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# Listening to voice hearers

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## Abstract

- *Summary:* This article considers what the Hearing Voices Network can offer to mental health social work. It combines an extensive literature review of voice hearing by Bob Sapey and the expertise by experience of Peter Bullimore who runs a peer support group for voice hearers.
- *Findings:* The re-framing of auditory hallucinations as voice hearing has significantly changed the way many voice hearers have been able to understand their experience. This new approach to working with voices was developed at the University of Maastricht, principally by social psychiatrist Marius Romme. By moving away from biological explanations of brain disease to psychological understandings of emotions, Romme and his colleagues have found ways of helping people cope with voices, rather than trying to get rid of them through medication. This has led to a network of voice hearing groups throughout the world. There is much of what happens in these groups and within the social psychiatric responses known as the Maastricht approach that can be practiced by social workers.
- *Applications:* The Maastricht approach to working with voices challenges the basis of pharmacological responses to psychosis and moves beyond anti-psychiatry by offering positive alternatives to the current biomedical treatment of schizophrenia. This approach can be undertaken by experts by experience and mental health professionals. We describe these approaches and argue that in adopting them, social workers can help voice hearers cope both with the content of their voices and the stigmatising responses to being diagnosed with schizophrenia.

## Keywords

Maastricht approach, mental health, social work, social work practice, critical social work, trauma, voice hearing

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## Introduction

The Hearing Voices Network (HVN) was formed in Holland in 1987 and a year later in England; it now includes more than 180 groups throughout the UK. The HVN aims to respect the ways in which individuals understand their own experiences of voices and unlike biomedical psychiatry, it does not label people as schizophrenic or treat their voices as hallucinations. Instead, HVN groups offer support by providing voice hearers with the space to talk freely about the issues which they feel affect them. HVN groups have contributed to a growing body of knowledge that the voices people hear, along with other unusual experiences that are usually referred to as psychosis, are in fact emotional and psychological responses to life experiences, particularly childhood abuse, bullying and poverty. However, viewing the experience of voice hearing as real rather than as a hallucination caused by an illness, contradicts and rejects the biomedical approach that has dominated psychiatry for more than a century. It therefore provides a significant challenge to medical practice and to other occupational groups which work within the mental health system, including social work.

In this article, we argue that the ways of working with voices used within the Hearing Voices Network, could be used by social workers to help voice hearers cope both with the content of their voices and the stigmatising responses to being diagnosed with schizophrenia. This article is based upon an extensive review of the literature on voice hearing undertaken by Bob Sapey and it draws on the experience of Peter Bullimore, of voice hearing and running a hearing voices group.

## Reimagining voice hearing

While social workers have long been encouraged to adopt social approaches to working in mental health services, they often remain a weak partner in health trusts and are in danger of losing their identity (Nathan & Webber, 2010). Although Carter (2004) has made the argument very strongly that social workers could adopt the approaches used by the Hearing Voices Network, recent textbooks aimed at introducing social work students to mental health practice present a confused picture in terms of social approaches. Golightley gives it scant attention, describing schizophrenia as a disorder which is treated, but not cured with medication that 'can dramatically correct serious and *abnormal* [emphasis added] phenomena such as hallucinations and delusions' (2008, p. 29). Gould (2010) is more circumspect about the merits of medication, but does not present any alternative to the biomedical construct of schizophrenia as a way of understanding voices. Karban (2011) explains the biomedical model, its criticisms and alternatives, but while clearly favouring a social approach she seems to envisage it existing alongside the biomedical model. On the other hand, Coppock and Dunn (2010) explain why the biomedical model is problematic and encourage social workers to adopt a social model that privileges the experiences of people with mental distress rather than

medicine. Their concern about the use of medication is reflected in their description of compulsory treatment in the community as a mental health control, not a mental health service. Tew (2011) is the one writer who seems to embrace the HVN approach of empowering voice hearers by valuing the way people define their experience of voices. He argues that:

An important message from people with lived experience is that we should not always see unusual mental experiences as inherently ‘bad’ and in need of eradication – as has been the implication of a biomedical approach. (Tew, 2011, p. 27)

He incorporates this understanding into the construction of an alternative social approach to working with mental distress, which challenges the continued hegemony of the biomedical approach.

