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Abstract

Objectives: This paper is a narrative review of the effectiveness of interventions aimed at understanding the content and meaning of the experience of voice hearing, also known as auditory verbal hallucinations, and putting them into the context of mental health nursing practice.

Background: The current literature around voice hearing reveals weaknesses in the traditional psychiatric understanding of voice hearing as a symptom of underlying biological illness. There is growing support for treating the voices as valuable and exploring their content and meaning, but little evidence to support this at present.

Methods: A narrative review of the literature is synthesised from the findings acquired through search of electronic databases, combined with additional manual searching, in respect of systematic inclusion and exclusion criteria.

Findings: Five papers meeting the inclusion criteria were selected. Following critical analysis, six themes emerged consisting of three insights (Experience of VH, Meaning, Personal Significance) leading to three therapeutic outcomes (Relationship with the Voices, Emotional Impact, and Functioning). Appraisal of the methodology found a lack of convincing empirical evidence for the intervention, but this was mitigated by the qualitative value of the research and the parallels with the extant literature.

Conclusions: Exploring the content and meaning of the voices may be a valuable intervention voice hearers could choose, however there are potential adverse effects which need careful consideration and management. The implications for incorporating the approach into evidence-based mental health nursing practice are discussed. Recommendations are made for further research.

Background

This introduction will define voice hearing (VH) and briefly examine psychiatric and psychotherapeutic approaches to it. Factors causing emotional distress in voice hearers, and the role of trauma, will be explored. Finally the Hearing Voices Movement (HVM) and the “Making Sense of the Voices” approach will be introduced, with a discussion of current literature on the subject and its relevance to mental health nursing.

Voice hearing (VH), often termed Auditory Verbal Hallucinations (AVH), refers to the experience of hearing voices when there is no speaker present, and is frequently encountered in psychiatric illness (Waters, 2010). Traditional psychiatry sees AVH as a symptom of an underlying biological disease (Kraepelin, 1919) such as schizophrenia or mania (WHO, 2010), and interventions aim to reduce or remove the voices, generally using antipsychotic medication (NICE, 2014). Antipsychotic effectiveness has been evaluated by measuring hallucination presence, frequency and intrusiveness, for example the Brief Psychiatric Rating Scale (Overall and Gorham, 1962) or the Positive and Negative Symptom Scale for Schizophrenia (Kay and Fiszbein, 1987). Antipsychotics have been associated with increased mortality (Joukamaa et al, 2006) and with poorer functioning at 7 year follow-up despite an improvement after the first 2 years (Wunderink et al, 2013). It is estimated that medication only produces significant benefits in around 20% of people with psychotic disorders (Morrison et al, 2012). Traditional psychiatry, therefore, views AVH as a symptom of underlying pathology and attempts to reduce or eliminate them. The methods used, however, can be ineffective and even harmful, and measures of their efficacy are based within the paradigm of “symptom” reduction. Increasingly, voice hearers are seeking

alternative explanations for their experiences (for example BPS, 2014). Romme and Escher (2000) argue that VH in itself is not pathological, as many voice hearers never need mental health services. This paper discusses “voice hearing” (VH) rather than AVH, as the latter implies a symptom to be treated rather than an experience to be understood.

Qualitative research into recovery from psychosis has found that “wellness” is associated with people learning to understand and manage psychotic experiences (Davidson, 2003; Dilks et al, 2010). Cognitive Behaviour Therapy aims to reduce the distress caused by VH by examining the beliefs people hold about their voices (Lakeman, 2001) and the way they react, supporting them to respond differently. Therapies aimed at improving the relationship of the person with their voices have had some success (Chin et al, 2009; Jackson et al, 2010). Newer approaches such as Avatar Therapy (Leff et al, 2014) are concerned with directly engaging with the voices people hear with the aim of allowing the voice hearer to improve their relationship with the voices.

