

Interpersonal and role-related schema influence the relationship with the dominant ‘voice’ in schizophrenia: a comparison of three models

MAX BIRCHWOOD, PAUL GILBERT*, JEAN GILBERT, PETER TROWER,
ALAN MEADEN, JUSTIN HAY, ELEANOR MURRAY AND JEREMY N. V. MILES

*Birmingham and Solihull Mental Health Trust; University of Derby; Derbyshire Mental Health Trust;
University of Birmingham; University of York*

ABSTRACT

Background. Auditory hallucinations in psychosis often contain critical evaluations of the voice-hearer (for example, attacks on self-worth). A voice-hearer’s experience with their dominant voice is a mirror of their social relationships in general, with experiences of feeling low in rank to both voices and others being associated with depression. However, the direction of the relationship between psychosis, depression and feeling subordinate is unclear.

Method. Covariance structural equation modelling was used with data from 125 participants diagnosed with schizophrenia to compare three ‘causal’ models: (1) that depression leads to the appraisal of low social rank, voice power and distress; (2) that psychotic illness leads to voice activity (frequency, audibility), which in turn leads to depression and the appraisal of voices’ power; (3) our hypothesized model, that perceptions of social rank and social power lead to the appraisal of voice power, distress and depression.

Results. Findings supported model 3, suggesting that the appraisal of social power and rank are primary organizing schema underlying the appraisal of voice power, and the distress of voices.

Conclusions. Voices can be seen to operate like external social relationships. Voice content and experience can mirror a person’s social sense of being powerless and controlled by others. These findings suggest important new targets for intervention with cognitive and social therapy.

INTRODUCTION

Auditory hallucinations are a core feature of the diagnosis of schizophrenia (Jablensky *et al.* 1994). They can also be found in other diagnoses (Altman *et al.* 1997) and in community samples who do not present to services (Van Os *et al.* 2001). The presence of auditory hallucinations in non-help-seeking community samples emphasizes that the experience of voices *per se* may not or may not be distressing. Previous research found that over 60% of voice-hearers were ‘severely depressed’ and over 75% reported that

they were ‘highly distressed’ by the experience (Birchwood *et al.* 2000). Our cognitive model of voices that we focus on here attempts to understand the factors which *maintain* the distress and depression attached to voice hearing, rather than to develop a causal model (for example, the theory of intrusions and misattributions (see Morrison & Haddock, 1997; Morrison *et al.* 2000).

There are three possible models linking auditory hallucinations, distress and depression (Birchwood *et al.* 2000), outlined in Fig. 1. The first model suggests that depression is a core symptom of psychosis itself, and has the effect of reducing the voice-hearer’s tolerance of his/her voices, thereby leading to more distress.

* Address for correspondence: Professor Paul Gilbert, Mental Health Research Unit, Kingsway Hospital, Derby DE22 3LZ, UK.
(Email: p.gilbert@derby.ac.uk)

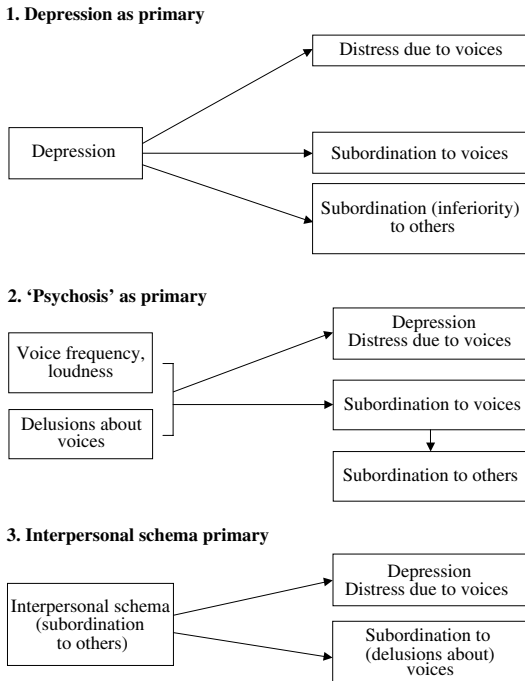


FIG. 1. Three models of distress arising from voices.

