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The group as a place of training and universality of the experience of voice hearers

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Abstract: *This article presents the results of an evaluative study of two groups as carried out in a psychosocial clubhouse, Le Pavois in Quebec City, with voice hearers. Based on a qualitative analysis of interviews conducted with 12 members who participated in one of the two training and support groups, this article emphasises the benefits perceived by the respondents following their participation in these innovative groups. While these groups are not actual therapy groups, the analysis sets forth six therapeutic factors fostered in the group method: training, universality, belonging, self-disclosure, instillation of hope, and destigmatisation. This study highlights the importance for voice hearers of meeting others with similar experiences so that they can share their experiences, acquire knowledge on the phenomenon and develop strategies to better deal with the voices.*

Key words: *groupwork; therapeutic factors; voice hearers; destigmatisation; universality; training*

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Introduction

Epidemiological studies estimate that between 10% and 39% of people in the general population have heard voices at least once in their lives (Shergill et al, 1998). Several studies have been conducted to understand and treat voice hearing, specifically in the context of developing the cognitive approach. However, very few articles are concerned with the experiences based on these approaches in a group of voice hearers (McLeod et al, 2007; Penn et al, 2009). Based on the results of evaluating the two training and support groups for voice hearers held in a psychosocial clubhouse in Quebec City, Canada (Ngo Nkouth et al, 2009; St-Onge et al, 2008), this article focuses on the changes perceived by the group participants. Using in-depth interviews carried out with participants at the end of the group, we let people express themselves, like Kingdon and Turkington (2005), based on their own theories and their knowledge of the voice phenomenon. However, unlike these British psychiatrists, the purpose of the groups was not to put these theories or beliefs in question. Participants described their experience, which we analysed based on therapeutic factors that were already identified by other researchers in different contexts. Indeed, Yalom and Leszcz (2005, p. 1) refer to the mechanisms of change [in group] as 'therapeutic factors'. '[They] suggest that [change in group] is an enormously complex process that occurs through an intricate interplay of human experiences, which [they] will refer to as 'therapeutic factors'.

Hearing voices

According to Beck and Rector

> Hallucinations are generally defined as perceptual experiences in the absence of external stimulation. They occur in the wakeful state (unlike dreaming) and are not under voluntary control (unlike daydreaming). (2003, p.19-20)

Hearing voices is more common in people with schizophrenia. On average, 50% to 80% of people with this problem have auditory hallucinations (Alpert, 1986; Andreasen and Flaum, 1991). Moreover, 25% to 50% of these people continue to hear voices even with taking neuroleptic medication, thus the importance of offering them other treatment options (Newton et al, 2005).

Voices can take the form of a single word, a short phrase or a conversation (Chadwick et al, 2003). The common function of voices is the regulation of activities, taking the form of orders, evaluations or questions (Leudar et al, 1997). In most cases, people report hearing more than one voice, and one of them usually takes on a predominant role (Nayani and David, 1996). The source of voices can also be external, i.e., the person hears it in his or her ears, or it can be internal, in the hearer's head or in other parts of his or her body (Romme, 1998). The identity of voices may be differentiated based on whether they are perceived as either real (member of their family, neighbour, etc.) or unreal (God, the devil, or entity, etc.). In addition, according to Chadwick and Birchwood (1994, 1995), voices are generally perceived as being either malevolent (want to do wrong or harm them, etc.) or benevolent; in the latter case, people believe that voices are there to help and protect them.

