TALKING TO VOICES

USING THE VOICE DIALOGUE METHOD WITH PEOPLE THAT HEAR VOICES

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This article presents a brief survey of techniques used to treat auditory hallucinations, especially with people that hear voices.

'What you ignore persists, what you look at disappears.' – N.D. Walsh

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Introduction
Epidemiological research of the past twenty years has shown that hearing voices with the characteristics of auditory hallucinations, occurs in two to four percent of the population. In the majority of cases, there is no mental disorder present. (Eaton, Romanowski & Anthony, 1991; Sidgewick, 1994; Tien, 1991). Recently, this was also demonstrated by the Dutch NEMESIS study, a screening of seven thousand people, performed by the Trimbos Institute (Bijl, Ravelli & Van Zessen, 1998). Often, social workers are surprised by this fact, as they only meet people who are actually bothered by the voices. Moreover, research has shown that the difference between those who become patients and those who do not, is linked to the attributes that are given to fear of the voices and to their power (Chadwick & Birchwood, 1994; Romme & Escher, 1989). There is no doubt that hearing voices is often attendant on symptoms as depression, anxiety, dissociation, suicidal tendencies and persistent beliefs. About one third of the people that hear voices suffer to such an extent that they seek professional help (Tien, 1991). However, there are countless voice hearers that have taught themselves or each other, how to deal with the voices (Romme & Escher, 1999). Various mental disorders involve hearing voices. In treating voice hearers, we focus on the symptom itself and the consequences experienced in daily life. Through the years, cognitive psychologists have developed various methods to treat voice hearers (for surveys, see Haddock, Bentall & Slade, 1996; Martindale, Bateman, Crowe & Margison, 2000; Romme & Escher, 1999). In The Netherlands, too, a number of groups are involved in this work, among others Jack Jenner in Groningen, Ben Steultjens in Ermelo, Mark van der Gaag in Leyden en Lucia Valmaggia in Assen. Without exception, their methods aim at enabling the voice hearer to deal with the voices. Methods from behavioral therapy and cognitive psychology are mostly used for this purpose.

Methods of treatment
Romme en Escher (1999) group methods and techniques of treating voices according to the amount of time invested.

Short-term techniques

Listening. Clients are encouraged to listen carefully to their voices. It is important to make a distinction between hearing (perceiving noises that we filter and leave in the background of our consciousness), listening (paying careful attention to what someone is saying without immediately judging the content and without allowing all kinds of emotions to emerge), and obeying (do what you are told without question).

Allocating time. The client is advised to allocate a specific time for listening carefully to the voices, on a daily basis. In this respect, it is useful to put neutral, open questions to the voices. If the voices appear outside the allocated time slot, they are directed to that time slot. (For example, 'I am willing to listen to you, but if you want me to, you must come back at 9 o'clock tonight'.) Voices want to be heard, is the adage. This comes as a surprise to many voice hearers. Often, the voices will change their content, allowing the hearers to develop a different relationship with them (cf. Korrelboom, 1989; Van der Werf, Hermans & Van Ree, 1989).

Negotiation. It may be necessary to negotiate with the voices. For example, when the voices give instructions that the voice hearer is willing to carry out, but not at the exact moment the voices ask him to. Sometimes this requires courage.

Recording. Recording what the voices are saying and how the voice hearer reacts, will increase control. Keeping a diary of voices is a tested method to reduce cognitive avoidance. Voice hearers often practice this avoidance, as phobic patients do. One voice hearer, upon practicing this method, was extremely surprised to notice that the voices became silent when he opened up to them, whereas in the past they would talk to him all day long (cf. Korrelboom, 1989).

Dialogue. It is possible for voice hearers to start a dialogue with their voices. If patients are already doing this, the counselor could suggest that they ask different questions, or answer differently themselves, and thus try to create a new situation for themselves and for the voices. When voices give instructions, quite often these are self-destructive. It is possible to talk about this, discussing for example who is really in charge.

