have his experience shared with me.

In the process of interview I felt validated in my skills, his experience, the research process and the connection that we shared.

2. Analysis of the narrative

    i. I transcribed the interview verbatim
   ii. I analysed the transcript by hand
  iii. I transferred the notes by hand to an electronic document, re-writing the analysis
  iv. I re-listened to the audio with particular questions in mind
   v. I re-listened to the audio and made further notes (in sub-headings below)

Re-listening to the audio and identifying a chronology of the narrative establish sequence, structure, subplots, turning points, and a beginning/middle/end

- Summary of life: quiet person - job, college
- HV/ill
- Family - West Indian community
- College/employment
- Hospitals (old - insitutions)
- Suicide/self-harm
- Classroom not cope because of HV
- HV - critical - 'growing thing'
- Relationship with father - hopes & expectations - West Indian family e.g. migration
- Cultural differences (Maths in school example) - education/class/culture
- Differences West Indian vs. British
- School - not experience racism (experienced by adults naming it only)
- 'Out of place' - talents - HV group facilitator
- Books (change in narrative) i.e. perform knowledge
- *Break to get water @ 38 min. approx.*
- Cultural understandings re HV = secret, shame, never spoken about, guilt in family
- Authored book (family not pleased)
- Friendships (not many)
- Literature re positive thinking e.g. Psychology, personal development
- Meditation
- Western model of HV/diagnosis
- Recovery
- Racism & discrimination
- Access to services / relationship with GP
- Experience of paranoia (1991) - lost, distressed, hospitalised
- HV this year (2015) triggered by bereavement
- Strategies to cope e.g. seek help with counselling (focus goals, recognise signs, pro-active)
- HV community (as a team, social, connection)
- Class & culture re HV (West Indian culture believe HV is a 'bad thing' - what others told him. 'our' pronoun used - framed as protective by/of parents
- Things different if in touch with self when young = identity/creativity
- 'Why put your dreams on hold?'
- Future goals i.e. life coaching with big organisations

Turning points

- Attempted suicide
- Speaking out vs. living in silence - write book, book to family, permanent form as adult
- Helping others - as XXXX (job title), as HV group facilitator (to be at ease with their voices, not feel alone, HV group as tool rather than recreation)

Discourses

Pressure from West Indian parents: cultural; age; gender

Hx, social, political

- migration
- institutions
- legal/MH care acts

Education - cultural differences in learning > class differences (poverty?) lead to stigma of "troublemakers"

Racism - perpetuated and maintained by adults

Employment - XXXX (job title); HV group facilitator; author

Macro system - broader societal discourses

Historical and political contexts of migration: 1950s referred to as the 'Windrush Era' with a wave of migration from the Caribbean to the UK. Communities were established and lived in dense populations in urban cities. Stories told reflected a sense of community within the West Indian culture, such as friends and relatives cooking together, sharing domestic and childcare resources, highlighting community relationships.

Social and cultural context of West Indian background and born and raised in inner-city UK.

Cultural stigma re HV from West Indian community & Pentecostal churches (religion see HV as 'devil'?)

Cultural discourses re what valued in a man (gendered discourses) i.e. "business-like", "sportsman-like", therefore not recognise or appreciate his creativity

1960s England/inner-cities - racism; social divisions

Historical reflections on the legal system in 1981 and the Community Care Act. Reflects discourses at the time around mental health hospitalisation and a social movement towards de-institutionalization.

Western values of young male adult (43m) - post hospitalisation was a young adult trying to "grapple with life" trying to find a "job" and a "girlfriend".

Western values of recovery - "settled" (family, partner?); "job (own business)" & "reasonable health" (off meds hopeful but unrealistic for p?). It is questionable that he does not identify himself as 'recovered', despite one of the greatest recovery stories of personal growths amongst all participants. Is this self-stigmatisation of still being on medication? Does taking medication mean he is not recovered, and if he were to not take medication would he be recovered or risk 'relapse'? Or is this how society positions him? How does his understanding and affiliation of recovery impact his identity?

Future ideals - £, rich, house, job - fit with Western discourse (capitalist & individualistic society) - (same ideals as Pp.D&E)

When asked where he will be 1 year from now he acknowledges climate of adversity. This reflects the wider political social systems of the current day (December 2015) and implies instability for the general public in relation to financial position and welfare as a response to cuts in the benefit system

Language

- ADULTISM
- PEOPLEISM
- disaster
- fell
- crisis
- ILL = tragedy
- separates concepts of mental health & physical health
- SH = traumatic
- growth

*high reps & long pauses employed throughout narrative

Dialogue & performance

- Performs knowledge with books
- Position self as expert e.g. as XXXX (job title), in HVN training certificates
- Shared sarcasm
- Shared laughter - humour and jokes used in conversation
- Delivery & tone = gentle, softly spoken, lengthy pauses, slow pace

- Reports turning 'cold' towards end (1hr10m) when talking re how relate to HV now

Relational reflexivity & position in co-construction

- Me as active summariser
- Validate e.g. "sorry to hear that"
- Laughter & rapport
- I sense make (sounds like a 'secret', 43m) and invite him to sense-make - demonstrates co-construction
- 1st half p more dominant in creating narrative, 2nd half narrative guided in line with interview schedule - balance of co-construction throughout - reflect that before his break for water he said "before you go" as if the interview was finishing, perhaps he had said all he wanted to say or assumed I had nothing further to ask. This is reflective of the style of the narrative shifting from being long p turns in first half, to the researcher bringing in questions more actively in the second half

Master narratives

- Crisis > plant metaphor re growing, coming out of the ground, changing direction
- Speaking out in permanent form = freedom from living in silence (46m)
- "Made the leap that covered the bridge"

Subplots

- Law & college as lost aspirations
- West Indian community - sense of sharing -
- Culture & HV = secret, shame, never spoken of, guilt in family (book went unnoticed/not recognised by family, a metaphor of p's exp of HV, p's identity, & position in family?)
- Institutionalization (old hospitals, p in daisy chains - fear not getting out)
- Attempted suicide/self-harm - acute crisis was found by neighbours/1st port of help/contact with services, not know re MH/HV
- HV as critical (father's voice) - anger with voices ("this is not me")
- Paranoia (10 years later) - Para & HV
- Relationship with father - admire, please, incapable
- Social divisions (radio in 1960s)
- Helping others, sharing - book, HV group facilitator, life coach
- Alternatives to estern model re HV - Positive thinking & secular ideas - PSYC - relaxations & meditation (contrast in use of language as 'ill')
- Western model = loss of hope - "that's it"

- Dx - not know what it meant, means something, not know now, "general attitude", can;t get job, double bind & double discrimination
- Recovery - settled (family), job (own business), reasonable health (off meds?) - change in relationship with voices

Quotes

Extracting relevant quotes in chronological order from the transcript, connecting quotes to themes and contexts within the narrative to formulate verbatim quotes into global impression

Ghostly audiences (speaking out)

Other people who HV

People who are not following their own path - identity, ambition