In support of this, recent factor analytic studies of psychotic symptoms have identified depression as a distinct dimension of psychosis, alongside the 'positive' and other symptoms, with its own regulators (Stefanis *et al.* 2002). The second model suggests that the greater the frequency and loudness of the voices, the greater the resulting distress and depression. In other words, the more severe the 'psychosis', the greater the distress. This is a common and classical position of psychiatry (Birchwood, 2003); severity of psychosis is a known risk factor in, for example, suicide (Westermeyer *et al.* 1991). The third model, our hypothesized model, stems from combining research on the cognitive model of 'voices' (Birchwood & Chadwick, 1997), with the social mentalities approach to interpersonal functioning (Gilbert, 1989, 1992, 2000).

Recent research on psychosis applying this integrated cognitive and social mentalities approach, with a focus on the social rank mentality (for recognizing and organizing dominate-subordinate interactions) and social power (Birchwood *et al.* 2000) has found that it is voice-hearers' appraisal of the power and omnipotence of voices (and their own subordination to them),

which determines their response, irrespective of the content. Thus, voices perceived as powerful and malevolent were at first resisted, but ultimately submitted to or appeased; 'benevolent' voices on the other hand, were courted and usually complied with (Beck-Sander *et al.* 1997; Birchwood & Chadwick, 1997). In a study of 70 voice-hearers (Birchwood & Chadwick, 1997), it was found that: (a) beliefs rather than content governed the response, and (b) the high rate of depression in this sample (60%) was directly attributable to the belief in the power of voices, and not voice frequency, loudness or indeed content. This work was independently replicated (Close & Garety, 1998; Sayer *et al.* 2000; van der Gaag *et al.* 2003) and in a subsequent study, it was found that these appraisals largely governed individuals' response to commands, rather than the command itself (Beck-Sander *et al.* 1997).

We have argued that the interpersonal relationship a voice-hearer has with his/her voice is partly shaped via recruitment of specialized social processing systems (social mentalities) that act as guides for social roles and scripts (for example, from attachment or social rank). People who experience others as powerful and threatening (perhaps as the result of past trauma or attachment problems – see Birchwood, 2003) are sensitized and attentive to threats and to the social power of others (i.e. others as hostile-dominant and self as vulnerable and subordinate) and the need to be vigilant to possible attacks, and take defensive actions. Birchwood *et al.* (2000) and Gilbert *et al.* (2001) found a significant relationship between how voice-hearers experience relationships with others in their everyday lives (for example, as relatively powerless, inferior and subordinated) and how subordinated and powerless they felt with their voices. Hence the dominant-subordinate social mentality becomes the social processing system that guides attention and evaluation of social signals, be they the relationship with the personified voice or others in the social domain.

As depicted in Fig. 1, there are a number of ways in which these key processes (for example, voice-self relationships and depression) may operate. First, depression 'drives' the linkage between hostile voice and subordinate self, that is, the more depressed one is, the more inferior one feels to voices and others and the more

distress voices will create. Secondly, a (delusional) belief in voice power could elicit subordinate self-perception and this, in the context of more severe (e.g. frequent) hallucinations, leads to depression and general distress. The third, hypothesized model, predicts that feeling inferior acts as the social mentality and psychobiological template to others in general, and thus sets the stage for the appraisal of voices as dominant, powerful and threatening, and the self as a subordinate, relatively powerless to resist or defend against the insults and shaming attacks of a voice. It is this trapped, shamed, beaten-down and threatened *social* experience which gives rise to distress and depression attached to voices.

Covariance structural equation modelling (SEM) was used in this study because it enables each of the 'paths' postulated to be tested (Ullman, 2000). SEM cannot 'prove' that a particular model is true, but it can reject competing models; this is analogous to the scientific method (Shadish *et al.* 2001). SEM has been used extensively in situations where there exist multiple independent and dependent variables (Bentler & Speckart, 1981).