Medication. Anti-psychotic medication may be of help, but should not be prescribed automatically. This kind of medication will help to reduce anxiety, but it seldom makes the voices disappear. Anti-depressants may also help to influence the way the voices are dealt with. Generally speaking, medication policy should be based on a careful anamnesis with regard to medication formerly used, the effects that were perceived, and particularly with regard to the patients wants and needs that are the result of his own former experiences.

To sum up, it may be stated that short-term techniques are aimed at enabling the voice hearer to exercise control over the voices.

Techniques for a middle long period

Cognitive therapy. Cognitive therapy is a tested method for people that hear voices and stick to persistent beliefs. Meanwhile three meta-analyses have been published that describe favorable effects. The meta-analysis of the Cochrane Library containing five studies (Cormac, Jones, and Campbell, 2002), the meta-analysis by Pilling et al. (2002) containing eight studies, and the most recent one, from the National Institute of Clinical Excellence in Great Britain, containing thirteen studies (NICE, 2002). Most of the time, cognitive therapy will look for a rationale explaining how the

voices came into existence (normalizing rationale; Kingdon & Turkington, 1994). Usually it involves the interaction between vulnerability and circumstances of life that are stressful. Next, the therapy will address the ideas the patient has with regard to the voices. Jointly, therapist and patient will question these suppositions as to their tenability, and they will challenge them (collaborative empiricism; Chadwick & Birchwood, 1994). An attempt is made to cast doubt on the beliefs of the patient. Experiments may tell the patient whether his ideas should be adjusted or not. This may have far-reaching effects on the experience of hearing voices. We refer to Corstens en Hofman (1997) for an extensive case description.

Self-help groups. Self-help groups can be of great importance assisting people that hear voices. The focus here is on empowerment and destigmatizing. Comparing experiences may help change the self-image of the voice hearer (Pennings & Romme, 1997).

Training in social skills. Many voice hearers have a problem restricting the power of the voices. Many voice hearers benefit from the statement “Treat the voices exactly in the same way as you treat your acquaintances.”

Long-term techniques

Long-term techniques focus not so much on the voices themselves as on the actual circumstances and underlying problems.

Rehabilitation. Rehabilitation is a lengthy process. It is essential to pay attention to a daily program, to work, intimacy, a social network and existential problems; this is something every human being needs.

Healing a trauma. Events in life that were very threatening often lie at the basis of hearing voices. If so, dealing with the trauma must be part of the therapy. It can help the patient to acquire more insight into, and grip on his own emotional environment. Often voice hearers are denied psychotherapy, based on different, often unjustified assumptions (causing a psychosis, fear of the voices), whereas this group, too, may definitely profit from such therapy (cf. Martindale et al., 2000).

Treating voice hearers is a process that requires an open mind, perseverance and a certain amount of creativity. Techniques are a means of helping this process along. Voice Dialogue can be one of the (long-term) techniques used to make a breach in the rigid pattern that keeps the voice hearer captive.

The Voice Dialogue technique

The Voice Dialogue technique was developed by Hal and Sidra Stone (Stone & Stone, 1993). The name of this technique, or rather, this method, points to the inner voices that are presumed to dwell inside us. The theory of the Stones’ presupposes that the human personality is not a single entity, but consists of various sub personalities. Each manifests itself in its own way. They come into existence as the result of a person’s experiences and they constitute a system of primary and disowned selves. Primary selves will assert themselves most clearly, because they were more successful than others in the environment the person lived in. One example of such a primary sub personality is the “Inner Critic”. This is a part that is especially critical of everything a person undertakes, and controls the adaptation to supposed standards. The disowned parts play a role in the background and may be the cause of inner conflicts with the primary selves. One example of such a disowned self is the “Inner Child”. It is a part in which the desires and needs of a child show themselves. The Voice Dialogue method, therefore, resembles Young’s scheme oriented, cognitive therapy (cf. for example Corstens & Arntz, 2000).