Various research has found that distress is greater when the voices are perceived as uncontrollable (Close and Garrety, 1998; Brett et al, 2014). Vaughan and Fowler (2004) noted that those whose voices were “dominating, insulting” were more distressed, as were those who reacted to their voices with suspicion and avoided communicating with them. Voice content has been shown to be the single most important factor determining whether the hearer is distressed and requires mental health interventions (Beavan and Read, 2010). On balance, the content of voices is clearly an important factor in the emotional impact of VH and might merit exploration.

There is a widely acknowledged link between adverse childhood experiences and psychosis in adulthood (Bendall et al, 2013; Manning and Stickley, 2009; Hammersley et al, 2008; Ackner et al, 2013). Further, the specific experience of VH has been shown to be especially common in survivors of childhood trauma, especially childhood sexual abuse (CSA) (McCarthy-Jones, 2011; Sheffield et al, 2013). Although McCarthy-Jones found no clear evidence for a causative link, he concedes there is evidence that voice content can be

influenced by CSA and that the structure of the developing brain changes in response to abuse. We know, therefore, that VH is linked to a person's life experiences, but not how; this lack of knowledge has been highlighted as a direction for future study (Thomas et al, 2014).

Mental health nurses are being urged to help voice hearers explore and make sense of their experiences (Lakeman, 2001; Cameron and McGowan, 2013; Sapey and Bullimore, 2013). Place et al (2011) report some very tentative evidence that supporting the voice hearer to construct a narrative to understand their voices produces positive results both for staff satisfaction and service user experience. Community mental health service users, likewise, felt their nurses' interventions would be more helpful if they investigated the content and meaning of voices more (Coffey and Hewitt, 2008). It is understandable that nurses ignoring voice content would be identified as a limitation given that until fairly recently, they were trained to dismiss hallucinations as nonsensical, to avoid reinforcing the patient's delusions. As recently as 1987, nurses were advised that "Basically the patient must learn to devalue his hallucinations" (p. 304), because "The nurse must avoid reinforcing the patient's break with reality" (p. 305). (Martin, 1987). Coffey and Hewitt (2008) found this belief still persisted among some practising mental health nurses.

Romme and Escher (1989; 2000; 2009; 2012) provoked a paradigm shift when they argued that many voice hearers function perfectly well, but that those with troublesome voices are traumatised individuals with adverse past experiences. They analysed fifty recovery stories and drew out eight themes of recovery informing their Maastricht Approach, supporting voice hearers to make sense of their voices. The HVM, inspired by Romme and Escher's work and led by voice hearers, sees value and meaning in voice content, viewing "Making Sense of the Voices" as critical to recovery (HVN, 2016) and running peer support "Hearing Voices Groups" (HVGs) to deliver this. Despite existing literature on HVGs, further research is required into the specific mechanisms by which they benefit voice hearers (Ruddle et al, 2011). There is therefore a need to isolate the intervention of exploring content and meaning

of voices in a one-to-one context, excluding other qualities such as peer support, and hence reliably establish whether the intervention brings about recovery.

Empirical evidence for the effectiveness of this approach is extremely limited despite its growing popularity; possibly because it is difficult territory to research (Corstens et al, 2014), thus national guidance does not support it (NICE, 2014). It is also worth noting that a significant proportion of health research is funded by the pharmaceutical industry (Cooksey, 2006). This limits the potential for research into interventions which reject the medical model of mental illness, as it is not in the interests of many who could fund it. Additionally, the HVM emphasises the importance of alternatives to existing mental health services and therefore its members are not inclined to participate in scientific research to make the interventions acceptable to the psychiatric establishment. The conflict is therefore reciprocal, however if practitioners are to base their practice on the best evidence (DH, 2011), then this needs to incorporate the wisdom of “experts by experience”. (Corstens et al, 2014, p. S285).

The limitations of traditional paradigms and new knowledge about the value and meaning of VH are therefore driving the Making Sense of the Voices approach. Mental health nurses are being encouraged to adopt this approach although it falls outside national guidance and can present attitudinal challenges. There is no recent review of the literature on this important emerging area for psychiatric nursing, necessitating a current literature review to evaluate the approach and assess its relevance to evidence-based nursing.

