

Changing Relationship with Voices: New Therapeutic Perspectives for Treating Hallucinations

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A growing body of research on verbal hallucinations shows the importance of beliefs about and relationships with the voices for their pathological course. In particular, beliefs about the omnipotence of the voices and the need to control them, and relationships with them that involve efforts to resist or fight them, have shown themselves to be more pathogenic than effective. Likewise, treatments aimed at eliminating the voices, be they based on medication or 'traditional' cognitive-behavioural therapy, have not always been successful. A series of strategies focused on changing relationships with the voices instead of trying to eliminate them—including mindfulness, acceptance, experiential role plays and re-authoring lives—is emerging as a new perspective for the treatment of hallucinations. All of these strategies are based on the person, not on the syndrome, which also represents a new conception of the problem, in a phenomenological-social perspective, alternative to the predominant medical conception. Copyright © 2008 John Wiley & Sons, Ltd.

THE TRADITIONAL CONCEPTION: SOME CRITICAL REMARKS

A new therapeutic perspective, such as that presented here, also represents a new conception of hallucinations, distinct from the one generally assumed. The traditional conception considers verbal auditory hallucinations as perceptions of speech that occur in the absence of any appropriate external stimulus. Thus, the *DSM-IV-TR* (American Psychiatric Association, 2000) defines 'hallucination' as 'a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ'. A recent and important

psychiatric text from Spain presents hallucinations as psychopathology of perception (Gastó, 2006). The current conception given, for example, by the *Concise Oxford Dictionary* (1990), is also along the same lines: hallucination is 'apparent or alleged perception of an object not actually present'.

Such a conception of hallucinations is inadequate if we are to take into account first-person experiences, as should be the case in any psychopathology or psychiatry worthy of the name (Kendler, 2005), which would lead, in turn, to phenomenology (Stanghellini & Cutting, 2003). It is interesting to note how after so much 'psychopathology' in the third person (typically DSM checklists of current symptoms), we are beginning to miss phenomenology (Andreasen, 2007).

The point is that conceiving of hallucinations as abnormal perceptions can be misleading, and for more than one reason. First of all, such a conception does not leave room for the subjective

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experience of people with hallucinations. Likewise, it is confusing for the study of the pathogenesis of this phenomenon, as it could lead one to assume that the correct way of understanding and explaining hallucinations is to seek some breakdown in the perceptual system. It is also confusing for both research and clinical practice with regard to the development of possible new therapies or treatments that avoid excessive concern with the elimination of hallucinations—even if, indeed, such a goal were possible. Indeed, many types of hallucination, among them the most stressful and high-risk varieties, such as command hallucinations, are resistant to treatment, whether with medication or ‘conventional’ cognitive-behavioural therapy (Birchwood & Spencer, 2002).

It is for these reasons that we shall present a relatively new conception of hallucinations, if only for contextualizing the new therapeutic perspective. It is a conception within the phenomenological perspective. Strictly speaking, it cannot be said to be a new perspective, as it is actually a classical one supported by abundant and up-to-date literature (see Rulf, 2003; Stanghellini, 2004a, p. 164). We use the term ‘new’ in relation to the established conception, with respect to which it would be an alternative. If phenomenology is indeed so sorely missed, the good news is that it is still with us.

RESITUATING HALLUCINATIONS IN THE CONTEXT OF THE PERSON AND ONE'S SOCIAL RELATIONS

In accordance with a phenomenological perspective, verbal auditory hallucinations would be a hyper-reflexivity disorder consisting in becoming conscious of inner dialogue (Stanghellini & Cutting, 2003). Inner dialogue with oneself in silence is a characteristic of normal psychological functioning, learned in the course of the education process (Vygotsky, 1934/1962). This dialogic duality is normally experienced as a unit of self-awareness. We experience these parts as distinct, but integrated within the experience of ourself, we being their author. One has a sense of ‘myness’ of inner dialogue.

Hallucinations consist in the loss of the sense of ‘myness’ of inner dialogue. As Stanghellini and Cutting (2003) put it, hallucinations constitute a ‘breaking the silence of inner dialogue’. Hallucinations irrupt into consciousness as strange (in the sense of ‘foreign’) voices proceeding from someone or some place outside of oneself. We can easily

imagine how strange this experience is, especially if they are voices criticizing us or ordering us to do something unacceptable. Although in time one becomes familiar with the voices and may even integrate them in one's life (Benjamin, 1989), they are nevertheless unusual experiences, difficult to share with others. Indeed, they are often stigmatizing, which makes them even more problematic.