METHOD

Participants

People conforming to the following criteria were identified from case registers held by the Assertive Outreach and Continuing Care Teams of the Mental Health Services of North Birmingham, South Birmingham and Derby, UK (population 1.5 million): voices heard for at least 2 years; conformed to ICD-10 criteria for schizophrenia, paranoid psychosis or schizophreniform disorder (WHO, 1992). Those with organic psychoses or psychoses linked to major substance misuse were excluded. The study was approved by local Research Ethics Committees in Birmingham and Derby health services.

Measures

Auditory hallucinations

Voice activity. Where patients reported more than one voice, they were asked to identify the more dominant or powerful one, which was the subject of the following voice assessment measures. It is acknowledged that by selecting

the most dominant voice this introduces a bias in favour of greater power differential; however, in our previous work, it was precisely the 'dominant' voice that was driving distress, and in this study we hypothesize this to be influenced by a social appraisal. Moreover, as in everyday relationships, although people can have a variety of relationships of different types, it is usually the most significant relationship(s) that will have the most powerful impact on affect. It is also usual for research to focus on one relationship, be this between a parent and child, boss and employee or romantic partner, rather than a host of possible relationships.

Voice topography. The attributes of the dominant voice were self-rated by patients using the Hustig and Hafner (1990) scale, which measures three dimensions: frequency, audibility and clarity. One week retest reliability for these scales was 0.8 or greater.

Distress. The Hustig and Hafner scale also enquires about the perceived distress experienced by the voices. This scale asks participants to rate how distressing (score 4 or 5) or comforting (score 1 or 2) they find the voice; a score of 3 represents neutral affect.

Voice beliefs and coping. Measures of voices' perceived malevolence and benevolence and two dimensions of coping, 'resistance' (e.g. 'I refuse to do what my voices say') and 'engagement' (e.g. 'I try to make contact with my voices') were taken using the Beliefs About Voices Questionnaire (BAVQ; Chadwick & Birchwood, 1995). These scales have sound psychometric properties (Cronbach's alpha 0.75–0.9; 1-week retest reliability 0.88–0.96). The content validity of these scales has been established in a series of studies (Chadwick & Birchwood, 1994, 1995; Birchwood & Chadwick, 1997; Birchwood *et al.* 2000; Chadwick *et al.* 2000) and independent replications (Close & Garety, 1998; Sayer *et al.* 2000; Van der Gaag *et al.* 2003).

Voice content: shame and humiliation. The capacity of voices to shame and insult is rated using the voice content scale of the BAVQ, which includes subscale measures of shame (i.e. 'the voice keeps reminding me of the bad things I have done'); omniscience ('the voice knows everything about me') and positive comments

(‘my voice tells me nice things about me’). Psychometric data on these scales have been previously reported (Chadwick & Birchwood, 1995); values for internal reliability range from 0.76 to 0.90 and retest reliability ranges from 0.88 to 0.90. The scale has high content validity (Chadwick & Birchwood, 1994).

Interpersonal and rank-focused schema

Power

The Voice Power Differential scale (VPD; Birchwood *et al.* 2000) employs a semantic differential scale of seven bipolar constructs linked to the concept of power and omnipotence. Hence the voice-hearer is asked the question, ‘in relation to my voice I feel ... much more powerful than my voice’ (score 1); ‘we have the same power as each other’ (score 3); ‘my voice is much more powerful than me’ (score 5), with intermediate descriptors for scores 2 and 4. Similar questions are asked in relation to voices’ perceived confidence, strength, knowledge, capacity to harm, respect and superiority. The internal reliability of the VPD is 0.85 (Cronbach’s alpha) and 1-week retest reliability is 0.8 (Birchwood *et al.* 2000).