The majority of people who hear voices experience hearing voices a number of times a day, which may last a few seconds to several hours (Chadwick et al, 2003). These authors noted in the first study they published in 1994 that people resist malevolent voices and follow benevolent ones. People who interact with their voices are significantly less distressed than those who resist them. According to Birchwood and Chadwick (1997), and Chadwick et al (2003), individuals who assign a malevolent nature to their voices—those perceived as negative—generally have higher levels of depression. As well, Nayani and David (1996) reported a high level of distress in people who had little control over their voices, few means to deal with them and whose voices were frightening. Voices can lead to social isolation, since these people are scared to talk about their perceptual experiences and feel alone or isolated from experiencing such phenomena (Romme and Escher, 1989). For their part, McLeod et al (2007) noted that the symptoms of distress may be a factor in developing depression, anxiety, low self-esteem and social isolation, and that these secondary experiences generally lead people to seek help other than medical assistance. Penn et al (2009) noticed that the persistence of residual symptoms after medical follow-up in people who hear voices has led researchers to explore related treatments and to look at more accessible and effective approaches, such as therapy groups.

Therapy groups with voice hearers

Several studies have reported the effectiveness of therapy groups for reducing negative beliefs about the voices, distress and related problems, and for improving self-knowledge and increasing social support of voice hearers, which enhances their well-being (McLeod et al, 2007; Newton et al, 2007; Penn et al, 2009; Wykes et al, 2005). In their study, McLeod et al (2007) investigated the effects of the group on the voices with 20 voice hearers: ten (10) people were seen in a cognitive therapy group and ten (10) others in a control group were given individual therapy. These authors noted that universality, i.e., the awareness that other people experience similar problems, stood out as one of the most beneficial therapeutic factors in the group intervention. These authors also observed differences between the people who had been in the group and those who had individual therapy: a significant reduction in the frequency of hearing voices in people in the group and no change in people seen individually; a significant reduction in beliefs regarding the power of the voices in people followed in the group, whereas these beliefs increased in the control population; a tendency toward lower distress levels in the group, whereas this tendency was weaker in the control population. McLeod et al (2007), concluding that this type of group is helpful in treating voice hearers.

In their study of 65 people with a schizophrenic disorder and auditory hallucinations, Penn et al (2009) compared the effectiveness of a cognitive therapy group (32 people) with that of a support therapy group (33 people). Their results showed that both groups were beneficial for the participants. However, they noted that, 12 months following the end of holding the groups, only the people in the support therapy group had reduced their negative beliefs about the voices versus the cognitive therapy group, which was associated with a general reduction in psychotic symptoms. They concluded that the support therapy group had a more specific impact on the auditory hallucinations, whereas the cognitive therapy group had a general impact on psychotic symptoms (Penn et al, 2009).

In a study of eight young voice hearers selected from four cognitive therapy groups, Newton et al (2007) came to similar conclusions: these young people reported that they considered the group to be a source of treatment, information and support. Moreover, these young voice hearers noted that the fact of meeting other voice hearers, sharing common experiences and acquiring knowledge on voice hearing enabled them to normalise this phenomenon and feel less stigmatised.

Based on a general perspective of psychotherapy groups, the work of Yalom and Leszcz (2005) focuses on the benefits of the group or therapeutic factors. These authors mentioned that the fact of meeting people with similar problems is an essential condition to therapeutic factors emerging in these groups. They identified 11 therapeutic factors that members individually take from the group: instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socialising techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors (Yalom and Leszcz, 2005, p. 1-2). According to these authors, the presence of these key factors contributes to the success of the group's interventions.

Methodology

Participants

Participants in training and support groups are members of the clubhouse. At the same time as the study, group activities were carried out as planned in developing the groups. The following process for recruiting the participants into the study was used: the research team met with the people registered in the groups to explain the study objectives and invite them to take part in the study. These people were informed that they would be asked to participate in a future interview in which they would be asked to talk about their experience regarding training and support groups. Twelve people who had participated in the groups were recruited voluntarily via telephone calls. At the end of the telephone interview, if the person was interested in participating in the study, the terms and conditions regarding the time and place of the interview were agreed on in order to present information and informed consent forms for the study. These forms contained all the relevant information so that an informed decision could be freely made regarding the study, in particular the nature of the study, the process involved, the confidential handling and use of the participants' data, the disadvantages and advantages of participating, the fact that participants can withdraw from the study at any time, and lastly financial compensation that they will receive in return for their participation. The data were collected from 12 people who completed the 12 meetings in one of the two training and support groups carried out in Quebec City at a psychosocial clubhouse. The participants ranged in age from 25 to 67. Nine respondents were single and three were separated. Their average income was CAN$19,025 (approximately £12,465). All had been diagnosed with a psychiatric disorder. The duration of hearing voices was from three to 30 years; two of the participants had started hearing voices in their youth.