However, voices are not in themselves a psychopathological disorder. Thus, for example, the voices Socrates heard were not voices of insanity but voices of reason (Leudar & Thomas, 2000). In fact, they were conceived as the voices of a *daemon*, Socrates' celebrated *daemon*, which guided his actions. Even though the *daemon* was an unusual experience, it was all the same not a strange experience, or the experience of an insane person. The *daemon* personified the voice of universal reason *inside* the person. Many people from the general, non-clinical population, without being Socrates, report hearing voices without subjectively experiencing them as a disorder.

Our conceptualization is situated within the perspective of continuity between psychotic symptoms and normal experiences in the general population (Johns & van Os, 2001). This assumes that there is a continuity of psychotic phenomena both in clinical samples and in the general population. Subclinical psychotic phenomena elicited by lay interviewers are continuous with clinical psychosis rated by psychiatrists (van Os, Hansen, Bijl, & Ravelli, 2000). This being the case, at least two important questions emerge. One concerns the potential appropriateness of defining or deconstructing psychosis according to a dimensional approach rather than classifying patients into categories that have little to offer in terms of diagnostic specificity (van Os & Tamminga, 2007); the other question concerns the study of the transition from having psychotic symptoms to becoming a patient with a psychotic disorder (Krabbendam, Myin-Germeys, Bak, & van Os, 2005). In this regard, the relationship with the voices—beliefs and coping strategies—will be important for their consideration as a disorder, and also for their possible prevention and treatment. The question concerning the relationship with the voices is that which will be contemplated here. In particular, we are interested in the crisis the voices will bring about in the person.

Beliefs about the voices are highly important, if not decisive, for their experience or not as a mental disorder, as reflected in a growing empirical literature. The literature distinguishes between beliefs about the content of the voice—their identity,

meaning or power—and meta-cognitive beliefs about the hallucinatory phenomenon itself—if I'm possessed, if the voices will make me lose control, if I should control them, if they help me to cope with the problems (Morrison, Nothard, Bowe, & Wells, 2004; Perona-Garcelán, 2006). Thus, for example, beliefs about the need to control the voices, as found in obsessive-compulsive disorder with intrusive thoughts, are related to a self-reflexive process that tends to maintain the disorder itself, in this case hallucinations (García-Montes, Pérez-Álvarez, Soto-Balbuena, Perona-Garcelán, & Cangas-Díaz, 2006; Morrison & Wells, 2003). The point here is that beliefs are an important mediating factor between the occurrence of the voices and their experience as a disorder or otherwise.

It is interesting to compare the perspective that emphasizes the importance of beliefs in the experience of the voices with the phenomenological perspective that emphasizes the crisis the voices bring about with regard to the person's integrity, even though this latter perspective is still excessively speculative. The concept of crisis used by phenomenology raises at least two points of interest here. On the one hand, the notion of crisis situates the disorder, in this case the voices, in the context of a breakdown of the (fluid) relationship of the person with the world (being-in-the world). On the other hand, the notion of crisis involves both a disorder and the attempt to establish a new order in the face of this breakdown, so that it would involve more of a personal effort to manage the problem than a mere disorder resulting from a supposed internal malfunction. Although neither aspect is far removed from the cognitive perspective, phenomenology has *speculated* more openly about this. At least both perspectives attempt to avoid the all-too-convenient neurobiological reductionism in relation to psychotic disorders. This alone is a good reason for giving it due consideration.