The Social Power Differential scale (SPD) uses the same bipolar constructs, but substitutes the word ‘others’ for ‘voices’; hence the lead question is, ‘in relation to *others*, I generally feel ...’ The internal reliability of this scale is 0.88 and retest reliability 0.80 (Birchwood *et al.* 2000). The content validity of these scales derives from the constituent items, which are drawn directly from social ranking theory (Gilbert, 1992).

Social rank

The Social Comparison (SCS) scale was designed as a measure for use with depressed people (Allan & Gilbert, 1995). The scale utilizes a semantic differential methodology whereby participants respond on a scale of 1–10; for example, ‘In relation to others I feel’ (e.g. Incompetent 1 2 3 4 5 6 7 8 9 10 Competent). The Cronbach’s alpha reported by Allan & Gilbert (1995) was 0.91. This scale has been used in a number of studies with good reliability (Allan & Gilbert, 1997; Gilbert & Allan, 1998). The five items used by Birchwood *et al.* (2000) were used here. Birchwood *et al.* (2000) used the same

items, but adapted the scale to measure the individual’s social rank or position *vis-à-vis* the voice (Voice Rank Scale, VRS). The internal reliability of this scale is 0.80 and retest reliability 0.77 (Birchwood *et al.* 2000).

In summary, measures of social rank and power were applied to two kinds of social relationship: with the dominant voice and with significant others.

Depression

The Beck Depression Inventory (BDI; Beck *et al.* 1979) was administered. The 21-item version of the BDI is regarded as a good measure of the severity of depression in clinical populations (Beck *et al.* 1988) including schizophrenia (Drury *et al.* 2000).

Statistical analysis

VPD, VRS and distress (Hustig & Hafner, 1990) were our primary dependent variables. To test the hypotheses, these were linked to the measures of social power and rank, following precisely the procedures in our original study. The data were then analysed using covariance structural equation modelling techniques (CSM, also known as structural equation modelling, SEM), to test each of the three models (Fig. 1). This allows us to hypothesize different models of the relationship amongst variables, and to determine which, if any, of these can best account for the data. The analysis was carried out using summed scale scores as variables, rather than using latent variable analysis, as the sample size did not justify the large number of parameters that would be required to be estimated if latent variables were used. Although this type of analysis frequently employs latent variables, Bollen (1989) points out that they are not necessary for the analysis to be useful, or valid. SEM is particularly relevant to situations where there is more than one independent and dependent variable. SEM can assist in *disproving* certain causal hypotheses; a hypothesized causal model may fail to be rejected, but cannot be ‘proved’ (Shadish *et al.* 2001). In this respect, the logic of SEM parallels that of the scientific method (Pearl, 2000).

To evaluate model fit, we use the χ^2 test, and its associated probability value, along with the RMSEA (root mean square error of approximation), the normed fit index (NFI) and the

Table 1. Comparison of patients appraising their voices with 'high' versus 'low' rank

		Social power† (SPD)	Social rank‡ (SCS)	Depression (BDI)	Distress (Hustig and Hafner)
Voice social rank (VRS)	High* (<i>n</i> = 57)				
	Mean (s.d.)	26.7 (4.3)	17.8 (9.7)	23.6 (13.5)	4.2 (1.1)
	Low (<i>n</i> = 69)				
	Mean (s.d.)	24.3 (4.2)	25.4 (8.4)	17.8 (10.8)	3.6 (1.2)
	<i>p</i>	<0.01	<0.01	<0.001	<0.01
Voice power* (VPD)	High (<i>n</i> = 65)				
	Mean (s.d.)	27.0 (4.2)	19.6 (10.2)	25.0 (12.5)	4.2 (1.1)
	Low (<i>n</i> = 60)				
	Mean (s.d.)	23.6 (3.9)	24.7 (8.6)	15.8 (10.5)	3.4 (1.3)
	<i>p</i>	<0.001	<0.01	<0.001	<0.01

* Where the perceived power of the voice is high the patient feels himself to be relatively powerless.

† Higher scores indicate that others have relatively higher social power than self.