Group intervention model

The training and support group for voice hearers is particularly innovative, since, to date, to our knowledge, there are no comparable groups in Quebec. Not only is this group a support group that offers a place for discussion among people who are experiencing a similar situation to promote the establishing of a support system, but also a program that focuses on education, in which the facilitators' role is to provide information, tools and exercises that will guide the people to becoming empowered regarding their voices and lives. The purpose of the group is for people to learn how to deal optimally with the voices so that they can adapt and live normally with or without them. This group is based on the concept of mutual aid, i.e., that members can help themselves and help others by sharing ideas, suggestions, solutions, feelings and information, and by comparing attitudes and experiences (Turcotte and Lindsay, 2001). With the exception of two people, the research participants were integrated into socioprofessional reintegration activities at the clubhouse. These were closed groups, which met twelve times, for two hours each week. The program was jointly led by two professionals working at two community mental health organisations. These professionals were not involved in collecting the data. Throughout the project, they adapted the program content to the pace and needs of the group. They also were very open to welcoming all the participants' experiences. This program is based on the work of Provencher (2002) on the recovery experience for people with psychiatric disorders. Therefore, this group is based on the recovery factors of this program.

The group scheduling is inspired by the strategies of Deegan (1995) on how to deal with disturbing voices, documents of Downs (2001) and Baker (2000), and the CHANGE (*Choice and AlterNatives for Growth and Experience)* method of Coleman and Smith (1997). Lastly, the scheduling includes content and varied activities ranging from discussions to the presentation of specific content about the voice phenomena, such as the process of adapting to the voices based on the three phases identified by Romme and Escher (1989): the phase of stupefaction, the phase of organisation, and the phase of stabilisation; a range of voice coping strategies divided into four categories: preventive, active, passive and dissuasive strategies; an approach related to the meaning and significance of the voices; the testimonial of an ex-voice hearer; a presentation of the studies in the field by the second author who specialises in this area; various reflection and introspection activities on the voices phenomenon. Group meetings are divided into two parties: the first has members freely and openly discussing their experiences as voice hearers, and the second has the facilitator presenting specific content on the voices phenomenon.

Data collection

Although this article focuses on the qualitative aspect, we should specify that our research is based on a mixed model (qualitative and quantitative). We also carried out a pre-mid-post group evaluation (quantitative) to measure the effects of the groups for participants on their beliefs about voices and their distress. Qualitatively, the preferred method for data collection was the semi-structured interview. An interview guide with a series of questions was developed. In addition to factual data on the participants' sociodemographic status, this interview guide was divided into two parts: the first looks at voice-related themes (their nature, beliefs, related distress, knowledge acquisition on voices, voice coping strategies and the development of well-being); the second part evaluates the effects of the group for voice hearers, the accent here being put on the assessment of changes perceived by the respondents following their group participation. Eight weeks after the end of each group, individual interviews were conducted with 12 participants. The average length of interview was between 50 minutes and 90 minutes.

Analysis

All interviews were transcribed verbatim and read several times to absorb the meaning and general ideas of each conversation. Next, the transcribed data were submitted for qualitative content analysis, which started by breaking the data down into predetermined themes as per the interview guide, and then organising and simplifying participants' answers into a limited number of mutually exclusive, homogenous and unequivocal categories (L'Écuyer, 1990; Patton, 1990). Mixed categorisation was used, i.e., categories were established first and allowances were made for the possibility of other categories cropping up during the content analysis (L'Écuyer, 1987). The answers were broken down into classification units, with each unit corresponding to a theme. A coding grid was then developed for each question based on all units (L'Écuyer, 1990). Although other items emerged from this analysis, we shall limit our results presentation to the benefits perceived by the participants.