According to the phenomenological perspective, the voices do not just simply 'happen', nor do they derive from a *breakdown* in neurocognitive functioning; rather, they represent a thoroughgoing crisis of common sense (Blankenburg, 2001; Sass, 2003; Stanghellini, 2004a). We are talking about a crisis in which, on the one hand, the world loses meaning for the person, or, as Merleau-Ponty would say, loses its 'expressive force' (Merleau-Ponty, 1962, p. 342), and on the other, the subject becomes conscious of implicit functions that are normally beneath conscious awareness, such as internal dialogue. All of this involves a weakening of one's relationship with the world, affecting interpersonal relations in

particular (Rojcewick & Rojcewick, 1997). Numerous studies have shown that difficulties in interpersonal relations during childhood and adolescence are the strongest predictors of schizophrenia. More specifically, research reveals the important role of the formation of the self, including the dialectical process between one's own bare individuality and the mores and institutions of the society to which one belongs, and the fragility of the forms of awareness involved, with their unstable wavering of implicit-pre-reflexive into explicit-reflexive modalities (Parnas & Handest, 2003; Stanghellini, 2004b).

In this context, the voices come to provide a substitutional interpersonal world. Given that, for interpersonal reasons, the normal link between the human being and the world has been broken or weakened, the voices can fill the gap and provide the possibility of a life in contact with others, or at least the superficial appearance of such a life. In this sense, hallucinations are understood as both a sign of crisis and an attempt to overcome the crisis. Filling a gap with voices would constitute an attempt to overcome a crisis. According to Romme and Escher (2000), 'Hearing voices is both an attack on personal identity and an attempt to keep it intact' (p. 64). On this view, hallucinations occur more for interpersonal *reasons* than merely due to neurocognitive *causes*. According to Rojcewick and Rojcewick, hallucinations 'can be understood only as a part of the totality of personality, only in the context of that person's entire being-in-the-world. That is to say, hallucinations can be understood only as taking up the slack in an existence where the world has become uninhabitable, that is, where the expressive force of that world has been slackened' (Rojcewick & Rojcewick, 1997, p. 20).

In this regard, it is interesting to consider the recent and growing body of empirical work on the relations between hallucinators and their voices. Two broad lines can be distinguished: one which starts out from the pragmatic properties of the voices via Vygotsky (1934/1962), and another based on Gilbert's (1992) social rank theory (Perona-Garcelán, 2006). The pragmatic line shows that verbal hallucinations are talk, 'voice-talk' with pragmatic properties (Leudar & Thomas, 2000; Leudar, Thomas, MacNally, & Glinski, 1997). Prominent among these properties are the individuation and personification in voice-talk—for example, the voices often correspond to individuals who are significant in the life of the hearer—the participant positioning of voice-talk—for example, the voices frequently advise or criticize the hearer—and the

sequential properties of voice-talk—for example, the voices regulate the activities of the hearer more than the other way around, following an asymmetric structure.

For its part, the social rank line shows how the voices reflect the social status of the hearer. Thus, a significant relationship has been found between how hearers of voices experience relationships with others in their everyday life (for example, as relatively powerless, inferior and subordinate), and how they also experience their voices powerlessly, and as subordinate to them (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000; Birchwood et al., 2004). Beyond the personal situation itself, it may be that the voices reflect the social atmosphere of the era in question. Thus, for example, times perceived as challenging and dangerous, such as the 1980s appear to have been, gave rise to more negative and hostile hallucinations than did, for example, the 1930s (Mitchell & Vierkant, 2001).

Even though hallucinations may constitute an attempt to overcome a crisis and thus have a pragmatic sense and reflect a social position, this does not prevent them from often being a problem. And they become more problematic the more they involve the hearer him/herself in a self-reflexive process.

What does this self-reflexive process consist in? Basically, it consists in some kind of counterproductive relationship with the voices, with vain attempts to avoid them or fight them. Indeed, both avoidance and fighting the voices often end up worsening the distress they cause, entangling the person in fruitless efforts; research shows that direct attempts to change or resist the voices, far from achieving their aim, make them more distressing (Farhall, Greenwood, & Jackson, 2007; Singh, Sharan, & Kulhara, 2003). Such fruitless effort is learned in our culture and promoted by clinical conventions bent on eliminating the symptoms. Although the idea of removing that which distresses is logical, and functions in many settings, it does not always work where private events—such as voices or intrusive thoughts—are concerned (García-Montes, Pérez-Álvarez, & Fidalgo, 2003, 2004), and avoidance or reaction just tend to exacerbate such experiences, giving rise to the ironic effect that the person has more of the same. In sum, as shown by the work of Birchwood et al., the distress arising from the activity of voices can be understood by reference to the individual's relationship with the voice, rather than voice content, topography or illness characteristics alone (Birchwood & Chadwick, 1997;

Birchwood, Meaden, Trower, & Plaistow, 2000). In such a context, what can be done?