Aims and Objectives

The aims of this paper are to critically appraise the most recent evidence regarding the effectiveness of investigating the content and meaning of VH as a one-to-one therapeutic intervention, and to examine whether and how it can be incorporated into mental health nursing practice.

Objectives:

1. To investigate the specific way in which content and meaning of voices was explored
2. To understand the context in which the intervention was delivered
3. To critically evaluate the rigour of the research conducted
4. To analyse the risks, benefits and ethical challenges of each approach
5. To evaluate therapeutic outcomes and their transferability to practice
6. To explore how each approach co-exists with other interventions for voice hearers.

Ethics

Only ethically sound literature was included in the review, and all material was appraised in a similar way to ensure justice. Ethical implications of the approach are addressed within the discussion section.

Method

Subject Identification

A preliminary search on CINAHL using the search terms “auditory hallucinations” and “content and meaning” found no systematic qualitative or quantitative research meeting the research aim (see Fig. 1), leading to the decision to conduct a narrative review including descriptive and non-research literature.

The screenshot displays a web browser window with the URL web.b.ebscohost.com/ehost/results?sid=a1738734-a376-457b-bac1-c155d2144588%40sessionmgr111&vid=2&hid=105&bquery=content+AND+meaning&bdata=JmRiPWnpbjwJnR5cGU9MCZzaX. The search interface includes a search history table and a list of search results.

Select/deselect all	Search with AND	Search with OR	Delete Searches	Refresh Search Results
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Search ID#	Search Terms	Search Options	Actions	
<input type="checkbox"/> S3	(content and meaning) AND (S1 AND S2)	Search modes - Boolean/Phrase	View Results (2) View Details Edit	
<input type="checkbox"/> S2	content and meaning	Search modes - Boolean/Phrase	View Results (1,711) View Details Edit	
<input type="checkbox"/> S1	auditory hallucinations	Search modes - Boolean/Phrase	View Results (237) View Details Edit	

Refine Results

Current Search: Boolean/Phrase: (content and meaning) AND (S1 AND S2)

Limit To: Linked Full Text, References Available, Abstract Available. Publication Date: 2009 to 2012.

Source Types: All Results, Academic Journals (2)

Search Results: 1 - 2 of 2

- Initial evaluation of the effects of competitive memory training (COMET) on depression in schizophrenia-spectrum patients with persistent auditory verbal hallucinations: A randomized controlled trial.**
(includes abstract) van der Gaag, Mark; van Oosterhout, Bas; Daalman, Kirstin; Sommer, Iris E; Korrelboom, Kees; British Journal of Clinical Psychology, Jun2012; 51(2): 158-171. 14p. (Journal Article - research, tables/charts, randomized controlled trial) ISSN: 0144-6657 PMID: 22574801
Subjects: Schizophrenia Complications; Depression Therapy; Memory; Hallucinations Therapy; Adult: 19-44 years; Middle Aged: 45-64 years; Male; Female
[Link to Full Text](#) [Check 360 Link for Full Text](#)
- "You don't talk about the voices": voice hearers and community mental health nurses talk about responding to voice hearing experiences.**
(includes abstract) Coffey M; Hewitt J; Journal of Clinical Nursing, Jun2008; 17(12): 1591-1600. 10p. (Journal Article - research, tables/charts) ISSN: 0962-1067 PMID: 18482121
Subjects: Community Mental Health Nursing; Hallucinations; Hallucinations Nursing; Nurse Attitudes Evaluation; Patient Attitudes Evaluation; Adult: 19-44 years; Middle Aged: 45-64 years; Female; Male
Cited References: (39) Times Cited in this Database: (8)
[Link to Full Text](#) [Check 360 Link for Full Text](#)

Page: 1

Figure 1: Screen shot of preliminary search on CINAHL

Inclusion and Exclusion Criteria

The search terms were broadened given the wide range of synonyms for both VH and “Making Sense of Voices” (Schnackenberg and Martin, 2013). In a narrative review, Green et al (2006) advise using systematic inclusion/exclusion criteria based around the research question. Table 1 details the criteria developed:

Inclusion Criteria:
<ol style="list-style-type: none">1. Presence of VH as primary issue2. All psychiatric diagnoses, and people without a diagnosis3. Content and meaning of voices explored as primary intervention4. Discussion of effectiveness of intervention5. Context of a professional therapeutic relationship
Exclusion criteria:
<ol style="list-style-type: none">1. Evidence from group interventions such as HVGs2. Does not meet majority of criteria on appropriate checklist

Table 1: Inclusion and Exclusion criteria

Search Strategy

The databases CINAHL, MEDLINE, PsycINFO, PubMed, TRIP Database Plus and the Cochrane Library were searched using the terms “Hearing voices OR voice hearing OR auditory hallucinations OR auditory verbal hallucinations OR psychotic experiences OR psychotic symptoms OR psychosis OR psychotic illness OR voices OR intrusions OR psychotic-like anomalous experiences” AND “Biographical OR narrative OR making sense OR exploring OR experience-focussed counselling OR hearing voices movement OR life history OR life experiences OR story”. The dates of the search were limited to between 1989 (the year of Romme and Escher’s first publication on the importance of exploring voice content and meaning) and 2015. The searches were carried out between 1st October and 30th November 2015. A manual search through the references cited in relevant articles found was also conducted.

Resources

The author carried out all searches alone, accessing literature free of charge via the university library and the local mental health NHS trust

Appraisal Strategy

The literature was analysed using checklists appropriate to the design (Green et al's (2006) Narrative Overview Rating Scale and the Joanna Briggs Institute's Critical Appraisal Checklist for Narrative, Expert Opinion and Text (JBI, 2014)). A score was given based on the checklist. Where an item was partially met, a score of $\frac{1}{2}$ was given. Figure 2 shows the article selection process used:

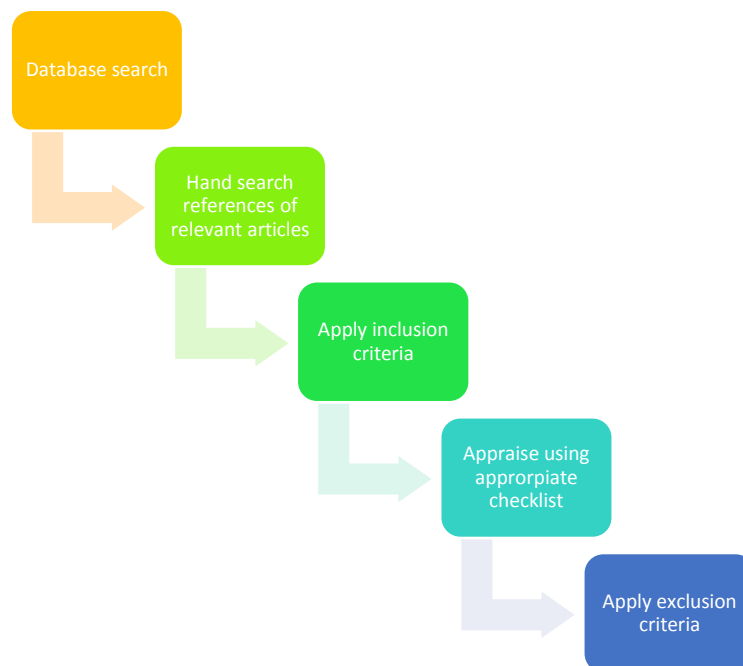


Figure 2: Flow Diagram of Article Selection Process

5 Results

Table 2 presents the five pieces of literature selected. Table 3 (Appendix 1) synthesises their main findings. They are ordered in terms of their strength according to the Hierarchy of Evidence (Guyatt et al, 1995) and then in terms of quality.

