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# The voices others cannot hear

Simon McCarthy-Jones and Eleanor Longden look at what they mean and, for people who want support, what is to be done

**The biological disease conception of auditory verbal hallucination holds that their causes and treatment are directed by biology alone, that their discussion is detrimental and their content arbitrary. An alternative view sees voice-hearing as a widespread and meaningful human experience, encouraging a dialogue with the voices in order to discover what they mean and change the hearer's relationship with them.**

**Is it possible to reconcile these two views?**

'You bitch!', a voice screams at you. 'Cut your throat! Cut it now!' Yet nobody is there; you are experiencing an auditory verbal hallucination (AVH). It's a symptom of brain disease, synonymous with schizophrenia. They should be eliminated using antipsychotic medications or other biomedical interventions which correct underlying neurochemical/neurophysiological imbalances. You lack insight, believing the AVH to be real. Discussing the content of the AVH is not advised: the content is meaningless and discussion will encourage delusional ideation.

This biological disease conception of AVHs, proposing their causes and treatment to be directed by biology alone, their discussion to be detrimental and their content to be arbitrary, will undoubtedly resonate with the training of some readers and the psychiatric service experiences of many voice-hearers. Since Ancient Greek physicians argued AVHs were caused by chemical imbalances (an excess of black bile), factors such as anatomical advances in the Renaissance, the 17th-century Anglican Church's decision to label rebellious people claiming to hear God's voice as physically ill, and the discovery that antipsychotic medication could help some people with AVHs (and be financially profitable), have fuelled the ascendancy of the biological disease framework (McCarthy-Jones, 2012a).

Contrastingly, there have always

existed 'semantically pregnant' understandings of voice-hearing (cf. Berrios, 2002), in which voice-utterances are understood as personally meaningful. In early civilisations this manifested in beliefs that (some) voices contained personally relevant messages from supernatural entities, an idea later prominent in 16th-century mysticism and 19th-century spiritualism. In 20th-century psychology/psychiatry semantically pregnant accounts focused on more earthbound sources of voice-utterances, relating them to events in the individual's life, past and present. Psychiatrists such as Kraepelin, Bleuler and Jaspers identified that voice-utterances had links to voice-hearers' experiences and psyche, an approach stressed by R.D. Laing and revived/extended today by the Hearing Voices Movement (McCarthy-Jones, 2012a; see box opposite).

This has led to an alternative conception of voice-hearing, characterisable as follows:

'You bitch!' a voice screams at you. 'Cut your throat. Cut it now!' Yet nobody is there; you are hearing voices. This is a widespread human experience, most commonly associated with emotional traumas. Voices contain messages for the hearer that may take the form of metaphors. Their content should be decoded (e.g. voices urging to end one's life may reflect a need for change or renewal, or the desire to escape from overwhelming distress) and any underlying emotional problems addressed. Individuals should be supported to engage in a dialogue with their voices to help discover what they mean, and to change their relationship with any distressing voices. Voice-hearers are not in need of cure, but emancipation, being allowed to have and understand their experiences without being pathologised or having their voices coercively suppressed.

The existence of these two views today

## questions

How can we draw on service-user expertise to inform and expand psychological understandings of mental health?

What is the role of community psychology in resisting attempts to reformulate distress and social injustice into symptoms of illness?

## resources

Romme, M., Escher, S., Dillon, J. et al. (Eds.) (2009). *Living with voices: Fifty stories of recovery*. Ross-on-Wye: PCCS Books.

Intervoice: The International Network for Training, Education and Research into Hearing Voices:

[www.intervoiceonline.org](http://intervoiceonline.org)

Hearing the Voice:

<http://hearingthevoice.org>

Eleanor Longden's TED talk:

<http://talentsearch.ted.com/video/Eleanor-Longden-Learning-from-t>

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- Dillon, J. (2011). The personal is the political. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalizing misery* (pp.141-157). Basingstoke: Palgrave Macmillan.

raises questions of their truth and potential reconciliation. Some aspects of the biological disease model can be easily refuted. First, AVHs are not synonymous with schizophrenia, as around two thirds of people with complex AVHs either have other psychiatric diagnoses, such as borderline personality disorder or post-traumatic stress disorder, or are 'healthy voice-hearers' (i.e. they hear voices in the absence of social/occupational dysfunction) (McCarthy-Jones, 2012a). Second, although AVHs have been deemed 'a symptom of brain disease just like blindness' (Stephane et al., 2003, p.186), the existence of healthy voice-hearers shows that the experience is not necessarily associated with pathology. Both observations are well known to psychologists working in this field (Morrison & Barratt, 2010).