CHANGING THE RELATIONSHIP WITH THE VOICES

Above all, changing one's relationships with one's own voices. How can this be done? Various strategies have been developed in recent times. It should be pointed out first of all that these strategies are situated in the framework of the recently developed cognitive-behavioural therapy for psychoses (Beck & Rector, 2004; Gaudiano, 2005; Temple, 2004), which has shown itself to be effective in reducing the transition to psychosis in people at ultra-high risk, becoming proposed as an acceptable alternative to antipsychotic medication (Morrison, French et al., 2004, 2007). Likewise, cognitive-behavioural therapy has emerged as effective in changing beliefs about the power and omnipotence of the voices and in reducing the distress and depression associated with them, and hence in reducing compliance (Farhall et al., 2007; Trower et al., 2004).

In the context of this general efficacy of cognitive-behavioural therapy in psychoses, it is important to highlight certain strategies aimed directly at changing the relationship with the voices. Placing the emphasis on these strategies may serve both to satisfy the demands for specification of the effectiveness of cognitive-behavioural therapy (Turkington, Kingdon, & Chadwick, 2003) and to underline how it goes beyond the neuroleptic metaphor whose sole criterion of success is the reduction of symptoms and prevention of relapse (Birchwood & Trower, 2006). It is not a question here of making an exhaustive review of the strategies in this line, but rather of indicating some of the most relevant, if only to illustrate the logic and viability of this possible treatment alternative. As a first and general point, it can be said that some attempt to promote acceptance of the voices—mindfulness meditation, acceptance and commitment, taking your mind for a walk, and the two-chair method—while others attempt to increase the power of the person and reduce that of the voices—Socratic dialogue and re-authoring lives.

Mindfulness Meditation

Mindfulness meditation as referred to here has two components: decentred awareness and meta-cognitive insight. The two are equally important,

and involved in a dialectical relationship, the one constantly informing and shaping the other. While decentred awareness is a clear, open and gentle awareness of whatever is present, marked by acceptance and the absence of reaction (avoidance, struggle, rumination etc.), metacognitive insight is explicit focus on reflective learning about the nature of experience (Chadwick, 2006, p. 12). It is this dual quality that makes it possible to integrate mindfulness and cognitive therapy.

In the specific case of voices, decentred awareness 'involves clear awareness and acceptance of psychotic sensations as transient experiences that are fundamentally "not me" (i.e., do not define the self), and not necessarily accurate reflections of reality [. . .] A mindful response involves observing psychotic sensations pass, and allowing this movement in and out of awareness without getting caught in rumination or confrontation' (Chadwick, Taylor, & Abba, 2005, p. 353).

It is a question, then, of letting go rather than reacting. Guidance might be: 'If you hear a voice, bring your awareness to it. Note to yourself "voice", or "hearing". Try not to react, but instead to observe it pass or fade. Then gently bring your awareness back to rest in the next in-breath' (Chadwick, 2006, p. 85). In the words of a participant who has followed this therapy: 'When you get voices, let them do what the voice is saying, let the voices happen and you'll find out that they meant nothing anyway. How can I put it? If you've got voices controlling you, try and just let it and then you'll find out that it didn't control you after all, it's just a voice' (Chadwick et al., 2005, p. 356).

For its part, metacognitive insight does not occur automatically, but rather has to be facilitated through education, discussion and discovery supported throughout the practice of meditation. In particular, Socratic dialogue is a powerful means of helping clients to express metacognitive insights with their own words, images and metaphors. In any case, metacognitive insight involves becoming aware of certain implicit metacognitive beliefs that are at the basis of stressful habitual reactions (e.g., believing that voices about doing something bad are the same as actually doing it) and formulating new ways of seeing things. Thus, Socratic dialogue carried out in mindfulness meditation in a group led one client to the following situation: 'Therapist: Yes, that's a really good point. Harming other people is bad, something to avoid. But is that the same as having a thought or voice *about* harming someone else?—Anna (*after a long pause*): There's

no harm in having these thoughts, just don't act on them'. (Chadwick, 2006, p. 92).