‡ Lower scores indicate relatively lower social rank of self.

comparative fit index (CFI). Values of RMSEA below 0.08 are considered to indicate satisfactory model fit and values below 0.05 are considered to indicate good model fit (Browne & Cudeck, 1992).

RESULTS

One hundred and twenty-five people consented to participate in the study and completed the protocol. The mean age was 33.7 years (s.d. = 9.3). Eighty-five (68%) were male, 40 (32%) were female. All had a clinical diagnosis of schizophrenia and symptoms recorded at the previous acute episode conformed to ICD-10 criteria for schizophrenia (*n* = 81), schizophreniform disorder (*n* = 15) or paranoid psychosis (*n* = 29). The sample reported a mean of 3.4 voices (s.d. = 3.0) and over 98% were receiving neuroleptic treatment. All measures were given in the context of a face-to-face interview which ensured all measures were completed without missing data.

Interpersonal schema and the relationship with the dominant voice

In this section, we test the hypothesis that patients who perceive themselves to possess low social power and social status ('rank'), will also perceive themselves to be subordinated to their dominant voice, i.e. the voice will be appraised as powerful and dominant. If confirmed, we proceed to test the three causal models outlined in Fig. 1.

In this analysis, VPD and VRS were dichotomized based on the median split (25.0 and 20.0

respectively) used in the initial study, to enable comparison with it (Birchwood *et al.* 2000). Comparisons were made between the resulting groups. The median split in the original study corresponded to the 55th and 52nd percentiles in the VPD and VRS respectively, using data from this sample.

Social power

Consistent with the initial study, patients who perceived themselves to have lower social power also perceived themselves to be more subordinate (powerless) relative to their voice ($p < 0.01$) (see Table 1).

Social rank

Table 1 also shows that where individuals perceived themselves to be of low social status, this was mirrored in their relationship with their dominant voice.

Distress attributed to hearing voices

Those who appraised the voice with higher power and rank than themselves were significantly more distressed by their voices (see Table 1).

Capacity of voices to shame

Voices rated as very powerful (VPD), had greater perceived capacity to shame ($p < 0.001$) and greater omniscience ($p < 0.01$), as rated by the voice content scale of the BAVQ.

Beliefs about voices and coping behaviour

In line with previous research (Chadwick & Birchwood, 1994; Close & Garety, 1998; Van der Gaag *et al.* 2003), voices rated as powerful and malevolent were closely linked to the

Table 2. Results of the covariance structure model

Model	χ^2 (df)	<i>p</i>	RMSEA	NFI	CFI
Null	171.0 (9)	<0.001	0.45	0.00	0
Model 1					
Depression primary	37.0 (4)	<0.001	0.26	0.76	0.77
Model 2					
Psychosis primary	60.0 (6)	<0.001	0.28	0.74	0.76
Model 3					
Social rank and power primary	1.2 (3)	0.75	0.00	0.99	1.00

RMSEA, root mean square error of approximation; NFI, normed fit index; CFI, comparative fit index.

‘resistance’ coping strategy ($r=0.73, p<0.01$); whereas ‘benevolent’ voices were linked with engagement strategies ($r=0.60, p<0.01$).

Depression and perceived voice power and rank

Of the sample 63.1% were at least moderately depressed (score >15) on the BDI (51% initial study; Birchwood et al. 2000). Replicating previous research, patients attributing to the voice greater power and rank than themselves were more depressed (Table 1).

Model-testing

Covariance SEM was used to test goodness of fit with each of the following models, in addition to the null model (see Fig. 1).

(1) Depression is primary and leads to the appraisal of social rank, voice power and distress.

(2) Greater voice activity (frequency, audibility), and the presence of delusions about voices, lead to depression and the appraisal of voices’ power.

(3) Social rank and social power lead to the appraisal of voice power, distress and depression (the hypothesized model).

