Mental Health- At a Glance: Working with People Who Hear Voices

Voice hearing can be described as the experience of hearing a voice/s in the absence of anyone in the immediate physical environment to whom the voice belongs (Hayward and May 2007; Chadwick and Hemingway 2017). Often referred to as auditory hallucinations, hearing voices is traditionally associated with diagnosis such as schizophrenia, bi-polar disorder or affective psychoses (Chadwick et al. 1996). However, it is important to note that voice hearing itself is not an illness (Kingdon and Turkington 1994).

Making Sense of Voice Hearing

Traditionally, based on a biomedical model of disease, such experiences have been understood as symptoms of psychiatric illness requiring treatment (Payne et al. 2017). However, a variety of frameworks have been used to describe voice-hearing experiences, with a growing interest in psychological explanations (Hayward and May 2007). Traumatic life experiences, for example bereavement or sexual abuse, have been identified as triggers to voice hearing experiences, particularly among children. In one study, 70% of participants reported that hearing voices started following a traumatic event (Romme and Escher 1989). In a study of 22 participants with a diagnosis of schizophrenia, Harrison et al (2008) found half of the participants understood their experiences as having mystical or religious significance rather than a pathological cause. Similarly, Boumans et al. (2017) considered the experiences of individuals experiencing 'psychotic like symptoms' including hallucinations, with only half of the participants considering their experiences as linked to mental illness. Other participants gave meaning to their experiences by using interpretive frameworks related to stress vulnerability, psychic/spiritual meaning, and the use of voice hearing as a defence mechanism in relation to social or psychological problems. This unconscious mental defence mechanism may be triggered for many reasons, but could be something seemingly harmless such as deprivation of sensory stimuli (Morrison et al. 2008). It is therefore important to consider the person's own understanding of their experiences.

Voice hearing may or may not be disturbing for the person. Some voice hearing experiences cause significant distress for example, hearing screaming, personal taunts, or commands to act in a certain way (often referred to as 'command hallucinations') (Forchuk et al. 2017). Hearing such commands is often regarded as high risk as well as distressing (Trower et al. 2004), with concern that people may act in a way as to cause harm to self or others. Factors such as intensity, frequency and uncontrollability of the voices have also been identified as causing distress (Freeman and Garety 2003). Such experiences are understandably disabling and distressing for the person; however, the experience of hearing voices does not necessarily cause distress for everybody. As Longden (2017) reports, estimates suggest around 13.2% of the general adult population have experienced such phenomena, although only one third to one fifth of these actually seek help from mental health services. Such individuals may not require professional services for a variety of reasons including: personal choice, a lack of distress from their experiences, or because they identify their experiences within a non-medical framework (Slade and Longden 2015). Contact with mental health services is more likely when the content of the voices is insulting or abusive because of the ways individuals respond to such negative experiences (Beavan and Read 2010). This suggests how an individual relates to the voice/s is an important consideration in determining the emotional impact of voice hearing.

Some people may experience voice hearing in a positive way, engaging with the voices and having control (Harrison et al. 2008). Others may connect with the spiritual meaning of the voices, considering their power to do as "an ability not a disability" (Boumans et al. 2017, 8). Hearing voices is also reported to serve an important function for some in combatting social factors such as loneliness, becoming a solution to the problem rather than the problem itself (Boumans et al. 2017). So, is voice hearing normal? In some societies voice hearing is valued and interpreted as coming from evangelical Christianity or Shamanism and are therefore accepted; if the voices are deemed to be distressing then they are not regarded as normal (Turkington et al. 2009).

Supportive Interventions

Traditional approaches to voice hearing have been for nurses to encourage individuals to ignore such experiences to avoid reinforcing ideas of a false reality (Chadwick and Hemmingway 2017). Harrison et al. (2008) found such an approach to be more distressing than the experience itself, when an individuals' reality is denied or rejected. Chadwick and Hemmingway (2017) challenge such an approach and offer a more contemporary understanding by viewing voice hearing as meaningful rather than nonsensical. Therefore, nurses are encouraged to accept the reality of voices and within the context of a therapeutic relationship, support individuals in exploring the nature of their voice hearing in order to make sense of such experiences (Lakeman 2001; Chadwick and Hemmingway 2017). Enhancing understanding of the causation of the distress for people who hear voices is a priority and reduction of this distress is a primary therapeutic aim (Sorrell et al. 2010). A view supported by service users engaged with community based services who identified nursing interventions aimed at exploring the content and meaning of the voices they experienced as most beneficial (Coffey and Hewitt 2008).

Antipsychotic medication can help some people manage their distressing voice hearing experiences (Royal College of Psychiatrists 2019), although people taking this type of medication will need monitoring for potential side effects. Other approaches may also be helpful in minimising the voices and dealing with the potential distress. Initially, and most importantly do not ignore the person, discuss their experience; this should be performed in an encouraging and supportive manner using empathy, respect and honesty (Bowers et al. 2009). Questionnaires or rating scales, for example the Belief about Voices Questionnaire, revised version [BAVQ-r] (Chadwick et al. 2000) and 'PSYRATS' for auditory hallucinations (Haddock et al. 1999), can be used as a foundation for conversations with people experiencing voices. Used in a compassionate way, such tools can be used to gain understanding of the experience and the impact on the person's level of functioning as a consequence of the voice(s). This demonstrates a move away from a dismissive approach that may infer lack of interest or confidence from the nurse.

Distraction techniques are practical and short-term ways of approaching voice hearing. Examples from Coleman and Smith (1997) include:

Thought Stopping: This is also useful for people with obsessive thoughts and can help control the thoughts. The voice hearer should practice this by replicating the feelings/thoughts that bring on the voice and then exercise control stopping it again. This takes practice and assistance at first.

Drowning out the voices: This is probably the most common method. The idea of using music or another sound to be loud enough so that the voices can no longer be heard. Headphones may be an option to keep this more private.

Using earplugs: Despite the simplicity, this approach often offers some relief to voice hearers. Although as with 'drowning out' this does not address any psychological distress.

Concurrent verbalisation: Based on the assumption that people find it difficult to concentrate on two things at the same time. Striking up conversation about topics of interest may reduce the distress from the voices as they become less noticeable.

Mobile phone ploy: If there is a desire to respond or talk back to the voices then the person may talk into their mobile phone and this would not attract suspicion or concern from the public. Therefore, the person hearing the voice may not stand out and appear 'conspicuous'.

Longer-term inter-personal approaches such as dialoguing with the voice/s aim to change the power relationship when there is an oppressive influence over the person (Hayward and May 2007). This includes activities such as; structuring time to engage with the voices that suits the person; keeping a record of the voices to allow the person to see patterns and gain deeper understanding of the motives or origins of the voices; checking out if what the voices say is true as a way of understanding that the voices are less powerful than initially thought.

Conclusion

Experiences of voice hearing can vary significantly. Whilst some may hear positive voices and not require any contact with mental health services, others experience extreme distress that places the person at significant risk. Nursing assessment and interventions should therefore adopt an individualised approach which:

- Shows interest in the experience of the person.
- Accepts the voices as real.
- Offers hope by normalising the experience.
- Offers opportunities to talk about the voices with active listening from the nurse.
- Works collaboratively with the person to develop strategies to minimise distress.

Such an approach challenges the traditional view of denying the reality of the person's experience. With a change of focus nurses can engage in meaningful dialogues with individuals in distress, offering interventions that support the person to successfully adapt to living with voices.

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