Mindfulness meditation should be used with caution in patients with severe psychoses. Chadwick et al. (2005) have made the following adaptations with a view to minimizing potential adverse effects. First, meditation is centred on the body, and begins with brief sessions of some 10 minutes' duration. Mindfulness is taught as 'choiceless attention' rather than concentration meditation, since states of deep absorption can be linked to the onset of hallucinations. Second, all mindfulness practice is guided, with instructions and gentle comments or reminders being offered every couple of minutes. This avoids long silences that might lead people to become lost in psychotic reactions. Third, homework is encouraged but not required, and further 10-minute sittings are suggested (audiotapes are provided to guide these). Fourth, the practice of meditation is structured in 90-minute sessions, which include 15 minutes' rest. And fifth, particular emphasis should be placed on the therapeutic relationship as a context of the practice and process of meditation. When meditation is used in this way, it can be beneficial for patients with psychosis.

A study of mindfulness applied in a group has shown that it is possible to establish a mindful relationship with psychotic experiences, which was associated with an improvement in general clinical functioning (Chadwick et al., 2005).

Acceptance and Commitment

Although we shall refer here specifically to acceptance in the context of acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), it is important to begin by considering acceptance in the perspective of decentred awareness and of mindfulness meditation. Acceptance of unpleasant and unwanted experiences does not mean resignation, agreement or endorsement. Acceptance involves a positive and open attitude toward the experience one would prefer not to have but which it is impossible to avoid, as tends to occur with voices. Accepting voices supports self-acceptance, because voices cease to define the self. The goal is not to eliminate or reject the voices, but to see them as simply one experience of self, not *the* self (Chadwick, 2006, p. 118). As one participant puts it: 'I suppose it just centres you. You don't have to worry about what's right and what's wrong in your head, you know it's that not judging what

goes through your head, it's just accepting it as it is, not worried about vindictive voices, or whatever, it's just accepting that's the way it is. Not right, no wrong' (Chadwick et al., 2005, p. 356). Acceptance can take place within a framework of mindfulness, as just one more aspect of it, in the form we have referred to.

Acceptance can also take place within a framework of behaviour therapy, which is indeed what ACT is (Hayes et al., 1999). Acceptance in the ACT perspective involves a distinction—though not a separation—between self-as-context and self-as-content, so that private events such as intrusive thoughts and voices can be understood as experiences of the self and not as the self. In fact, this is a distinction that already exists in ordinary language, as *I-me*, where *I* has the sense of transsituational and transtemporal (context) identity and *me* has the sense of event, which may be one or another, but is always one that is taking place—the voices one hears at the moment, for example. Making this distinction explicit in therapy is important, with a view to breaking the self-voices fusion that tends to be found in patients with hallucinations on taking them literally. The acceptance proposed to the patient is based on this distinction. It is a case of accepting something that forms part of oneself instead of following it, which would leave one in the power of the voices, or of combating it, which would serve only to exacerbate the unwanted experience. The strategy of the following point—taking your mind for a walk—shows the therapeutic alternative to these natural, maladaptive responses patients tend to make. A person-based notion such as this one of ACT, also present in mindfulness meditation, as shown above (Chadwick, 2006), permits one to conceive of and experience the voices *without* separating them from the self (as a supposed alternate being/entity), but also without identifying with them.

Acceptance within ACT is applied in conjunction with commitment to act in the direction of valued goals. ACT encourages clients to increase their willingness to accept the experience of psychotic symptoms non-judgmentally *while* working toward valued behavioural goals (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). Controlled studies show that ACT reduces the stress associated with hallucinations and belief in them, as well as reducing rehospitalizations, compared with the usual treatment consisting in medication, case management and psychotherapy (psychoeducation, stress reduction etc.). Specifically, in the study by Bach and Hayes (2002), patients who received

ACT reported decreased symptom-associated distress and decreased believability of symptoms, and increased symptom frequency compared with the control group. This apparently paradoxical result of increased frequency of symptoms and decreased stress and believability is explained by the authors in terms of patients' acceptance of the symptoms. ACT also reduced rehospitalization by 50%, compared with treatment-as-usual. In the study by Gaudiano and Herbert (2006), patients who received ACT showed greater improvement in clinician-rated mood symptoms, self-reported distress related to hallucinations and impaired social functioning, and clinically significant symptom change in overall psychopathology compared with the control group. The believability of hallucinations also diminished, and ACT reduced rehospitalization by 38%. A case study suggests that involvement with valued goals (work and friendships) *in spite of* the voices may reduce not only the stress they cause and their credibility, but also their frequency and the delusions associated with them (Veiga-Martínez, Pérez-Álvarez, & García-Montes, *in press*).