The HVN treats voice hearing as a real experience, not a hallucination. However people construct their experience, as aliens, God, a devil, a dead relative or a symptom of an illness, they are accepted as real and something to be worked with, rather than eradicated. The breakthrough in accepting voices in this way came in the 1980s when Marius Romme, a psychiatrist at the University of Maastricht, and his partner Sandra Escher, a science journalist, plus other colleagues, found that many more people heard voices than was previously thought, but about one-third of them did not find this to be a problem and so were not in contact with any of the psychiatric services (Romme, Honig, Noorthoorn, & Escher, 1992). Voice hearers who did not cope with their voices were twice as likely to be receiving psychiatric care. Romme found that in his psychiatric practice, if he accepted the reality of people’s voices rather than viewing them as hallucinations, he was able to find out much more about their origin and meaning, and so develop more effective ways of helping people.

...voices are expressing emotions, and these emotions are those the voice hearer experienced as the result of the traumatic situation. The recovery process is one of turning points in the relationship with the voices, with the person becoming more powerful and independent . . . It doesn’t make sense to attempt to cure signals of problems, and it’s not an approach that is particularly successful either because the traumatic background is not recognised and the emotions involved are not coped with. (Romme, 2009a, p. 9)

Romme and Escher (2000) are critical of the Kraepelinian<sup>1</sup> construct of psychosis as caused by illnesses and criticise Kraepelin’s methods and assumptions, which continue to inform psychiatry. They point out that his observations took place in clinical settings and did not include people who were not in receipt of treatment; that he thought the distress was a result of one specific disease rather than as a response to the voices. Because of the latter he assumed the cause was organic and ignored his patients’ life experiences. On the other hand, their own work, which has been developing over the past 25 years, has increasingly valued the personal

testimony of voice hearers. Traditionally this type of evidence has been rejected or at least seriously devalued in the world of randomised controlled trials, although it has had a stronger place in social work practice (Gould, 2006). However, the challenge this work is now providing to biological psychiatry is quite fundamental; it is opening up a new paradigm of understanding. Professor de Chávez<sup>2</sup> describes Romme and Escher's work as comparable to that of William Tuke into non-restraint, that they have provided insights into a new way of understanding the phenomenon of voice hearing.

Only a few times in the history of psychiatry have there been revealing events, initiatives and observations that have unexpectedly had an impact on professionals and users and significantly influenced the subsequent course of knowledge and practice of this science. (de Chávez, 2012, p. xiii)

Romme<sup>3</sup> takes a more political view of the changes his work demands, and he compares the situation of voice hearers to that of homosexuals up to the 1960s, as a group in need of liberation from psychiatry. He compares eradicating people's voices to forcing homosexuals to become heterosexual.

The relationship between psychosis and trauma, particularly due to childhood abuse and neglect, is one of the main foci of researchers investigating this alternative understanding of voice hearing. Bebbington et al. (2004) found a correlation between experiencing victimisation and the development of psychosis in their survey of households in Great Britain. Fisher et al. (2011) found that claims of childhood abuse by people with psychosis were reliable and if anything it was likely that abuse is under-reported because of the fear of the legal ramifications. However, they also found that clinicians commonly fail to enquire about traumatic experiences, particularly when a person is felt to be severely disturbed. In their review of the research into the link between trauma and psychosis, Read, Fink, Rudegeair, Felitti and Whitfield (2008) found a clear relationship between childhood abuse and voice hearing and delusions. They found the relationship between such childhood experiences and thought disorder to be weak unless it is accompanied by adult abuse. But they found that there was a dose response in relation to voice hearing, that is, the longer the abuse occurred, the greater the risks to the child. They argue that these social causes have been ignored in biomedical psychiatry and that the stress-vulnerability model, which originally explained the way social experiences might make people more susceptible to psychological distress, had been modified by geneticists who act 'as if the brain exists in a social vacuum, ignoring the fact that a primary function of the brain is to react to the environment' (Read et al., 2008, p. 246). The idea that vulnerability to trauma is genetic simply does not stand up to scrutiny in groups of voice hearers where the experience of abuse is commonly felt to have caused people's distress. Despite the strength of Read's evidence showing the link to trauma, Johnstone (2011) has concerns that his focus on psychosis may be reifying it, giving it the status of a disease. She is warning

that care needs to be taken with the way we discuss unusual experiences if a paradigm change is to be achieved rather than simply a shift from one diagnosis to another.