### Evaluating interventions

To address other issues raised by these two contrasting approaches, an evaluation of existing interventions is necessary.

### Biomedical treatments

Antipsychotic medication remains the first-line treatment. The contention that AVHs arise from a chemical imbalance comes from the putative ability of dopamine (D2) receptor-blocking drugs (antipsychotics) to help voice-hearers. This raises two questions: (1) Do antipsychotics help voice-hearers? (2) If so, does this mean dopamine is causally involved?

Clinical experience suggests that antipsychotics do help some voice-hearers.

## The Hearing Voices Movement (HVM)

The contention that voice-hearers 'are people with problems, not patients with illnesses' (Johnstone, 2011, p.27) owes its momentum to the research of Marius Romme and Sandra Escher. Devised in partnership with both patient and non-patient voice-hearers, their work has advanced the principles that 'hearing voices', a term viewed as less colonialising of experience than 'AVHs', is a common human experience that has a personal, interpretable meaning in relation with life history, and that is often



precipitated and sustained by overwhelming, disempowering life events (Romme & Escher, 2000). Correspondingly, they have advocated a process of normalising voice-hearing, accepting and making sense of voice presence, and respecting the subjective reality of the voice-hearer (Longden & Dillon, 2013).

These initiatives have gained increasing currency over the last 20 years and together incorporate the HVM, a social, clinical, and political collective in which groups of voice-hearers and professional allies (known as Hearing Voices Networks) work together to promote empowering accounts of voice-hearing and to support distressed individuals in respectful, effectual ways that promote recovery (Longden, et al., 2013). There are now official networks in 21 countries, coordinated and supported via Intervoice: The International Network for Training, Education and Research into Hearing Voices. Intervoice attempts to diminish the divide between workers and psychiatric survivors by emphasising a fusion of experience-based expertise (voice-hearers) and professional expertise (mental health practitioners, academics). Nevertheless, primacy is accorded to user-led politics, which privilege the choice, control, and autonomy of voice-hearers themselves.

However, it has been noted that there is no available research that monitors the specific effect of antipsychotic medication on AVHs in a scientifically valid way (Corstens et al., 2012b). Randomised controlled trials (RCTs) of antipsychotics that report on AVH-change give mixed results and suffer from staggering drop-out rates, biases potentially introduced by pharmaceutical company funding and, particularly in the case of older trials, statistical and methodological limitations

(see McCarthy-Jones, 2012a). Although Sommer et al. (2012) report the percentage of first-episode psychosis patients with at least mild levels of hallucinations decreased from 100 per cent at baseline to only 8 per cent after a year of antipsychotic treatment, this study had no non-antipsychotic control group (see Corstens et al., 2012b, for a full critique). Indeed, the evidence base for antipsychotics' effectiveness in treating psychosis has been questioned. Regarding chlorpromazine,

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Garety, P.A., Fowler, D.G., Freeman, D. et al. (2008). Cognitive-behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis. *British Journal of Psychiatry*, 192, 412–423.

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et al. (in press). Dopaminergic function in the psychosis spectrum: An [18F]-DOPA imaging study in healthy individuals with auditory hallucinations. *Schizophrenia Bulletin*.

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Kapur, S. (2003). Psychosis as a state of

aberrant salience. *American Journal of Psychiatry*, 160(1), 13–23.

Lepping, P., Sambhi, R.S., Whittington, R. et al. (2011). Clinical relevance of findings in trials of antipsychotics: Systematic review. *British Journal of Psychiatry*, 198(5), 341–345.

Longden, E., Corstens, D. & Dillon, J. (2013). Recovery, discovery and revolution: The work of Intervoice and the hearing voices movement. In

Adams et al. (2007) recently concluded that in spite of 45 years of research ‘very little can be said from trials regarding its direct effect on mental state in general or specific symptoms of schizophrenia’, and argued that the ‘use of chlorpromazine for millions of people is based on clinical experience rather than the poorly reported trials that involve, in total, only a few thousand participants’ (p.13). Regarding Risperidone, Rattehalli et al. (2010) have concluded that it ‘may well help people with schizophrenia’ but that the data in their review of RCTs was, ‘unconvincing’, and hence ‘people with schizophrenia or their advocates may want to lobby regulatory authorities to insist on better studies being available before wide release of a compound with the subsequent beguiling advertising’ (p.18). Similarly, Lepping et al. (2011) recently found that the clinical significance of improvements reported by trials of antipsychotic drugs for people with schizophrenia or other psychotic illnesses improvements was ‘disappointingly limited’ (p.344). Thus, although it seems that antipsychotics do help some people with AVHs, this conclusion appears to be based more on clinical experience than blinded RCTs (and certainly not on any meta-analyses).