Maximum likelihood estimation of the models was carried out, based on the covariance matrices using LISREL 8.51 (Jöreskog & Sörbom, 1999). Previous research findings indicate that a correlation between social power and social comparison would be expected (Birchwood et al. 2000). In addition, a correlation between depression and power of voices was expected (Birchwood & Chadwick, 1997; Birchwood et al. 2000; Gilbert et al. 2001). The perception of the frequency of voices is influenced by their

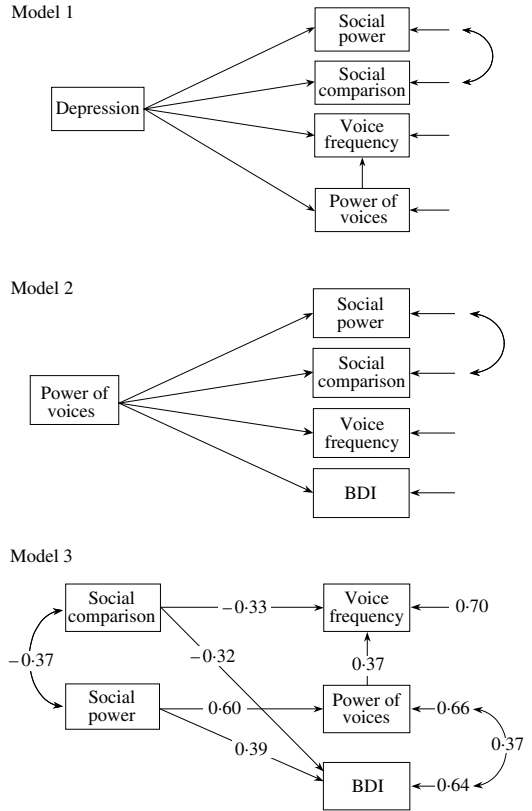


FIG. 2. SEM results, path diagrams. Model 1: depression primary ($\chi^2=36.9, df=4, p<0.0001$). Model 2: delusions about voices primary ($\chi^2=43.9, df=5, p<0.0001$). Model 3: social rank and power primary ($\chi^2=1.2, df=3, p=0.75$; standardized estimates shown: all parameter estimates statistically significant at $p<0.005$).

perceived power: the perceived power of the voice increases vigilance, thus giving rise to a greater awareness of voice activity (Birchwood et al. 2000). These three parameters were therefore added to all models (where appropriate).

Table 2 and Fig. 2 show the results for each model. These show that the null model (no relationship between variables), model 1 (depression primary) and model 2 (psychosis primary) were each rejected. The hypothesized model 3 (social rank and power are primary) failed to be rejected and provided the best fit to the data.

The direction and magnitude of the path coefficients show that the appraisal of social power and status had a major influence, in statistical terms, on the voice-hearer’s appraisal of the power and influence of the voices. The SEM

results also revealed that the high rate of depression in this sample flowed from these social-rank-focused, social and interpersonal schema (SCS, SPD). As in our previous research, depression was strongly correlated with voice power; the SEM results suggest that the key variables underlying this are the broader rank-focused social mentality of the voice-hearer.

In regard to voice frequency, the direction and magnitude of the path coefficients suggest that the perception of voice frequency is jointly influenced by the appraisal of voice power (VPD) and social position (SCS); this replicates our previous work and suggests that where the individual feels under threat, this leads to heightened vigilance and an apparent increase in (perceived) voice frequency.

DISCUSSION

The key findings may be summarized as follows. First, voices, as internally generated signals, are commonly appraised as powerful, dominant, shaming/insulting persecutor(s); and the self is seen as subordinated, shamed and inferior. Secondly, a majority of voice-hearers are highly distressed, with nearly two-thirds experiencing at least moderate depression. It is the degree of powerlessness in relation to the dominant persecutory voice that is closely linked to distress and depression. Thirdly, the path diagram shows that it is powerlessness and inferiority that voice-hearers experience in their relationships with others in general, which is linked strongly to the power of voices (standardized path coefficient = 0.60). This suggests that the role relationships a person has with others (for example, experiences of interpersonal powerlessness/subordination) are mirrored in the inner experiences with voices. Moreover, feeling inferior to others (negative social comparison) is linked to general feelings of powerlessness. These findings confirm the importance of the dominant-subordinate-relating style for voice-hearers. Hence, just as hostile social relationships can have powerful effects on physiological and psychological processes (Gilbert & McGuire, 1998) so may internal relationships with voices (Gilbert *et al.* 2001).