Paper	Author(s)	Year	Title	Type of Study
Paper 1	Schnackenberg, J. K. and Martin, C. R. (2014).	2014	The Need for Experience-Focused Counselling (EFC) with Voice Hearers in Training and Practice: A Review of the Literature	Narrative Review
Paper 2	Suri, R.	2011	Making Sense of Voices: An Exploration of Meaningfulness in Auditory Hallucinations in Schizophrenia	Narrative review with case study
Paper 3	Corstens, D., Longden, E. and May, R.	2012	Talking With Voices: Exploring what is Expressed by the Voices People Hear. Psychosis	Description of method, with case examples
Paper 4	Longden, E., Corstens, D., Escher, S. and Romme, M.	2012	Voice Hearing in a Biographical Context: A Model for Formulating the Relationship Between Voices and Life History	Description of method, with case study
Paper 5	Davies, P., Thomas, P. and Leudar, I.	1999	Dialogical Engagement with Voices: A Single Case Study	Description of method, with case study

Table 2: The five papers selected for review.

Each paper's rationale for the "Making Sense of Voices" approach and the methods and interventions employed by each are now examined.

Rationale

Paper 2 summarises related psychoanalytic theory, viewing VH as a way the psyche communicates difficult issues. Paper 4, similarly, describes VH as a defence mechanism developed to cope with unbearable emotions and propose that exploring voice meaning can help uncover and address the emotions involved. Paper 3 is based on the principles of Voice Dialogue (Stone and Stone, 1989), seeing voices as being dissociated parts of the personality, and seeking to reintegrate them into the psyche. Paper 1 asserts that passivity and biological explanations of voices are unhelpful, arguing that seeking meaning within the experience must increase empowerment and active recovery. Paper 5 identifies and builds upon the more helpful aspects of cognitive therapy such as the realisation that ignoring the voices can lead to an increase in their perseverative and intrusive qualities. These stances show two different strands of thought, the first being that voices indicate unresolved issues and emotions which can be exposed and addressed by exploring voice content and meaning. The second, more pragmatic, strand builds on what is known about the helpfulness of existing approaches.

Context

While Paper 1 explores Experience-Focussed Counselling by all mental health professionals, the remaining papers take place within the context of psychotherapy and involve therapy-specific skills such as dialogical analysis and the use of structured interviews, meaning a mental health nurse would likely require further training to use the methods.

Interventions

Papers 3 and 4 used a structured interview based upon the Maastricht Approach (Romme and Escher, (2000). In Paper 4 the information gathered is used to identify who, or what, the voices represent, and the social and/or emotional problems represented by the voices. A psychotherapeutic treatment plan is developed from these answers.

Paper 3 uses the Maastricht Interview only to understand context. The “facilitator” then explores the voices by speaking with them directly through the voice hearer. The voices are treated as separate personalities with their own wants and needs. The approach used in Paper 5 is similar to Papers 3 and 4 in that it uses a structured interview; in this case it is the Leudar and Thomas Interview (1995). The findings are analysed dialogically (exploring the “conversation”), focusing on how the voices relate to the hearer and who they could represent. Paper 3, then, is different in that the voices are seen as separate entities and are communicated with directly, whereas the others involve the voice hearer and therapist collaboratively exploring content from an external perspective. This may contradict Romme’s (2012) recovery theme of “recognising your voice as personal” (p. 158), as treating the voices as separate entities might prevent recognition of their personal significance.

Discussion

Critical analysis of the five papers revealed six emerging themes of insights leading to therapeutic outcomes (Figure 3); these are discussed below. The findings are then critically appraised with respect to ethical challenges, bias, validity, reliability and generalisability. The implications for practice and future research are evaluated throughout.