If antipsychotics do help some voice-hearers then, given their mechanism of action, does this mean that dopamine plays a causal role in AVHs? Not necessarily. First, a recent (albeit small) study of healthy voice-hearers found that they did not have different dopamine synthesis capacities to healthy non-voice hearers (Howes et al., in press), raising the question as to whether dopamine is necessarily involved in all AVHs. Second, the way antipsychotics appear to work (when they do) is through simply making AVHs less salient (Kapur, 2003); that is, the voice remains but the hearer is less affected by it. But if a bully was punching your arm, and you anaesthetised your arm to make the bully less bothersome, you would not think that the anaesthetic was a cure, or that its absence was the cause of the punching. Indeed, Johnstone (2011)

has proposed that antipsychotics act to suppress experiences (such as voices) rather than allow people to understand them. Therefore, although dopamine is likely to play some role in many AVHs, ending the debate on the causes of AVHs with a dopamine-based account leaves many more interesting and important questions unasked, such as where did the content of the voice come from in the first place?

Evidence for other biomedical interventions for AVHs is either inconclusive or, in the case of electroconvulsive therapy, non-existent (Sommer et al., 2012). Early meta-analyses found large effect sizes for transcranial magnetic stimulation (TMS) of AVHs. However, negative findings from larger, subsequent RCTs have resulted in the most recent meta-analysis only finding a small effect size of TMS, and questioning whether it may only help some voice-hearers (Slotema et al., 2012). Going beyond TMS, a recent study has suggested that transcranial direct current stimulation (tDCS) may be effective for voice-hearers (Brunelin et al., 2012). Other biomedical interventions have also been proposed, such as neurofeedback (McCarthy-Jones, 2012b) and remyelinating medications (Whitford et al., 2012), but these await empirical testing.

Traditional psychological interventions Should we talk about voices? The cognitive model of AVHs argues that the level of distress voices cause predicts the need for care and that distress is in turn predicted by specific beliefs about the voices, such as their perceived omnipotence. Talking about voices in order to reduce distress caused by unrealistic/inaccurate appraisals, the core of cognitive behavioural therapy (CBT) for AVHs, therefore seems sensible.

What is the evidence this works? Most blinded RCTs of CBT for psychosis report negative findings for AVH-change (e.g. Garety et al., 2008), perhaps due to a lack of specific focus on AVHs. Of the two blinded RCTs of individualised CBT

specifically for AVHs (which both focused on command hallucinations) the first found large reductions in distress and voice frequency, and increased control over voices, compared to treatment as usual (TAU: Trower et al., 2004). However, the second later study suggested that these improvements may lack specificity to CBT, finding CBT (including an element of acceptance and commitment therapy) to be no better than a befriending control condition (Shawyer et al., 2012). Blinded RCTs of group CBT for AVHs mirror this pattern, with McLeod et al. (2007) finding CBT better than TAU, but Penn et al. (2009) finding no difference between CBT and an ‘enhanced supportive therapy’ control condition.

One interpretation of these findings is that therapeutic alliance (or in the case of befriending, simply listening/empathising), rather than CBT-specific techniques, explain the effect of CBT with AVHs (e.g. Bentall, 2009). However, we still await a definitive, well-powered blinded RCT of CBT for AVHs, which can detect any potential small to medium-size effects of CBT compared to non-specific therapies. Another explanation for a lack of evidence for large effect sizes specific to CBT is that by focusing primarily on beliefs about voices CBT, like antipsychotic prescription, may often not address the core reasons why the voices are there. Surprisingly, it is not psychology driving this ‘why’ question, but a body situated beyond the mental health system.

#### The Hearing Voices Movement (HVM) approach

The HVM (see box on p.571) emphasises links between voice content and traumatic/emotional life-events, which it systematically examines using the Maastricht Interview (Romme & Escher, 2000). This assesses potential associations between the person’s life history and their voices through exploration of voice characteristics, content, triggers, and development, as well as significant related life events. Voices are conceptualised as bearing messages for the voice-hearer, and

S. Coles, S. Keenan & B. Diamond (Eds.) *Madness contested: Power and practice* (pp.161–180). Ross-on-Wye: PCCS Books.

Longden, E., Corstens, D., Escher, S. & Romme, M. (2012). Voice hearing in biographical context. *Psychosis: Psychological, Social and Integrative Approaches*. 4(3), 224–234.