In Voice Dialogue, the therapist (here called the "facilitator") tries to make contact with the sub personalities. The aim is not so much to interfere actively with their behavior, but rather to instigate a process during which these parts can step forward and express themselves fully. The parts that present themselves are not judged in any way, but they are asked after their characteristics and their role, in a respectful manner. An effort is made to establish contact with both primary and disowned selves. The ultimate aim is for the patients to develop an Aware Ego, which allows them to distance themselves from their sub personalities, and develop more control. More information on this is to be found in Stone & Stone (1993) and Stamboliev (1993).
The Voice Dialogue method, which at this time is used with only a few psychiatric patients, gave us the idea to talk to the voices of people that hear them. Therefore, together with Robert Stamboliev, we started using the method with some of our patients, and to our surprise, we found that it is possible to bring about lasting changes in just a few sessions. Furthermore, the voice hearers were very satisfied with the method.

How is Voice Dialogue used in treating voice hearers?

Grounds for treatment
The Voice Dialogue method is applied with the patient's consent only. For many voice hearers it is a natural thing to talk to their voices, but it feel strange when others will do so. Therefore, it is important to provide them with reassuring information. In most cases, the voice hearer feels he is being taken seriously, for the therapist approaches the voices as if they were real. The voice hearer can stop any moment he wants to, he controls the process, and the therapist makes sure the session is ended in a proper manner.
It is not advisable to treat people who are very confused with this method, because it can make the confusion worse. The method should not be used with persons suffering from an acute psychosis, who are still very frightened of the voices, either. In such cases, creating a feeling of safety is much more important. However, there is no counter-indication in the case of diagnosed schizophrenia. Many of these patients are capable of making a distinction between the voices and themselves, and of establishing a dialogue; they may profit from a better relationship with their voices.

Making an inventory
After the first introductions and an assessment of the help that is needed, the therapist will conduct the so-called interview with the voices (Romme & Escher, 1999). It consists of a list of questions that address different aspects of hearing voices. For example, how many voices are present, what are they saying, who do they represent, when did they originate and under what circumstances? The therapist also asks the voice hearer how he interprets the voices, how they can be called up, and how he deals with them.

It often happens that the voices forbid anything being said about them, or that the voice hearers expect such a negative reaction that they are afraid to discuss it (cf. Van der Werf et al., 1989). Therefore, many voice hearers are relieved to be able to talk about the voices at long last. At the same time, the therapist may convey reassuring and optimistic information about hearing voices during the interview. The therapist will point to experiences of others. An atmosphere of hope is created, based on the fact that several voice hearers have succeeded in dealing with the voices. Often, the voice hearers who are seeking help, want the voices to disappear. The interviewer will stress the fact that this goal is not a realistic one, though it does sometimes happen. The focus is on reducing the trouble that the voices are causing.

The inventory is completed by a written report. In it, the interviewer will show – with a construct, or diagnosis – how life experiences, conflicts and voices are related to each other. On the basis of this report, interventions can take place. More information can be found in Romme & Escher (1999). Another option is to give people the workbook of Coleman en Smith (1997), in which voice hearers can answer questions about their voices by themselves. This workbook is full of suggestions how people can change the way they deal with their voices.

Establishing contact with a voice

The first step in the method is to ask the voice hearer how the voices would feel about talking to the therapist. It is elaborately explained that there is no intention of trying to repress the voices or chase them away, but that the focus is on getting to know them better. Obviously, they must give their consent. This explanation may reduce initial resistance. Giving examples of positive experiences with the method may also add to the willingness to cooperate. It is important to make the voice hearer and his voices curious of the process.

If necessary, the voice hearer can pass on the questions of the therapist to the voice and subsequently convey the answers of the voice (cf. Korrelboom, 1989; Van der Werf et al., 1993). Of course, this is an indirect method, allowing interference by the voice hearer. However, sometimes patients need this type of control. Others very easily identify themselves with the voice(s) and make “direct” contact, as in a “normal” Voice Dialogue session. In such cases, the voice will talk directly to the therapist.