A new finding indicates that malevolent voices are not only experienced as dominant, but

also shaming, for example for past peccadilloes or criticisms of the individual's character. It is the voices' apparent access to private and 'shameful' information about the person which disposes the individual to appraise voices as omnipotent and potentially harmful to the individual (Byrne *et al.* 2003). Indeed, voices have much in common with self-critical thoughts in depression and the behaviour of critical relatives (Gilbert *et al.* 2001). The tendency to be self-critical/attacking is common to many forms of psychopathology, especially depression and borderline personality disorders; such self-critical, self-shaming and at times self-hating thoughts may play a significant role in the form and maintenance of disorders because people can feel 'beaten down', defeated and shamed by their own thoughts about themselves (Gilbert, 2000*a*; Gilbert & Irons, in press; Gilbert *et al.* 2004). Given this, a future focus of research on voices may seek to better understand why and how such thoughts become externalized. Once a person becomes psychotic and begins to hear voices they can be 'shamed and criticized', literally 'harassed' into depression, and be intensely distressed, as if there were a real person at their shoulder constantly drawing attention to their failures, bringing attention to past problematic behaviours and thoughts, shaming them, and *warning* them about others ('nobody will like you; others think you are stupid').

This study makes the assumption that voices *are* personified by patients, in part because the processing systems involved and recruited into voice activity are posited to have evolved for social processing and role orientation; that is to say, humans constantly try to work out what kind of role they can or need to enact with others, what others are thinking about them, what others might know or not know about them, and whether others will be hostile or friendly (Gilbert, 1989, 1992, 2000*a*). The measures we employ reflect this to a degree; however, it could be argued that we have simply socialized patients into this framework. This is unlikely for three reasons. First, in qualitative research the personification and power of voices in clinical samples are often spontaneously disclosed (Chadwick & Birchwood, 1994). Further, voices as personified experiences recruit relating styles of interaction has been widely reported by Benjamin (1989), in our own work

(Chadwick & Birchwood, 1994) and its replications (Close & Garety, 1998; Sayer *et al.* 2000; Van der Gaag *et al.* 2003), by phenomenological studies of the auditory hallucination (Bauer, 1970; Carter *et al.* 1995; Nayani & David, 1996) and in children with early psychosis (Escher *et al.* 2001). Secondly, if individuals do not believe their voices to be imbued with human characteristics, they would simply indicate this in their response to the questions ('voices cannot harm me') and shame would become irrelevant. Finally, in a recent paper we provided evidence that depressed people with intrusive negative thoughts, while they do not personify them, attribute power and omnipotence to them, see them as issuing commands ('you must ...', 'you should ...') experience them as shaming (for example, taking the form of 'you are bad, inadequate') and warning/threatening about what others will be thinking about them ('others will see you as bad or inadequate') (Gilbert *et al.* 2001). This is similar to how some voice-hearers experience their voices.

A second possible limitation concerns the choice of the most dominant and powerful voice as the focus for assessment. In this, as in our previous study (Birchwood *et al.* 2000), we observed no link between power, distress and voice topography, including number of voices. Hence, the number of voices does not offer a potential confound. On the other hand, one might predict subordinate self-experience to operate in relation to all voices, not just the dominant. However, this was not the focus of our research. Rather, as is common in studies of social relationships, we focused on one relationship at a time, and the one leading to most distress, which was the most dominant voice. Finally, the contemporaneous measurement of role-related schemas, depression and voice power raises the question of their possible mutual contamination; in particular whether schema are merely mood-linked appraisals. This study aimed to address this issue using SEM and found little evidence to support this possibility (see model 1).