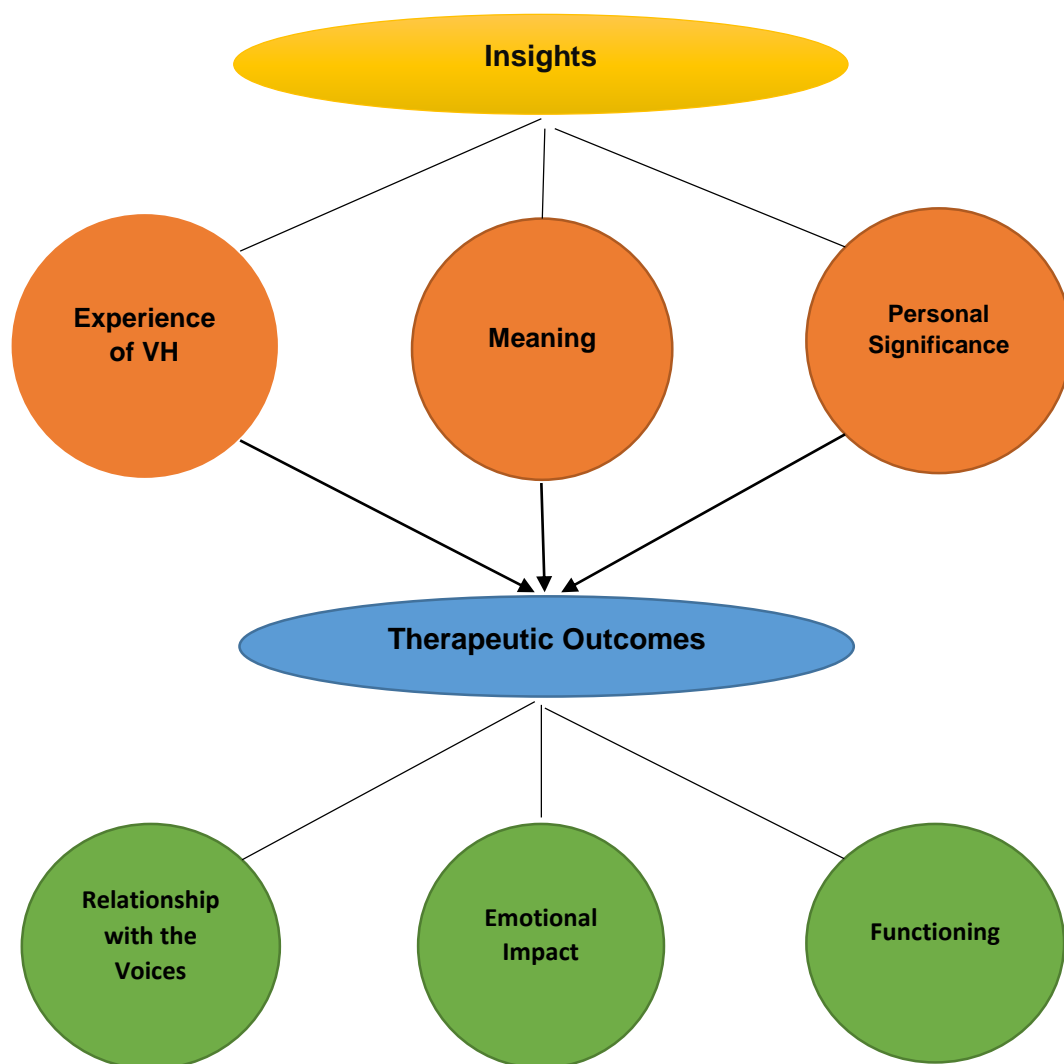


Figure 3: Emerging themes from the literature

Themes from Findings

Insights

Experience of VH

None of the literature reviewed sought to reduce or eliminate VH. Paper 1 describes the person learning to live with and not eliminate the voices. Paper 3's authors sought to accept the voices and improve the relationship with them. Paper 5's objective, likewise, was reduction in distress, not reduction in voices. Paper 4's case experienced a reduction in the more distressing voices, but this was not the intention of the intervention, and the patient began to notice the protective role of her voices. Thus although the voices remained present, their presence ceased to be a problem; these findings agree with the view of Romme and Escher (2000) and contrast starkly with the traditional psychiatric model of seeing VH as a symptom to be cured (Kraepelin, 1919)

Meaning

Papers 1, 2, 4 and 5 concluded that voice meaning highlights issues such as unresolved emotions, specific relationships and dissociated trauma, which fits logically with the concept of VH being linked to past adverse experiences. The fact that they all agree lends weight to the argument that VH is meaningful and should not be dismissed as nonsensical. Previous advice such as that of Martin (1987), rejecting the meaningfulness of VH, can therefore be challenged in light of these findings. Although Paper 3's introduction does acknowledge the role of trauma, the conclusions focus more on changes in the relationship with the voices as a result of the intervention and less on making sense of how the voices relate to past experiences