Usually the therapist asks the voice if it is willing to move to another position in the consulting room, making it easier for patient and therapist to know who is talking. Moreover, the therapist will stress the fact that the patient always remains in control. The therapist will also make it very clear that in the end, they will return to the original situation, and in that position will review the session and wrap it up. If the voice has doubts about all this, the therapist will negotiate with it. It is not advisable to let people leave in a dissociated state.

Some people have amnesia with regard to conversations with the voices. Others will remember everything quite well. When people can recall nothing at all of a conversation with the voices, the therapist can tell them what the voice said. Alternatively, the voice hearer can later watch a video registration of the conversation.

Questions to the voice

In actual practice, the therapist uses open questions, meant to clarify matters. It must be stressed that the therapist is not to enter into a discussion with the voice. Examples of questions:

– Who are you?
– Do you have a name?
– How old are you?
– Does the person know you?
– When did you first appear in the person’s life?
– What caused your appearance?
– How were circumstances at that time?
– What things are you taking care of?
– What is your aim?
– What would happen if you were not there?
– How is the person treating you?
– What difficulties do you experience in your contact with the person?

The therapist makes sure the voice will speak about the patient as if he or she were someone else. A dialogue will be established in which the voice will comment on his or her role in the life of the patient. The patient's vulnerabilities and underlying emotional topics will now come to the surface, which subsequently make it clear where the shortcomings of the voice hearer may be found, but also what kind of protection the voice is offering.

A voice in Wil, for example, (see the case description) is constantly telling Wil that he should kill himself. In a discussion with the voice, it becomes clear that actually Wil should put up more resistance against people in his environment. Moreover, that in putting up resistance against the voice itself, he will be able to set limits with regard to people who want to humiliate him. In this way, the emotional logic of the voice becomes apparent, and the voice's manner will be transformed from threatening to protective. In this example, the voice became "the teacher", whereas before it had a menacing nature. Actually, this amounts to cognitive restructuring, by putting a positive label on the voice's message.

On the basis of two case descriptions, we will illustrate how the method can make a breach in a long-existing, rigid pattern that keeps the voice hearer captive.

Case descriptions

Case description 1: Karen and her frustrated protectors
Karen was a thirty-year-old, married woman who had been hearing voices from the time she was four years old. At this time, the voices were supportive and talked positively. As the voices had acquired negative and destructive characteristics by the time she was twenty-one, she consulted a therapist (the first author of this article). The voices refused to recede into the background, in spite of four years of hospitalization, prolonged separations because of self-destructive behavior, and high doses of neuroleptics. At a certain point, however, she decided not to hurt herself anymore and showed she was capable of entering into a relationship and to live on her own. Nevertheless, the voices and her negotiations with them, still dominated her daily life to a large extent. Karen was diagnosed as suffering from a borderline personality disorder. After making an inventory, it was found that she was hearing four male voices. Karen agreed to let the therapist talk to the voices. In the first session, the four voices presented themselves one after another. They mentioned their names, which Karen herself did not know, and explained that they were urging Karen to kill herself. When they were asked why they were doing this, we arrived at the point in time when Karen, twenty-one years old, had joined a religious sect. Her fellow sectarians had called her voices instruments of the devil. Before, when she was a child and an adolescent, Karen had accepted the voices and allowed them to protect her, in an environment in which she was neglected and abused. Each voice individually stated being angry because it had lost its influence on Karen. From the very moment Karen started rejecting them, the voices started to turn against her. They longed to be meaningful in her life again, to support her and to protect her.
In a second session, one month later, two voices appeared to have withdrawn. There was another talk with the two remaining voices, and again it became clear that the voices wanted to exercise more influence. After the fourth session, Karen indicated that she had learned enough to be able to deal with the voices by herself. She kept an account of her talks with the voices, which the therapist was not allowed to read, by the way, and negotiated with her two voices at a fixed time every day. She worked hard herself on dealing with the voices and received support from her own counsellor, who hardly talked about the voices with her. In the meantime, Karen had found a new balance between herself and the voices.

