July 2013

Engaging with voices: Rethinking the clinical treatment of psychosis
COMMENT, CRITIQUE, AND INSPIRATION COLUMN

Engaging with Voices: Rethinking the Clinical Treatment of Psychosis

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Although the hearing voices movement (HVM) has yet to take root in the US to the extent it has in the UK (and parts of Australia and Europe), recent publications and events, including a keynote presentation by UK hearing voices trainer Ron Coleman at the 2012 Annual NAMI convention and a TED 2013 talk in Los Angeles by British voice hearer and psychologist Eleanor Longden, suggest that the tide is starting to turn (Arenella, 2012; Grantham, 2012; Thomas, 2012). At its core, the HVM emphasizes a few basic, but important points: that antipsychotic pharmacotherapy and various forms of psychotherapy that aim to suppress psychotic experiences are often—for too many people—ineffective or insufficient; that voices and other extreme experiences and beliefs carry important messages that need to be explored rather than silenced, and that voices themselves are often less of the problem than the difficulties individuals have in coping and negotiating with them (Corstens, Escher, & Romme, 2008; Longden, Corstens, Escher, & Romme, 2012; Place, Foxcroft, & Shaw, 2011).

Stanford anthropologist Tanya Luhrmann (2012), an expert in voices and unusual experiences as manifest in both religious and psychiatric contexts, underscores an even farther-reaching “insight” of the HVM—namely “that the way we understand our mental experiences has the potential to alter them fundamentally.” As voice hearers’ testimonials underscore, voices that are ignored, temporarily suppressed, or feared to the point that both clients and clinicians are unwilling to engage with them, often persist indefinitely, remaining abusive, distressing, and inaccessible, their “messages” unheard. By engaging with voices, the other hand—approaching them as real, meaning-laden “actors” in the theater of the mind—voice hearers can begin a dialogue with the potential to restructure not only the content and valence of their voices, but their form and structure (Romme et al., 2009). For some voice hearers involved with the HVM, abusive voices gradually become neutral, or even positive; others successfully bargain with their voices for more time alone, or persuade a muffled voice to “come out,” to speak louder, and to clarify what it wants. Disruptive external voices, on the other hand, may become more thought-like and controllable, while greater mastery of voice dialogue may also lead to significant insights regarding healthy internal dialogue, the nature of the self, and the normative interplay between wanted and unwanted thoughts.

Our own work confirms the complexity of the relationship between intentional engagement and experience: Participants in an in-depth phenomenological study of psychosis we are currently conducting, for example, have reported consciously assigning inherently ambiguous unusual sensory experiences to a single modality (such as voice or sight), focusing on only certain experiences and thus, over time, strengthening those experiences while others drop away, or explicitly focusing on sounds, objects, or thoughts to the point that they become more and more auditory, voice-like, or visibly transformed. Others underscore the power of explanatory frameworks—either imposed by clinicians or indigenously developed—to transform the nature of experience; not only reducing the cognitive dissonance of radically unusual experiences, but also providing metaphysical or spiritual frameworks through which such experiences can be organized, interpreted, and brought into meaningful relationships with one another. “The real suffering,” as one participant stressed, “is not what my clinicians call the delusions, but the inability to express what I’m experiencing . . . to make sense of it in any way that anyone else would understand.”

Our point is certainly not to imply that individuals are responsible for or fully in control of psychosis, but rather to underscore the importance of understanding the always only partial (but crucial) role of agency in refashioning subjective experience, both as part of the process of psychosis and of recovery (or the negotiation of a fundamentally changed world). If clinicians and researchers ignore such influences completely, we are
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unsurprisingly left thinking that psychotropic drugs (which intervene directly at the level of the brain) or self-initiated “blocking” strategies (in which agency is limited to suppressing symptoms over which clients have no real control) are the only tools available to manage the often distressing experience of voices and psychosis.

Although the approaches advocated by the HVM may at first be perceived by clinicians as encouraging a potentially dangerous form of collusion (affirming or validating the reality of delusions or hallucinations), it is worth remembering that many beliefs and belief systems (including an array of religious and spiritual frameworks) can be—and in everyday discussions regarded as the voice of a higher power—is typically starting to talk with service users and voice hearers about the history and content of their voices and unusual beliefs, just as we would other meaningful, important aspects of human experience.

**Declaration of interest**: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

**REFERENCES**