Taking Your Mind for a Walk

Taking your mind for a walk is an experiential role-play strategy developed by Hayes et al. (1999, pp. 162–163) for helping clients to make contact with private events (such as thoughts and voices) *without* taking them literally. In this exercise, the therapist acts as the participant's 'mind' as they take a walk. The therapist walks behind the participant, continually making remarks about the things and events they find on their way, describing, evaluating, analyzing, predicting and recommending actions, such as 'shout', 'turn left', 'stop' (similar to the stream of thought, and where applicable, to voices that command something).

The point is for the participant to be aware of what the 'mind' says, *without* trying to communicate with it or to do what it asks. The idea of the exercise is to break the pernicious thought-action fusion that characterizes certain disorders, including auditory hallucinations (García-Montes, Pérez-Álvarez, Soto-Balbuena, Perona-Garcelán, & Cangas-Díaz, 2006). Thus, the client finds that it is possible to hear hostile or demanding voices, and even to feel distressed by them, but nevertheless remain firm, doing what he/she has to do, letting them pass (Veiga-Martínez et al., *in press*).

Two-Chair Method

The two-chair method is also an experiential role-play strategy adapted by Chadwick (2003, 2006) for psychosis, after Greenberg, Rice and Elliott (1993). This method attempts to create a new, more varied and flexible model of the self. Specifically, it attempts to help people to move from a fixed, simplified and emotionally negative model of the self to a more complex and varied one that admits self-discrepancies. The point is to integrate in the self the negative experiences of the voices on an even footing with the positive ones, the latter often being eclipsed by the former. The goal is to see the voices as simply a part of the self, not *as* the self.

The rationale given to the client is that the procedure provides an opportunity for exploring different experiences of the self, creating space for positive experiences that may have gone unnoticed. The procedure, in four stages, consists in a role-play involving different aspects of oneself, in this case negative experiences, positive experiences, the acceptance of both, and, as a result, the experience of a new self. To this end, two chairs are used, on which the client sits at different times, depending on whether he/she is playing one role or the other.

Step 1: experiencing the negative self schema. The client, sitting on a chair, relives a negative experience related to the voices. Thus, with regard to critical and powerful voices, he may play the part by saying in the first person what the voices say: 'I'm weak, pathetic. Everyone at school hates me. I don't deserve to have my girl back'.

Step 2: articulating and embodying a positive self schema. Changing to the other chair, the client now relives a positive experience characterized by self-acceptance (i.e., different schematic meaning from negative chair) related to another person. 'I [think] they view me as somebody who can hold a proper conversation, I'm not completely stupid. And that I had something to offer' (Chadwick, 2006, p. 128). Although at times it is difficult at first for clients to find positive experiences, the therapist will help them explore until they do find some.

Step 3: acceptance of the positive and negative schema. The client remains on this second chair, the positive experience chair, and the therapist raises the discussion of how both the negative and positive experiences are part of the same person. The two have equal validity and are equally real. The therapist must show genuine acceptance of both experiences. The two-chair method allows the two experiences to be placed literally side by side,

incorporating a broader definition of the self. 'It [negative self-experience] is part of me, just not all of me', in the words of one client (Chadwick, 2006, p. 135).

Step 4: a new metacognitive symbolic self. Finally, the client, still on the second chair, tries to see through his own experience that the negative experience is not the whole story. There is a positive experience of being with others. One is not *only* what the voices say. Indeed, one is more complex and even more contradictory than one appears to be. If up to now negative experiences have predominated over positive ones, there is no reason why this balance cannot change in the future. As one client says: 'I had always thought there was just that one part of me, a negative one. I thought this all my life. It's nice to find this isn't true' (Chadwick, 2006, p. 135). The therapist, in total collaboration with the client, ensures throughout the process that the stages are followed and the appropriate experiences emerge.