Then Karen got pregnant. Medication was reduced drastically, without any adverse effect on the voices or her anxiety level. She gave birth to a son, and after the delivery showed she was capable of functioning normally. Karen consulted her therapist once more, for more support of the practical measures she had taken. A few months later she sent a letter, stating that the voices had disappeared after she had had a spiritual experience. Recently, some two years ago, Karen wrote that she was using a low dose of neuroleptics and that she was hearing a positive voice that supports her in making choices. The negative influence of the voices is still absent.

Commentary
Karen was frightened to death of her voices. She was able to experience how the voices changed their behavior and became less negative, as the therapist encountered the voices with an open mind and without any fear. When Karen took on the same neutral manner in talking to the voices, the content of their messages changed, making it easier for her to deal with the voices. Talking to the voices made it clear to her why the disowned selves asserted themselves. The protective nature of the voices became more apparent.

Case description 2: Wil and his inner tutor
Wil was a twenty-three year old man, he was jobless and lived alone. He was referred to us because he was hearing a voice. He had being diagnosed with an obsessive-compulsive disorder and his obsession with control had been treated rather successfully. In the past, Wil has been hospitalized with a psychosis a number of times. Clinical treatment in a psychotherapeutical community had been ended prematurely because he was considered too passive. An unorthodox healer had succeeded in making some of the voices disappear, leaving only one. During our contact it became apparent that during the night he would suffer from dissociative fugues. Wil was frightened of the voice he was hearing and avoided all kinds of situations in which he could endanger himself by order of the voice.

Wil's life story boils down to the fact that he had worked himself to death at school, in order to live up to his parents' expectations; his parents were also very critical of him. Wil had not been abused, sexually or otherwise. One week before he would receive a permanent contract for the job of his dreams (which was not the job his parents had envisaged for him, by the way), he started hearing voices, became psychotic (his anxiety and paranoia increasing seriously) and was forcibly hospitalized. His experiences with psychiatry were such that he asked his therapist never to have him hospitalized again. Wil uses a lot of medication, which, according to him, has a beneficial effect on his mood and his anxiety. However, the medication does not help against the voice.
The interview with the voices was done with Wil, too, in a number of sessions. Wil heard a voice that would criticize him severely. As for the content, the voice resembled the voice of one of his parents. The voice urged him to kill himself by jumping in front of a train. Wil would hear the voice all day long. When Wil allocated time to listen to the voice without prejudice, the voice kept silent. For Wil this was an experience of relief and control. When the therapist asked Wil if he could talk to the voice, the voice gave its consent. The therapist asked Wil to speak from the position of the voice, but sitting in another chair than his usual one. When the voice had sat down it spoke loudly, announcing that it wanted Wil dead. After the therapist had established a more elaborate contact with the voice, it stated that it considered Wil a wimp who allowed himself to be messed about with, someone without a backbone. The voice thought Wil should stick up for himself, and not always say yes to everything. The voice agreed that its aim was for Wil to stand up for himself more successfully, and was willing to investigate whether Wil could reach this goal with its help. The therapist then gave the title of "tutor" to the voice, of which it was very proud. Once back in his usual chair Wil indicated that he could remember nothing of what had been said. The therapist

sketched in broad outlines how the conversation had developed, with Wil listening in genuine astonishment. The therapist then advised Wil to keep in contact with the voice every day and told him that the tenor of the conversation was that the voice would try to support him.
At regular intervals the therapist held more conversations with the voice from which it became clear that the voice was happy with the results achieved and especially with the fact that Wil accepted him fully.

During treatment it became apparent that Wil was hearing more voices than one. Clearly, all these voices represented different aspects of his life. For the most part, this involved situations in which Wil had felt vulnerable, and the voices had "adopted" certain emotions, usually anger. The therapist talked to some of these voices. Wil himself talked to them every day. Meanwhile Wil knew ups and downs; during one period the fugues took place every night. (Neurological examinations, and EEG and CT scans did not show any defects.) At a certain point the nightly dissociations ceased. The obsession with control became more serious, but would also fade again.