Presentation of results

In a group intervention, the facilitator must put certain conditions in place so that the group becomes a setting for helping members reach their goals. These conditions may be looked at from the perspective of the group dynamic, and focus on the dynamics of mutual aid based on which members individually benefit from the group. The angle we have chosen to use is that of therapeutic factors (Turcotte and Lindsay, 2001). Therefore, this article focuses on the therapeutic factors perceived by voice hearers after their participation in training and support groups. All respondents report that they appreciated their group experience because they met other voice hearers and were able to share their experience. In their opinion, the fact of forming a group whose name is explicitly *voice hearers* is already exceptional in itself:

> *[…] And it's the first group as well, which is something to be proud of, the first group in Quebec of voice hearers […]. I had to tell myself […] that I was a pioneer among pioneers* [G1Participant 3]

The results of our study reveal that the group created for voice hearers is a preferred way of talking about this type of experience. According to the participants, this contact with other voice hearers has promoted freedom of expression on this phenomenon and gives them the opportunity to discuss it openly. These observations are in line with the results of clinical research where cognitive therapy was used in a group of voice hearers (Chadwick et al, 2000; McLeod et al, 2007; Newton et al, 2007). The qualitative analysis enabled us to identify six therapeutic factors already observed by others (Yalom and Leszcz, 2005, Newton et al, 2007): training, universality, belonging, self-disclosure; instillation of hope; destigmatisation. It can be noted that this sixth factor comes out of the results of the specific study on voice hearers (Newton et al, 2007).

Training

All respondents referred to training as being a major benefit to them, especially in sharing experiences with other members of the group, but also in exchanging information with the facilitators:

> *When the facilitators talked, it gave us a better understanding… sometimes when the group talked about it, it was better.* [G2Participant 3]

> *With the people in the group, I could talk about the voices I hear. It gave me a new understanding about things (…). Next, it also gave me certain knowledge about phenomena that others had had in hearing voices.* [G2Participant 2]

In general, participants perceived that the sharing of experiences between members who were voice hearers allowed them to acquire new knowledge; they acted as support people for each other. This contributed to a better understanding of the voices phenomenon:

> *Knowledge […] of the real-life experience of certain people who were able to write on the subject, knowledge also shared by other participants, some things I had not experienced, and then I would tell myself I don't think that it could go so far. Yes, it gave me more information on the phenomenon.* [G2Participant 6]

Training also referred to the acquisition of voice coping strategies.

In the opinion of the majority of participants, group meetings gave them the opportunity to share and become informed on various voice coping strategies. They said that sharing this information, especially through group discussions and documentation provided on this topic, promoted knowledge acquisition. Everything learned let them develop new skills to better deal with the voices, review strategies already known or identify those that they found useful or not.

> *I agreed to come to the group to be able to see how others were managing their voices, etc. Well, it was constructive, since I learned that there are certain methods that can help us.* [G1Participant 5]

Universality of experience

Universality is also a major therapeutic factor coming out of the analysis. Based on the opinion of the respondents, participation in the groups brought about a feeling of a common experience with the other voice hearers. They noted that they had experienced a similar phenomenon, even if they might be leading different lives, and discovered that they shared common points regarding the characteristics associated with the voices, concerns or emotional reactions that they experience upon hearing them, etc. Participants then noticed that, through these common traits and their perceptual experiences, they became closer. When a member explained his or her case, it enabled the others to draw a parallel with their own situation and realise that others also had problems with their voices. Participants considered that this allowed them to become aware that they were not the only ones dealing with the voices phenomenon and, in turn, they felt less isolated than when they first came to the group.