Personal Significance

Paper 4's subject began to recover as she made sense of how the voices related to her past experiences. Similarly, in Paper 2 the male subject realised he needed to understand the

function of his voices and address the trauma at their root. Paper 5 describes the importance of “focusing” to tease out the personal significance of voice content. These findings strengthen Romme’s (2012) assertion that recognising the personal significance of VH is integral to recovery, and also indicate that exploring voice content and meaning might illuminate the relationship between trauma and VH, as called for by Thomas et al (2014).

Therapeutic Outcomes

Relationship with Voices

Romme (2012) highlights the importance of changing the relationship with the voices, a process cited as significant in Papers 3, 4 and 5. In Paper 3, the facilitator negotiated directly with the voice, for example suggesting ways it could become more supportive and less critical of the hearer. In Paper 4, on the other hand, recognition of the significance of past events indirectly led to the voices being perceived as less bullying, critical and intimidating, and to the hearer recognising their protective role. Paper 5’s case developed a new, supportive and reassuring, voice which mediated between the hearer and her other voices. Thus while Papers 4 and 5 found indirect improvements in the relationships with the voices, Paper 3 targeted this directly, almost conducting “relationship counselling” between voice and hearer. These are positive outcomes, as improved relationships with the voices reduce the distress felt by the hearer (Vaughan and Fowler, 2004).

Emotional Impact

Paper 3 reports their approach is empowering and validating, and reduces the sense of isolation. Paper 5’s subject felt comforted and reassured by the new voice, and her friend noticed an improvement in her self-esteem. The individual in Paper 4 experienced a reduction in fear and shame. If, as Beavan and Read (2010), point out, distress is the most important factor determining whether an individual requires mental health services, then improved emotional wellbeing could be a significant outcome.

Functioning

Paper 4's patient started studying at university, met a new partner and was able to reduce her antipsychotic medication with a view to discontinuation. A friend of Paper 5's subject felt her functioning improved; she also began driving again and felt able to suggest a reduction in her antipsychotic medication. Paper 3 reports that one of their patients became able to work with his voices to set attainable occupational and social goals. These anecdotal findings are encouraging, but less compelling than empirical evidence (Houser, 2015).

Risks

In view of the link with childhood trauma (McCarthy Jones, 2011; Sheffield et al, 2013) and the concept of VH as a defence mechanism for unbearable emotions (Longden et al, 2012), exploring voice content may cause harm. The ethical consideration of non-maleficence - ensuring interventions do not harm their recipients (Beauchamp and Childress, 2013) is relevant here. As previously noted, Paper 5's patient developed a new voice, which could be seen as evidence of mental deterioration. Paper 3 warns of a risk of dissociation, recommending the approach not be undertaken without adequate skill in responding appropriately to trauma, and discussing coping strategies beforehand. Paper 4 identifies a supportive therapeutic relationship as crucial because of the painful emotions which may be uncovered. The therapeutic relationship is a cornerstone of nursing (NMC, 2015) thus the nurse can amply deliver this requirement. It is worth noting that all interventions were carried out by experienced psychotherapists skilled enough to support the voice hearer through a sometimes difficult process. The current evidence, therefore, does not support attempting such approaches without adequate skill, especially around psychological trauma.

Further, De Jager et al (2015) identified two distinct ways that voice hearers recover. The first involved exploring and understanding the voices, however the second involved "turning away" from them as a basic survival strategy. On balance, whilst exploring the voices could

be useful, it is not always appropriate. Decisions about care should be made by the individual receiving it (NMC, 2015), so informed consent is paramount

Limitations

Bias

In all the papers, a lack of randomisation and discussion of how cases were recruited could indicate selection bias (Polit and Beck, 2014). There is no discussion of cases where the approach was used unsuccessfully, which may suggest reporting bias (Polit and Beck, 2014). Papers 1 and 5 in particular suffered from a lack of critical analysis of other pertinent research. Much of the literature was written by the same authors, relying heavily on their own work. Paper 4, co-authored by Romme, for instance, uses Romme and Escher's (2009) 50 stories of recovery; Paper 5 similarly relies on previous work by its authors (Leudar et al, 1997). These factors could again produce bias. Bias is widely recognised as a limitation in qualitative literature, but the insights gained can nonetheless be valuable (Flick, 2011), however this indicates the need for future work by varied researchers to generate objective evidence.