The voice of the "tutor" is still positive and supportive. Wil is still bothered by three voices that he is afraid of, but is increasing his control over them. He is looking for job opportunities again, does all kinds of odd jobs and has restored the relationship with his parents. His suicidal ideation has receded into the background, and Wil is now capable of entering into relationships. There is still some way to go, but he is better able to control his experiences.

Commentary
Will has always strongly repressed his aggression, and he has put up a tremendous performance, trying to achieve as much as possible, in order to win the affection of his parents. His disowned selves mostly show an aggressive manner, and their nature is dissociative. With the help of the afore-mentioned technique these aggressive parts have been transformed into a protective and supportive system. A next step for Wil could be to work on the grief he experienced when he felt his needs were not appreciated by his parents and his environment. It is still difficult for him to acknowledge this.

Considerations
In Directive Therapy, part three (Directieve therapie, deel drie, Van der Velden, 1989), two chapters explain how dealing with voices can be learned (Korrelboom, 1989; Van der Werf et al., 1989). It is interesting to compare the method we have described above with the approach they have put forward.

The directive-therapeutical strategy that Van der Werf et al. illustrate in their chapter, is to some extent similar to our method. Their strategy contains six steps. To summarize:

1. formulate a limited objective;
2. acknowledge the suffering that is brought about by the voices and that the patient cannot or is forbidden to, discuss;
3. normalize the experience and offer support;
4. make the voices more concrete, offer to collaborate in fighting the voices;
5. give the instruction to make contact with the voices on their own, keep a record of this, and put questions to the voices, enter into a discussion with them, during sessions with the therapist;
6. examine the meaning of what the voices are saying and the connection with the patient's life story.

A point of agreement between this method and ours is the therapist joining the frightening

experience. He acknowledges that the voices are a reality for the patient. He supports the patient in establishing a dialogue with the voice and encourages the patient to listen to the voices, put different questions to them, and behave himself or herself differently during the communication with the voices. Offering hope and normalizing the experience is characteristic of their strategy, as it is of ours. It is our aim, too, to discover the connection between the statements of the voices and the life story of the patient. In this way the content of what the voices are saying becomes meaningful, allowing the patient's ownership of his voices to be restored.

The method described in Van der Werf's chapter is significantly different from ours, in that the therapist actually becomes involved in a fight against the voices. Korrelboom, too, gives a fascinating description of how he is helping the patient conquer the voice of the devil, using a mixture of paradoxical ("don't make a fool of yourself") and congruent ("engage in battle and make sure you win") instructions. Both therapists make contact with the voices indirectly, that is, they help the patients deal with the influence of the voices. It is the voice hearer himself who talks to the voices.

A defense is built, because they are jointly gaining more insight into the way the voices operate. Both therapist help the patient defend himself against voices that, in the experience of therapists, too, are aggressive.

The Voice Dialogue method can be seen as positive re-labeling, with regard to hearing voices. Starting-point is the conviction that the voices are significant in someone's life. In the first instance, the voice hearer considers the voices to be enemies, and is trapped by his own fears. The therapist accepts the psychological reality of the voices, and by establishing a dialogue with the voices, provides a model of alternative behavior. In this way, the frightening conflict becomes negotiable, and a situation is created in which both parties stand to gain something. The voices become allies instead of enemies.

In the strategies proposed by Van der Werf en Korrelboom, aimed at fighting the voices together, the result is uncertain. If the patient feels he cannot stand up to the voices, he will keep "losing". The voice hearer may be caught in a prolonged and exhausting battle against the voices, and the creativity needed by the therapist to keep up the fight, will be depleted. Whenever there are two parties fighting, a mediator will rarely suggest that one party should fight even harder. The mediator will try to change the way the enemies view each other, in order to create possibilities for negotiation.

Conclusion

The Voice Dialogue method has turned out to be a welcome addition to our arsenal of techniques used with voice hearers. Our preliminary conclusion is that voice hearers feel they are taken seriously, and that it helps them deal with their voices in a different and more constructive way. It is a method that is not concerned with interpretation but may bring about immediate changes in the rigid systems that are keeping the voice hearers captive.

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