The thematic analyses of subjective experiences of clients to whom the two-chair method is applied reveal a new, emotionally and cognitively more varied and flexible model of the self (Chadwick, 2003, 2006).

Socratic Dialogue

Socratic dialogue with voices is another experiential role-play strategy developed by Chadwick (2006). Socratic dialogue not only questions what the voices mean with their judgements and criticisms—'What do the voices mean when they say you are useless?' 'Have they ever said you've done things well, or are you still waiting to hear it?'—but questions it through role-playing exercises. The role-playing begins with the therapist playing the client and the client playing the role of the voices. The client tries to be critical and disparaging with the therapist. The therapist presents a calm and detached Socratic attitude, in contrast to the client's usually submissive or combative one: 'Are you calling me stupid? What do you mean? What evidence is there that I'm always wrong? I know I make mistakes—everyone does—but what evidence is there that I do everything wrong? Why can't you see the things I do well?'

After this, it is useful for the client to do a role play 'defending' a friend or someone he/she admires. In this case, the therapist plays the role of critical voice, addressing comments to the friend or admired person played by the client, not to the

client him/herself. The clients' role consists in defending themselves from these critical voices. Next, the therapist plays the role of the voices and the client plays him or herself. The therapist begins with moderate criticisms chosen from the client's repertoire of voices. Therapist and client select two or three Socratic questions that work best for the latter and seem the most useful.

Socratic dialogue, as a central component of a cognitive therapy for command hallucinations (Trower et al., 2004), has succeeded in reducing significantly the behaviour of obeying the voices, their degree of credibility and power, and the associated distress and depression.

Re-authoring Lives

Re-authoring lives is a method for helping the voice hearer regain control of his or her own life instead of being subjugated by the voices. This method, developed by Michael White, is described by Romme and Escher (2000, p. 87ff). The method consists in interrogating the voices so that the hearer begins to see them as personalities. In the case of the voices, these personalities present themselves as though they were 'experts', speaking impersonally, without revealing the reasons for or the purposes of what they say, nor how they acquired such information, and excluding the personal details that influenced their opinion or their version of reality. These 'personalities', with their strongly held opinions, certainly annul any power in those they subjugate.

In order to 'unmask' the voices, the hearer must ask them about their motives and purposes, their personal experiences, their status and how they acquired their information about the person. Thus, for example, with regard to the motives and purposes, one question might be: 'You have strong opinions about what I should do. Tell me, in voicing your opinion in this way, what effect do you hope this might have on what I do?' The therapist's role also consists in asking questions of the client that help him or her to clarify the nature of the voices and gain control over his/her own life. 'What is it that the voices are trying to convince you of at this time?' How does this fit with their overall plans for your life?'

As Romme and Escher say: 'De-authorising the voices through personification puts them into perspective by getting to know their specific background [. . .] Turning voices into personalities also makes it easier to help the voice-hearer change their

relationship with the voices' (Romme & Escher, 2000, pp. 88–89).

The question may be raised of a potential iatrogenic effect of considering the voices as 'personalities' in vulnerable people. However, this is not expected to occur, as patients themselves already see the voices as persons—the voices are *someone* for them. What the clinician who uses this strategy does is to accept the voices as the persons they are for the patient and try to 'unmask' them through the above-mentioned interrogation carried out by the patient himself or herself. Such an interrogation or dialogue with between the voices themselves and the patient would not have taken place previously, and may mark the beginning of a change in the habitual power-submission relationship. This 'face-to-face' dialogue with the voices succeeds in reducing their power at the same time as giving one the opportunity to become more aware of one's knowledge and abilities in contrast with the submission experienced up to now. Re-authoring lives can equally include writing about the voices, which can also probably contribute to making them less dominant in one's life.

It is not a question, then, of eliminating the voices, but rather of helping the hearer to develop a different kind of relationship with them and reduce their influence. Clients report it being thus: the relationship with the voices is changed for a more normalized and less pathological one, and they are no longer subjugated to them, thus gaining initiative in their lives (Romme & Escher, 2000, pp. 116–118).