> *I think it was a great experience. It allowed me to realise that I was not alone in this […]. And to share experiences, that brought a certain pride.* [G2Participant 2]

> *[…] I had the impression that we were sharing the same things, the same experiences… sure, it was different, but it was still voices they were hearing.* [G1Participant 6]

Self-disclosure

Self-disclosure was another factor that came out of the analysis. According to the respondents, freedom of expression and the accepting setting in the groups helped them deal with their voices and they felt enough at ease to talk about their personal situation in the group. To them, just speaking about their voices with other people in the group was already a way to broach this subject, which is considered taboo, and to adopt an open attitude about what was happening to them. For example, certain participants mentioned that, upon seeing others daring to talk about the beliefs they had about voices (especially regarding their identity, their benevolent or malevolent nature); they were able to reveal their own personal beliefs about voices. The respondents also believed that good communication in the groups encouraged them to express themselves on personal subjects that they had never revealed up to then:

> *It is as if, let's say, you're feeling alone with a secret and then, all of a sudden, you share it with a few people, and you feel better, because you are no longer keeping that secret on your own.* [G2Participant 6]

Moreover, all respondents indicated that they could openly communicate their experience as voice hearers and freely share their experience without being judged, or censured by other members of the group or the facilitators. They saw the environment of trust created by those involved encouraged touching on difficult subjects concerning the voices they heard. By seeing others expressing themselves about their experiences as voice hearers, it encouraged them to participate in the discussions and talk about sensitive subjects:

> *Each person had problems, because they heard voices, and without any prejudices about it, we were really able to talk about our voices and speak freely.* [G2Participant 2]

> *[...] The fact of hearing voices for me is a topic I could touch on with these others, since there were no taboos or judgements in the group... the two facilitators also were not judgemental.* [G1Participant 5]

Belonging to a group

Belonging to a group of voice hearers is another factor that came out of our analysis. Certain respondents reported that they developed a feeling of belonging, that they had forged ties with other group members and that they felt accepted in the group:

> *Well, I liked it because it allowed me to get to know the others better, and also I felt at ease, and had the impression that I could talk and express myself in the group with the others… we had created ties between us.* [G1Participant 6]

Other respondents reported that they felt at ease in the group and that they could count on the understanding of the other members when they talked about their real-life experience. They pointed out that the fact of forming a group made up of people having similar experiences as voice hearers promoted the development of this feeling of belonging to the group:

> *[…] we all had the same problem, we heard voices. If someone started to talk about his voices, the others [all] understood…* [G2Participant 5]

> *I think that it was a wonderful experience […] It [the group] made me feel like I belonged, and to finally be able to say that I was not the only one going through that.* [G2Participant 2]

Instillation of hope

Hope is the fifth therapeutic factor that came out of the analysis. Certain respondents pointed out that the fact of sharing their experience with other voice hearers and having information on former voice hearers who had managed to better deal with their voices gave them more self-confidence and helped them accept their problems and voices. This instilled a feeling of hope that they could improve their lives, even if the voices persisted:

> *I learned […] that it was possible for the voices to remain, but that it was just as possible to have a positive life even with the voices […] This made me more confident, […], more accepting [of my problems] and that I could live. So I would say it gave me hope…* [G2Participant 2]

Destigmatisation

Lastly, the analysis revealed destigmatisation as a major benefit for participants in the two training and support groups. Sharing similar experiences with other voice hearers enabled them to realise they were not alone with this problem; to feel less isolated; to develop a sense of normalcy regarding their voices… Some respondents saw participation in the group as a way of removing certain 'labels' or reducing the feeling of being 'abnormal' related to the phenomenon of voices:

> *Well, as I said, it removed the prejudices. I would also like to say that I now don't care as much about what everyone thinks. I mean I know I can get about and it's as though the 'label' on my forehead is smaller… a bit like I said… it removed prejudices.* [G1Participant 4]

In short, the respondents believed that when they met people who had had similar difficulties or experiences and with whom they could identify, they felt less isolated and less of an outsider. They could then adopt a more objective, more detached vision of their own situation, which helped play down the problems.