That paradigm change involves treating and preventing distress, and Hammersley, Bullimore, Fiddler, and Read (2008) argue that studies of abused children who have received support at the time show a lower incidence of the development of psychosis and drug misuse as adults, reinforcing the view that such experiences are socially caused and can be socially prevented. Actions such as believing the child and punishing the abuser can be supportive. Escher et al. (2004) found that children who were hearing voices responded positively to support from mental health professionals, but also to what they described as supplementary care that was aimed at normalising the experience of voice hearing rather than suppressing the voices; this is support from people who are not highly qualified. Children were also helped to view their voices more positively, which helped them to cope. In addition to this 'psycho-education', the researchers found techniques aimed at reducing anxiety to be supportive.

Hornstein (2009), a US psychology professor who specialises in the use of first-person narratives in her teaching, views the HVN in the UK as having achieved extraordinary success in establishing an alternative therapeutic service to pharmacological psychiatry. The groups are led by voice hearers using their own explanations to help others. When a voice hearer seeks help from the HVN they are not diagnosed, rather they are listened to and their explanation of their voices is valued and understood. Instead of making presumptions about the voices, the focus is on taking a lead from what people believe to be their problems; it is a commonsense approach to working with people and respecting their views on what they need. This is in contrast to the experience of contacting professionals, which inevitably results in diagnostic labelling. While many people value a medical explanation and find benefit in medication, what Hornstein uncovers in people's firsthand accounts is that this process of medicalising unusual experiences can commonly result in silencing discussion of those experiences. As Rufus May has argued, 'Madness is when other people choose to stop trying to understand you'.<sup>4</sup>

HVN groups are not in themselves a form of therapy; rather they offer therapeutic support and education. Professionals such as pharmacists and sympathetic psychiatrists may well attend to provide information, while group members provide expertise through experience to professional courses in some universities. This approach appears to have been successful. Meddings, Walley, Collins, Tullett and McEwan (2006) undertook an evaluation of one group in Sussex and found that it contributed to significant improvements for some of the participants. It led to a reduction in the number of hospital admissions and to fewer days spent in hospital; it led to people having a greater range of coping strategies; it led to an improved quality of life and to an increased sense of empowerment. In a more recent evaluation of a group undertaken in a secure hospital, patients,

nurses and psychologists tended to agree that the group was broadly positive. However, this was in contrast to the responsible clinicians who were quite negative about the group and perceived it as anti-psychiatry and outside of their control (Jones, 2010).

## **Changing paradigms of working**

Instead of viewing voices as a symptom of an illness, the Maastricht approach argues for voices to be understood as a psychological or emotional response to environmental experiences, and for people to be helped to cope, rather than for the voices to be obliterated with neuroleptic medicines. Bentall has long argued for a change in the way we understand psychosis as the evidence for the existence of a disease; the schizophrenia hypothesis he argues, lacks both reliability and validity. He proposes that a complaint focussed paradigm that is concerned with the reasons people seek help should replace the Kraepelinian disease construct in which these complaints are merely symptoms (Bentall, 2006). This would mean a focus on auditory hallucinations and delusional beliefs, which he argues would produce more effective therapies than trying to treat an illness that cannot be found. Bentall suggests that the fundamental error of psychology is to view others' actions as genetic while explaining ourselves in terms of our experience. The three consequences of this in relation to psychosis are covering up other explanations; creating rather than diminishing stigma; and wasting resources that could be better used elsewhere (Bentall, 2009).

Bentall is also critical of the use of neuroleptics and of the exaggerated claims made by pharmaceutical companies in order to increase profits. While there may be some short-term effectiveness with aspects of psychosis, these drugs cause long-term deterioration. In making the case for the use of psychotherapeutic approaches instead of drugs, he argues that the evidence points to good relationships as possibly the most important element of care, but that:

At the tail-end of the neo-Kraepelinian era, after decades in which clinicians have neglected the personal dimensions of treatment and placed their faith in biomedical remedies for the miseries of life, this idea seems almost revolutionary. (Bentall, 2009, pp. 260–261)

Bentall contrasts two visions of mental health service, one based on a 'paternalistic-medical' approach, the other 'autonomy-promoting' (2009, pp. 268–270). The latter approach has many similarities to the 'empowerment-community integration paradigm' which grew out of the development of user controlled services in Canada in the 1990s (Nelson, Lord, & Ochoka, 2001) and few social workers would have any difficulty subscribing to these in principle as they place the service user at the centre and put professionals in the role of collaborator, rather than expert. However, in practice, along with other mental

health professionals they may find themselves working in paternalistic-medical environments where,