Validity

A strength of Paper 3 was the detailed description of the method, making it much easier to replicate and study further. As the researchers, however, base their approach on a working relationship with the patient, this compromises validity because it is not clear whether it is the relationship or the intervention which helped (Orlinsky et al, 2004). The authors intend to proceed with further systematic research into the "Talking With Voices" method. It would be useful, although difficult, if further research could isolate the intervention from the therapeutic relationship.

Reliability

No objective outcome measures were used in any papers, making it difficult to assess the reliability of the interventions. Recovery is by definition an individual process (Rethink, 2014), and recovery goals are different for everyone. Objectivity becomes nonsensical when working with individual meaning (Suri, 2011). Interventions offered by health care professionals, however, are only justified if the intended outcome is understood, and outcomes must be measurable to allow evaluation of the intervention. One solution could be using the Mental Health Recovery Star (Triangle, 2015) as a holistic and collaborative way of measuring recovery progress, although this has not had its reliability and validity assessed. The emotional impact of interventions could equally be measured in further research.

Generalisability

Paper 2 concerns only people diagnosed with schizophrenia, contrary to Romme's (2012) assertion that many people, with and without psychiatric diagnoses, hear voices. There is, however, a growing argument that psychiatric diagnoses are unhelpful and should be abolished (Szasz, 1976; BPS, 2014; Timimi, 2014), making Paper 2's focus an arbitrary subset of individuals within the broader population of voice hearers. Paper 2's findings could therefore be generalisable. The sample sizes were small, meaning we do not know whether the individuals studied are representative of the population. Paper 5 explicitly notes it was not originally designed as an intervention study and is therefore not replicable. This indicates the need for research into a larger sample.

Evaluation

The above limitations were also noticed by Paper 1, whose thorough critical appraisal of the literature meant that all relevant articles were excluded from their systematic review due to lack of scientific rigour. This tactic ensures only the best evidence is used, but risks overlooking potentially valuable insights (Flick, 2011). The authors proceeded with a narrative review, and they advocate using more traditional research methods in future study.

Whilst the current evidence lacks scientific rigour, the evidence base for biological models and treatment of psychosis is also limited (Schnackenberg and Martin, 2013; BPS, 2014). There is clearly an appetite amongst voice hearers for Making Sense of Voices given the growth of the HVM (Corstens et al, 2014), therefore as Suri (2011) points out “on what grounds do we disregard auditory hallucinations?” (p. 166).

Limitations

This was not an exhaustive review due to constraints of time and being limited to articles which could be accessed free of charge; nor was it systematic as it used different appraisal checklists. Although Green et al (2006) suggest contacting authors of previously published research, time and resource limitations constraints of time meant this was not possible.

Conclusions/Recommendations

This paper has reviewed current evidence around exploring the content and meaning of VH as a one-to-one intervention. The lack of systematic research found led to a narrative review, and various approaches were identified. Interventions were collaborative and largely carried out by psychotherapists; mental health nurses may require further training to provide them effectively, although the therapeutic relationship is a key existing skill. Elimination of the voices was not an objective. The significance and meaning of VH was highlighted. Outcomes involved better relationships with the voices, increased emotional wellbeing and improved functioning. Potential risks include development of more voices, emotional distress, and dissociation, necessitating informed consent and appropriate skills. The findings are not scientifically compelling; however nor is the evidence surrounding traditional biological constructs of VH. Further objective and systematic study with many more voice hearers, using clear outcome measures, is indicated. On balance, the positive outcomes noted suggest that ethically exploring the content and meaning of VH could be a valuable addition to existing nursing interventions for VH.

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