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McCarthy-Jones, S., Trauer, T., Mackinnon, A. et al. (2012). A new



needing to be actively engaged with and listened to in order to understand the underlying emotional problems potentially represented by their presence. The HVM technique of 'voice dialoguing' involves the therapist speaking directly to the voices by addressing questions to them, asking the voice-hearer to relay the voices' responses, and using exploratory dialoguing techniques to engage with voices in order to instigate integration and reconciliation (e.g. Corstens et al., 2012a). The voice can thus be questioned about what it 'wants' and why it is there; an approach frequently employed by therapists in the field of dissociative disorders, and consistent with the emerging clinical/conceptual overlaps between dissociation and psychosis (Moskowitz et al., 2008).

To date there have been no rigorous scientific trials of the HVM approach. The evidence for its success is limited to individual testimonies (e.g. Coleman, 2011; Dillon, 2011), suggestive quasi case-studies (e.g. Romme et al., 2009) and the clinical/personal experience of those working in this tradition (e.g. Hornstein, 2009).

### Truth, reconciliation and the benefits of partnership

How does the above aid our assessment of biological disease and semantically pregnant understandings? First, as dopamine-based interventions appear to work through reducing the emotional impact of voices (and say nothing about the aetiology of voice content), this raises concerns over accounts of AVHs which focus on disease-based neurological imbalances occurring independently of social contexts. Second, and potentially in part related to this focus on molecules rather than meaning, there is the possibility that antipsychotics may impede recovery, or actually be harmful for some people (Whitaker, 2010). Third,

if mental representations or emotions underpinning critical, malevolent voices still remain when the voices are made less salient, they may continue to exert malign effects on the person's functioning through other routes, such as low self-esteem, dissociation, or self-harm. In this sense, by medicating voices away, or only



**What proportion of individuals hear voices with content that makes sense in the context of their lives?**

using CBT to change them into a less impactful experience, we may be merely muting the messenger.

At present a major barrier to progress is that there is no concrete, scientific data available to assess the HVM's claim about the meaningfulness of voice content. The first key question for future research is what proportion of individuals hear voices with content that makes sense in the context of their lives? Careful formulation, using tools like the Maastricht Interview, may be one way to assess this (Longden, Corstens et al., 2012). For voices that are adjudged semantically pregnant, the next key question is whether exploring voice content can reduce social and occupational impairment by improving the hearer's relationship with their voices (or even resolve/eliminate them entirely, depending

on their goals) and aiding any underlying emotional issues; or whether underpinning emotions should simply be addressed directly.

We should be cautious of thinking that either a biological disease or a semantically pregnant account is correct. Both may contain significant truth, but each in relation to a specific subset of AVHs. Voices with content that appears random and biographically intangible may be best conceptualised and treated in a biological disease framework. Voices that appear to be linked to life events and communicating a meaningful message may be better conceptualised at a psychological level, and intervened with by an HVM-inspired framework, supplemented by antipsychotic medication if helpful. Correctly determining the meaning of a given voice is hence crucial. As St Paul wrote, 'if I know not the meaning of the voice, I shall be unto him that speaketh a barbarian, and he that speaketh shall be a barbarian unto me' (1 Corinthians 14:11).

So rather than seeing these models as having distinct dominions, how may reconciliation take place? Semantically pregnant approaches can inform biological understandings by examining how emotional/traumatic life events may cause some of the neural changes associated with hearing voices. Links between voice-hearing and life adversity are well established (e.g. Longden, Madill et al., 2012), and the similarities between the developmental impact of trauma/stress and the neurological changes apparent in persons diagnosed with schizophrenia have been highlighted (Read et al., 2001). Conversely, biology may inform the semantically pregnant approach by examining whether genetic differences can account for why some people experience trauma and don't go on to develop voices, whereas others do.