> *Because, for example, if I had as much anger before not having experienced the group, I would have been scared of what could have happened to me, that is I would have been afraid of ending up in the hospital. Whereas, when I was talking there, I put into perspective more what was happening to me versus the others, and I felt less of an outsider… I felt less alone.* [G1Participant 6]

Discussion and conclusion

This article presents the results of an evaluative study of two groups carried out in a psychosocial clubhouse in Quebec City with voice hearers. We used a qualitative approach based on semi-structured in-depth interviews to encourage participants to freely share their points of view and experience in the groups. The content analysis allowed other themes to emerge, which enabled us to learn more about their individual experiences and the group processes. The qualitative method is especially suited to exploring and learning more about individual experiences; its creative component contributes to bring out aspects that are still unknown about a phenomenon (Whittemore et al, 2001). Lastly, it can be noted that this evaluative study cannot claim to cover all changes that the program may have brought about, neither does it allow us to affirm that the progress perceived by the participants is directly attributed to the program, given that other external components can be the source of these changes (Turcotte and Tard, 2000). It is also possible that the context proposed promotes social desirability, i.e., the desire of the respondents to provide researchers with a more positive opinion regarding the benefits that they get out of the group, instead of what they actually perceive in their situation. Nevertheless, we believe that these results can be transferred to similar groups.

Even if there were no clinical objectives involved in participating in the groups, the results are in line with those of previous studies, namely that as an intervention modality, the group is beneficial for helping people dealing with auditory hallucinations (Chadwick et al, 2000; McLoed et al, 2007; Newton et al, 2007, Penn et al, 2009). As many authors observed (McLoed et al, 2007; Newton et al, 2007), sharing information is a major therapeutic factor for voice hearers who take part in groups. This result is not surprising, since training refers to the educational component of groups evaluated by our study. We observed that, in these groups, a real exchange came out between members who learned from each other, which reflects mutual aid and support. Our qualitative analysis concerning this factor revealed that voice hearers acquired knowledge on voice phenomena, and that they developed a certain number of skills, either stopping the voices: for example, one of the participants reported that she stopped hearing the voices; or reducing the voice activity when they felt uncomfortable or disturbed by them, by ignoring them by using distraction, listening to music, sleeping, talking to someone, saying ‘stop’ to the voices, contradicting them, challenging them or dismissing them, welcoming the voices and trying to integrate them into their experience, etc. It can be noted that we did not judge the efficiency of one strategy compared with another. This result reflects a group process that consists of leading a person to develop his or her own positive adaptation strategies to take back power over his or her voices. However, we are aware that certain strategies are not effective in the long term. In this regard, in the next group experience, specific attention will be paid on the aspect of the efficiency of voice adaptation strategies.

As previously mentioned, one of our objectives for the group was to enable each member to gain more control over the voices in their own way. Our results suggest that certain respondents seem to have gained power over their voices. Based on their perceptions, this empowerment stems from the acquisition of knowledge on the phenomenon and new coping strategies, the development of skills and aptitudes to identify strategies and techniques best adapted to their cases and that can be applied to them if necessary. In the opinion of participants, a better understanding of the phenomenon appeared imperative to the process of taking power over the voices, since, when we know a phenomenon, it is easier to take steps to face it. This is what made certain respondents say, after this first group experience, that they were not yet at a stage of taking power over the voices, but they were in a transition and experiencing a new wave of self-confidence. However, we noted that this process is triggered in respondents and is in keeping with the group pace. Since this comes out of the literature, it can take a certain amount of time before the people take control over their voices and become more empowered in this regard. It is in this sense that McLeod et al (2007) suggested that using a slow, repetitive approach in the groups to take into account the difficulty that these people have to accept and understand the information that is given to them during the group meetings.