As discussed above, we can discount the possibility that the appraisal of voice power, social rank and distress are mood-linked appraisals arising from depressed affect (model 1). Similarly, the hypothesis that psychosis and the ensuing voice activity and secondary delusions

drive the appraisal of voice power and distress was also rejected (model 2). The failure to reject our hypothesized model 3 paves the way to experimentally manipulate social processing and voice-power variables, both in self-to-other and self-to-self relating (see Trower *et al.* 2004).

There are two limitations of SEM analysis. First is the power of the study to reject models because of sample size. In one sense, this was not an issue – the sample size was sufficient to reject two models. With a larger sample the analysis would have had more power to examine the model that was hypothesized; in particular, a larger sample would have allowed us to perform the analysis at the item level. Secondly, the analysis was, necessarily, cross-sectional. SEM analyses sometimes add a sheen of respectability to analysis – allowing researchers to make stronger causal statements than with other analyses. This is not the case here – there is no magic statistical technique which will allow us to make strong causal statements from cross-sectional data (nor indeed from longitudinal data) without intervention (Miles & Shevlin, 2001).

In regard to therapeutic implications, it seems clear that if it is the relationship with the voice that is crucial, then this should be a target of intervention. Indeed, voice experience should not be 'dismissed' as symptoms of the illness, for which drugs alone can be used. If malevolent voices are a form of (intense and often very nasty) bullying which may be rooted in earlier traumatic experiences and harassment (Birchwood, 2003), then the therapist needs to align himself with the patient in reducing the experience of being bullied. Exploring possible shamed-based origins of feeling subordinated (e.g. abuse) is important. Hence cognitive therapists new to this area of work may need to be mindful of this kind of (bullying) experience, the power and fear of shame, and thus extend their work beyond treating voices as intrusive thoughts or misattributions to which a person can be encouraged to apply cognitive behavioural techniques. Indeed, some people can be ashamed and fearful of revealing what voices are saying in case the therapist 'discovers' things about them and sides with the voice in further shaming and persecuting them.

Many research groups are advancing the understanding and psychological treatment of

people with psychosis (see Morrison, 2002). The cognitive therapy approach to voices developed by our group (Chadwick & Birchwood, 1994; Chadwick *et al.* 1996) focuses less on eliminating voice activity than on de-shaming, and re-evaluating and testing the beliefs about voices' power and the validity of shame messages, which this research suggests underpins the experience of distress. The therapist takes a highly empathic position to the experience of voice-bullying/harassing, and may even label the process as one of being or feeling bullied and victimized. A therapist may also reflect on a patient's courage and endurance, positively support their coping efforts and become a therapeutic ally. In our recent trial of cognitive therapy with command hallucinations (Trower *et al.* 2004), therapy seeks to disempower the omnipotent voice by enabling the patient to discover that: (1) he or she can influence the onset as well as the offset of voice activity; (2) voices' assertions and predictions are untrue; and (3) failing to comply does not lead to the anticipated consequence (for example, harm to self). Developing inner compassion for the self may also be therapeutic (Gilbert & Irons, in press). We also encouraged patients to be more assertive with the voice, and advised how to apply this to everyday social encounters, where patients felt ineffective and subservient to others. This also involved working with patients' concerns that others would shame them if they were to try to form friendships with them. Clues to the origins of why the voice-hearer has become so focused on the power of others, and attentive to attacks, may be found in individuals' developmental history, including the experience of trauma, which is common in people with psychosis (Birchwood, 2003). Unresolved shame arising from abuse and trauma may continue to undermine the person's sense of worth and sense of safeness with others. As we better understand the types and processes of (non-psychotic) self-attacking, and its link to abuse, trauma and shame and how to reduce internal hostility (Gilbert & Irons, in press), new ways of working with malevolent voices may also develop.

DECLARATION OF INTEREST

None.

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