Biology may also both complement or challenge first-person accounts by inferring what cognitive process are likely to be occurring during AVHs from an examination of neural activation during and before voice-hearing. For example,

phenomenological survey of auditory hallucinations. *Schizophrenia Bulletin*. Advance online publication. doi:10.1093/schbul/sbs156  
McLeod, T., Morris, M., Birchwood, M. & Dovey, A. (2007). Cognitive behavioural therapy group work with voice hearers. Part 2. *British Journal of Nursing*, 16, 292-295.  
Morrison, A.P. & Barratt, S. (2010). What are the components of CBT for

psychosis? A Delphi study. *Schizophrenia Bulletin*, 36, 136-142.  
Moskowitz, A. & Corstens, D. (2007). Auditory hallucinations. *Journal of Psychological Trauma*, 6(2/3), 35-63.  
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para-hippocampal involvement immediately preceding some AVHs (Diederer et al., 2010) may support contentions that memory processes are involved. Indeed, this claim has since found support from the largest study of the phenomenology of AVHs (McCarthy-Jones et al., 2012). Ultimately, by working from both a first-person phenomenological perspective, and a neurological bottom-up approach, we may be able to better determine the role and significance of different voice-hearing experiences.

### Taking interventions and research forward

Taken together, the HVM's proposals and the lack of evidence for the specificity of CBT for AVHs suggests CBT needs to involve more than just working with clients' beliefs about their voices. There is already a consensus among experts in CBT for psychosis that therapists 'should work directly with content of voices to explore its relationship to life experiences and beliefs about the self' (Morrison & Barratt, 2010, p.139). It may be that CBT simply needs a quantitative change rather than a qualitative one, focusing more on this element of therapy. Trials of CBT stressing this therapeutic element, as opposed to simple belief change, may aid its specificity. This change would continue the influence of the HVM on CBT, rather than begin it, as several psychologists who pioneered CBT for voice-hearing developed fruitful partnerships with the leaders of the English HVM during the 1990s. The effects of this influence can also be seen today in the development of other therapeutic techniques, such as 'relating therapy,' which involves enhancing reciprocity and power dynamics in the relationship between hearer and voice (Chin et al., 2009).

The emphasis HVM places on associations between adverse life events and voice-hearing is already helping overcome the reluctance to offer trauma-based therapies to voice-hearers with

psychotic diagnoses, and there is now increasing evidence to suggest such methods may be suitable to engage people in order to understand, interpret and overcome their distress (Longden, Madill et al., 2012). Trauma-related emotions such as guilt and shame, which appear central to many instances of voice-hearing (McCarthy-Jones, 2012a) could also be addressed through 'compassionate mind training' (CMT) for voice-hearers (Mayhew & Gilbert, 2008). Both CMT, and the effectiveness of befriending interventions (Shawyer et al., 2012), highlight that love and attachment may also be of central importance (McCarthy-Jones & Davidson, 2012).

Involving voice-hearers as active partners in research protocols could also enhance future investigative endeavours. Ideally this would include devising hypotheses and questions that voice-hearers identify as relevant for their daily lives, and increasing efforts to evaluate interventions according to user-defined criteria. In this respect, outcome measures developed in partnership with service-users would be a welcome addition to the field.

### Expanding psychology

Finally, it is worth considering what voice-hearing offers psychology. Voice-hearing incorporates the process of 'Other' dynamically engaging with 'Self' (Moskowitz & Corstens, 2007). It hence invites a range of rich conjecture including the concept of voices as dissociated representations of the self, or self-other relationships, which grow disparate and disowned, possibly through stress exposure (Longden, Madill et al., 2012). The tendency of voices to take different perspectives to the voice-hearer (e.g. speaking about them in the third person) raises questions about how representations of self are generated and stored. It also adds support to the concept of both the self (Hermans, 2001)

and inner speech (Fernyhough, 2004) as dialogical. As such, voice-hearing – literally – speaks to the philosophical notion of co-consciousness, and human personality as a fluid, non-unitary entity, and is fertile ground for improved psychological understandings of the nature of the self.

Politically, the HVM locates itself as a civil rights body that advocates respect, dignity, citizenship, and inclusion for its members, and uses collective protest and debate to challenge an established system. As with other reformative activism, it aims to transform a persecuted minority experience to a position of solidarity and collective empowerment; a true form of social and psychiatric revolution (Longden et al., 2013). This corresponds to other approaches that resist attempts to reformulate pain and oppression into symptoms of illness, thus deflecting attention from harmful social systems into individual pathology (e.g., Herman, 1992). This challenges psychologists to look at the wider meaning of voice-hearing (McCarthy-Jones, 2012a).

Psychology has much to offer voice-hearers, and voice-hearing in turn offers much to psychology. It is now time to work together to fulfill this promise.

"voice-hearing in turn offers much to psychology"



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