Universality develops when participants in the group become aware that other people go through similar problems and share concerns and emotions with others (Turcotte and Lindsay, 2001). Based on McLeod et al (2007) and Newton et al (2007), we saw that universality is one of the more beneficial therapeutic factors for the group. Our study came to the same conclusions as these authors, namely that voice hearers meeting other people with similar experiences feel less alone and isolated. The results of our study suggest that a group approach without any clinical objectives is also beneficial to help voice hearers to better deal with their voices. We are aware that the training and support groups for voice hearers were not used optimally as in the clinical studies; nevertheless, they produced interesting results, which breaks new ground for developing groupwork with this clientele.

Self-disclosure, the feeling of belonging to the group and the instillation of hope also emerge from our analysis. These factors come through in the interactions with other members. Self-disclosure refers to sharing with other members of the group personal and intimate information that is rarely revealed (Turcotte and Lindsay, 2001). This factor arises when a climate of trust and mutual respect is apparent in the group. The facilitators of the training and support groups were able to create this ideal climate for the group to run smoothly, which enabled members to freely express themselves without fear of being judged about their experience as voice hearers.

The sense of belonging is a therapeutic factor related to group cohesion. Turcotte and Lindsay (2001) pointed out the fact that feeling accepted by the other group members is especially important for people who are isolated and feel rejected, since the group is the only place where they feel accepted for who they are. In the opinion of respondents, training and support groups were a place where they felt accepted, since they participated without fear of being judged and no prejudice was expressed.

The instillation of hope was expressed though the relief and optimism experienced by the members when they saw other people in the same situation who are making progress and improving their life (Turcotte and Lindsay, 2001). The groups evaluated were guided by the recovery approach. Hope also is one of the factors that facilitate recovery. While the feeling of hope enables participants to put effort into the group, it also enables members to dream and hope for a better life, even if the voices persist. In general, following their participation in the group, respondents perceived positive changes in their life even if a lot remained to be done towards taking control and power over their voices.

Given the social taboo and stigma surrounding hearing voices, most voice hearers are not inclined to discussing this phenomenon with other people and prefer to keep this experience secret, thus avoiding being judged by others who all too often convey to them that hearing voices is an 'abnormal' thing (Romme and Escher, 1993). As shown by McLeod et al (2007) and Newton et al (2007), the results of our study indicate that the training and support groups enable participants to feel less isolated, reduce the feeling of being stigmatised or perceived as marginal because of the voices, and normalise their situation.

The results of this study, like those of British research (Chadwick et al, 2000; McLeod et al, 2007; Newton et al, 2007), pointed to a number of benefits that voice hearers gained in speaking about the phenomenon and sharing this experience with others as part of the group process: they can build ties with other people, which reduces the feeling of isolation, improve their repertoire of adaptation strategies in dealing with voices, normalise their perceptual experience, share information, acquire new knowledge on the phenomenon.

This group approach with its flexible facilitation is based on the strengths of people and their abilities to adapt to voices. In light of the results of our study, we believe that the training and support groups would gain by being well structured given their educational component. As pointed out by Turcotte and Lindsay (2001), the group facilitator in educational groups must set up a structure that fosters the acquisition of knowledge and learning of behaviour that they deem useful. We believe that it would be appropriate to spread out the group programming over a one-year period in order to follow the group pace, probe deeper into the subjects discussed and facilitate the integration of concepts and practices acquired by people in their day-to-day life. We believe that it would be important to form larger groups in order that more people with similar characteristics that take part and thus facilitate the identification, development of a sense of belonging and universality of the experience (McLeod et al, 2007; Newton et al, 2007). In our opinion, and given that the recovery process of these people is long and generally starts when they begin talking about their experience, it is important to make sure that this support network is not interrupted once the group meetings are over and to offer people the possibility of maintaining ties developed during the group process. For example, members who so wish could join a support group following their participation in the training and support group, as is done in England (Hearing Voices Network). These support groups would be self-regulated, would constitute an extension of group meetings, and would probably satisfy the needs of members to continue meeting to maintain a long-term support dynamic and satisfy daily or ad-hoc needs. In this way, social workers could contribute to setting up these types of groups.

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