... public protection has become the predominant aim of the mental health system, exemplified by the government's tenacity in pushing through more coercive mental health legislation despite longstanding opposition from professional, voluntary and user organizations. (Langan, 2009, pp. 470–471)

In these settings, social workers are often forced to take a risk management strategy and even this is becoming standardised by the technologies being used in the NHS (Langan, 2009). Nathan and Webber (2010) are also concerned about the impact of 'bureau-medicalisation' on mental health social work, particularly with the increasing employment of social workers in health trusts and the tendency towards a unified mental health practitioner. Drawing on the IFSW definition of social work, they believe that social workers should see themselves as working at the interface of service users and institutions; that they should take a 'best interests' approach as in child protection. They argue that psychosocial, social work is necessary to prevent the biomedical model from gaining dominance in the NHS, but they stop short of challenging the Kraepelinian construct of schizophrenia, which would be essential to truly engage with voices in more effective ways. Barnes (1999), however, has called for an approach to social work that recognises and respects the impact of trauma on mental health. She has been very critical of those who she perceives as compounding the stigma associated to psychosis by their own uncritical use of biomedical models (Barnes, 2001). An approach that respects people would also have to be non-coercive as detention and compulsory treatment betray an individual's right to choose.

It has always struck me as odd that we place people, at their most vulnerable, into a ward full of the very people that the public does not feel safe or at ease with. (Plumb, 1999, p. 460)

Spandler and Calton (2009) argue that people should have the human right to experience psychosis without being compulsorily medicated and that they should have access to appropriate support. That support might more appropriately be provided by a social worker than a psychiatrist. Corstens, Escher and Romme (2008, p. 328) argue that not only is neuroleptic medication ineffective, it also 'reduces a person's emotionality which is useful in the short term but diminishes recovery effects because coping with emotion is not learned'. Moncrieff (2008) has concluded that a better way of using medication would be to take a drug-centred, rather than disease-centred, approach. She argues that neuroleptic drugs create an abnormal brain state, rather than correcting one; as there is no evidence to support the view that psychiatric drugs have an impact on either the cause or process of diseases, they should only be used because of the effects they are known to have on symptoms. Read et al. (2008, p. 215) also found that 'care orientated toward

discontinuation of the voices by 'medication only' hampered the children's development'.

Romme (2009b, p. 25) argues that the diagnosis of schizophrenia itself is ineffective as it 'alienates the voice hearer from their experience; it makes them a passive victim of disease'. In this critical literature, many psychiatrists and psychologists question the existence of schizophrenia as a specific disease, thus always refer to it as a diagnosis. While acknowledging that there are bound to be biological processes involved in psychological events, Read and colleagues are critical of the biomedical approach to researching schizophrenia as a disease, mainly led and financed by pharmaceutical companies, in which correlations are treated as evidence of causality.

This is akin to assuming that because the brain operates differently when we are grieving, it is the brain that caused our sadness. (Read et al., 2008, p. 246)

Hammersley, Langshaw et al. (2008) argue that the current deconstruction of the concept of schizophrenia is different to the earlier anti-psychiatry movement, which did not produce an alternative understanding of psychosis, but instead tried to offer an alternative psychosocial explanation of the cause of the 'illness'. Bentall (2009) concurs with this view and describes his own approach as utilitarian in that it offers effective therapeutic alternatives to medicine, while describing Szasz's (1960) approach as deontological, that he was opposed to the medicalisation of distress on principle, regardless of the outcome for the person in distress. The common feature of this alternative paradigm being promoted by various psychologists and psychiatrists is their focus on the so-called symptoms as real issues in their own right. Voice hearing, disordered thoughts and paranoia are the problems people face and with which they need help from outside the traditional biomedical framework of understanding.

Such help need not necessarily remain the province of the psychiatrist and as the work of the HVN shows, it can and should include experts by experience. Spandler and Calton (2009) are concerned that if non-medical professional practice follows a social model approach that is too concerned with social barriers, it would fail to connect with the real issues of mental distress that people with psychosis face. Social workers must engage with the critique of Kraepelinian psychiatry that is at the heart of the international movement of voice hearers and be prepared to undertake therapeutic practice in an alternative paradigm. Tew (2002) has argued against the process of diagnosis and the dominant place it occupies in the labelling and treatment of people in mental health services.