CHANGE IN THE RELATIONSHIP WITH THE VOICES AS THERAPY IN ITS OWN RIGHT

These strategies, mindfulness meditation, acceptance and commitment, taking your mind for a walk, two-chair method, Socratic dialogue and re-authoring lives, are generally applied within the framework of broader therapies or interventions, but can also be applied as therapies in their own right.

Thus, mindfulness, including acceptance, Socratic dialogue and the two-chair method, is normally applied in the context of a person-based cognitive therapy for distressing psychosis (PBCT) developed by Chadwick (2003, 2006). Acceptance can equally form part, as stated above, of ACT, which also includes taking your mind for a walk. ACT begins by exploring the attempts at coping

that have failed so far, concentrating in particular on how avoidance or fighting the symptoms, despite being reasonable courses of action, have served only to worsen things. ACT includes the use of metaphors and other experiential exercises, as well as the commitment to work in the direction of personally valued goals. This therapy may take between 10 and 15 sessions (Veiga-Martínez et al., in press), though it is also possible to apply it in around four (Bach & Hayes, 2002; Gaudiano & Herbert, 2006).

Re-authoring lives is usually applied within the framework of self-help groups, and involves understanding the voices within the person's life story and current circumstances (Romme & Escher, 2000).

However, these strategies can also be applied as therapies in their own right. All that would be necessary would be to create the appropriate therapeutic context—rationale, therapeutic relationship and so on. Future research may determine their specific efficacy or the best combination of them. In particular, it would be interesting to study the possible differential efficacy of the strategies oriented to acceptance (mindfulness meditation, acceptance and commitment, taking your mind for a walk, and two-chair method) with respect to those oriented to increasing the power of the person and reducing that of the voices (Socratic dialogue and re-authoring lives), or whether this possible differential efficacy depends on some characteristic of the voices (such as their power and omnipotence), or of the persons themselves (their social position, for example). It may indeed also be the case that the supposed difference between acceptance of the voices and the acquisition of power over them is more apparent than real, insofar as acceptance is actually a form of being strong and having power over experiences that one was previously overcome by.

In any case, the important thing is to see that all are based on the person, not on the syndrome. Although they work with the symptom, as we have seen, it is understood as action and reaction of the person involved in a crisis. Thus, the goal of these strategies is not to suppress the symptom, which in one way or another is the objective of antipsychotic medication and traditional cognitive therapy, but rather to change one's relationship with it, in this case, with the voices. The most antipsychotic medication can do is to dampen the voices as an effect of a general dampening of aberrant salience (Kapur, 2003). As far as cognitive-behavioural therapy is concerned, although it is not aimed directly

at getting rid of the voices, but rather at easing distress by working with meaning—consisting mainly in challenging thoughts and beliefs—the truth is that its efficacy has generally been measured according to the criterion more akin to that of medication, which is the reduction of symptoms (Birchwood & Trower, 2006). On the other hand, we now know that it is not necessary to challenge thoughts and beliefs, as cognitive-behavioural therapy assumed (Longmore & Worrell, 2007). Indeed, cognitive-behavioural therapy is itself moving in the direction of the strategies outlined here, good examples of this being PBCT and ACT (Chadwick, 2006; Gaudiano, 2005). In particular, the study of these strategies may contribute to meeting the demands for specification of the effective ingredients of cognitive-behavioural therapy (Turkington et al., 2003), and to going beyond the neuroleptic metaphor employed for their assessment (Birchwood & Trower, 2006).

In this new perspective, the symptom is understood within the person as a whole, in his or her efforts to stay firm in the face of the circumstances. The problem, as we have stated, is not so much the symptoms (in this case, voices) as the person's own relationship with and *against* them, which often drags him or her into a tangled pathological self-reflexive web. What these strategies do is to change one's relationship with the voices, be it by accepting them as another experience or by giving more power to the person and weakening the power the voices have appropriated. In any case, from the applied clinical point of view, these strategies should always be applied in conjunction with other resources. Thus, for example, change in the relationship with the voices should take place within the framework of a coherent family context, of acceptance and support for the person with his or her voices. Likewise, the change in the relationship with the voices should go hand in hand with behavioural activation in the direction of worthwhile goals, in the sense suggested by ACT. The crucial point would seem to be not only the *deactivation* of the tangled web resulting from the voices, but also the *reactivation* of the life course in the direction of personally valued goals *in spite of them*.

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