Of profound importance is a shift from a discourse of 'symptoms' in which the content of people's experience or behaviour is not seen as important in terms of its intrinsic meaning, only in terms of any clues it provides as to where a person may fit within a system of diagnosis. (Tew, 2002, p. 146)

Social work assessments need to focus on that intrinsic meaning and to be undertaken collaboratively with service users.

## Social work practice with voices

If social workers listen to voice hearers and draw on the experience of the Hearing Voices Network in their own practice, they will need to:

- Develop a different understanding of voices to the traditional view of biomedical psychiatry, that they are hallucinations, indicating an underlying illness.
- Develop positive attitudes to voice hearers, respecting their expertise and experiences as valid.
- Understand the role of childhood trauma, particularly abuse and neglect in the development of voices.
- Develop therapeutic skills so as to work with voice hearers and with voices.

In terms of developing the skills and knowledge required, there are many events run by members of the HVN throughout the UK which social workers can attend, and it should be included within both qualifying and post-qualifying social work education. It is important not to indoctrinate social work students further with the biomedical model if they are to prove themselves of value to voice hearers in practice. The most comprehensive guide to working with voice hearers is Romme and Escher's (2000) book, *Making Sense of Voices*.

The primary aim of our approach is to make explicit the relationship between individual history and the voices. In other words, to take it out of the realm of psychopathology and put it into the context of people's life-problems and their personal philosophy... Our secondary aim is to demystify the voices. Hearing voices is an unusual experience, but not one that requires an extraordinary explanation. (Romme & Escher, 2000: 10)

This approach is against the current trend in mental health services towards greater control. The new Supervised Community Treatment Orders are intended to exert greater control over more people even though the evidence shows that they are an ineffective over-reaction (Kisely, Campbell, & Preston, 2008) and contribute little to improving social functioning. While biomedical coercive discourses have been dominant in shaping policy, social workers reportedly prefer non-coercive roles and to work with psychosocial understandings of mental health.

... the majority of mental health social workers oppose assuming a statutory role in involuntary admissions to hospital, mainly because of concern about how this might adversely affect their relationship and ability to act as advocates on behalf of service users. (Wilson & Daly, 2007, p. 429)

One U.S. social worker, who was interested in the provision of psychotherapy to people with psychosis, undertook a meta-analysis of research into the impact of not providing medication to people in early episode psychosis and found that there was no evidence of any long term damage of doing so (Bola, 2005). For example, the Soteria project, in which patients were treated with minimal or no medication, but instead received social and emotional support from unskilled staff, resulted in better recovery with fewer patients requiring ongoing medication (Bola & Mosher, 2003). The evidence that intensive interpersonal care is more effective than neuroleptic medications at treating people during the onset of psychosis is important in the argument against continuation of the biomedical control of psychiatric services. The 'Finnish Need-Adapted Approach' is a good example of an effective psychotherapeutic, family centred approach to working with people experiencing psychosis. The work is planned and carried out flexibly with individuals so that their real and changing needs are met. The approach is based on the premise that the Kraepelinian view of schizophrenia is not proven (Alanen, Lehtinen, Rakkolainen, & Aaltonen, 1991).

Hammersley, Burston and Read (2004) argue that in nursing it is necessary to counter the tendency to ignore psychotic people in research and to disbelieve psychotic patients in practice. They say that psychiatric nurses should be trained to ask their patients about childhood sex abuse. Such training could help give them the courage to ask and the expertise to listen. The same may be necessary in social work, particularly in services that may not be primarily concerned with mental health. The prevalence of mental distress amongst children in care is about five times greater than for other children (McAuley & Young, 2006) and this is understandable given the greater likelihood of these children having experienced abuse and neglect. However, as McAuley and Young also point out, the care system itself tends to lack stability which may add to the vulnerability of children who are already traumatised. Specialist help via Child and Adolescent Mental Health Service (CAMHS) tends to be difficult to access and children will need a lot of support from people with less training, including care staff and foster parents. In groups, voice hearers report the experience of having their accounts of voices and trauma either denied or ignored by professionals as re-traumatising. Hammersley and colleagues make a simple but important suggestion which many professional could follow:

The current approach which asks people 'what is wrong with you?' rather than 'what has happened to you?', misses the crucial point that all distress and behaviour, however seemingly bizarre, is a meaningful attempt to survive maddening experiences in what for some of us can be a crazy world. (Hammersley, Langshaw, et al., 2008b, p. 19)

Coffey and Hewitt (2008) found that there were many obstacles to getting people to change their ways of working with voice hearers to one of talking about the content

and meaning of voices, rather than seeing them as symptoms of an illness and focussing on pharmaceutical solutions. In their study of nurses and service users, they found that voice hearers felt this type of change would be useful and while nurses recognised that changes were taking place, this approach was different to how they were trained. Sharing experiences was important to most voice hearers, but the nurses felt lacking in skills and confidence. In working with nurses on training courses, Peter Bullimore found that nurse students ask if it is alright to 'pry' into people's life stories which suggests that they are being socialised into treating the nursing role as limited to physical care, even in mental health nursing. As Coffey and Hewitt have said:

The contrasting views of nurses and users of services . . . reveal multiple social realities that represent a challenge to accepted professional responses in the provision of mental health care. (Coffey & Hewitt, 2008, p. 1591)

Karlsson (2008) argues that social workers need to have an understanding of the way voices are experienced in order to work differently. He believes that social workers need to think about the language they use if they are to work more effectively with voice hearers without being dependent on medical terminology, which distorts the meaning of voice hearing.

It was irrelevant whether others considered the voices unreal or not, since they were real to the participants. Whether the voices were pathological or not in a biomedical sense seemed irrelevant, too. The participants were doing on their own what inspired social workers should be helping their clients to do, i.e. to explore their inner world. (Karlsson, 2008, p. 372)

*Making Sense of Voices* is a comprehensive guide to how such exploration and other aspects of working with voices and voice hearers can be achieved. Therapy is vital, as

. . . patients need help in dealing with their own emotional or behavioural responses to their problems, as well as with the problems themselves. The emphasis should not be on suppressing that response medicinally. (Romme & Escher, 2000, p. 15)

In outline, the Maastricht approach to working with voice hearers consists of some key elements. The first of these is an interview schedule that is used to find out more about the voices and to create a construct regarding their identity and meaning. The interview should be carried out without imposing any particular understanding on the questions and answers, which can lead to making wrong assumptions early into the interview; Romme and Escher recommend a journalistic approach to the interview rather than an expert-professional approach that might lead to making diagnostic assumptions. The interview aims to find out

more about the voices and the voice hearer's past by focussing on five main areas (Romme & Escher, 2000, p. 53):

- The identity of the voices
- Their characteristics (including content)
- The history
- The triggers (including impact)
- Childhood and adolescence

Eleanor Longden, herself a voice hearer has described how she felt when her new psychiatrist introduced her to the Maastricht approach.

But there was one big barrier between me and the future and it was this voice. I had become so demoralised and tormented by it I'd even tried to drill a hole in my forehead in an attempt to get it out. But Pat told me about the philosophy of Marius Romme and Sandra Escher and about the Hearing Voices Network and that this is just normal human experience, and the importance of conceptualising it in your own way. These experiences are so complex and so meaningful. It doesn't happen in a social, emotional or spiritual vacuum. There is a context to it, and this can be interpreted and deciphered. (Longden, 2010, p. 257)

Following the interview the therapist creates a construct which becomes a means of sharing ideas between therapist and voice hearer. In creating the construct, the therapist is asking 'how' the voices have started, not 'why' as in medical diagnosis which seeks to find an illness explanation. Longden and colleagues describe the construct as 'a dynamic, psychosocial formulation that explores possible interpretations of the original situation that prompted voice emergence'. While the psychological processes that cause voice hearing are not fully understood, the experience is conceptualised as 'a manifestation of a vital defensive manoeuvre whereby transforming emotional conflict into voices is psychologically advantageous' (Longden, Corstens, Escher, & Romme, 2011, pp. 224–234).

Following this the intervention is set out in three phases, short, medium and long term. Short-term techniques are aimed at helping people gain greater control over the voices and the way they affect the voice hearer's life. Ten techniques used at this stage have mainly come from voice hearers. (Romme & Escher, 2000, p. 65):

- Replying to the voices
- Designating a set time and duration for the voices
- Dismissing the voices for a certain period
- Writing down what the voices say and want
- Checking whether what the voices say is true
- Creating boundaries
- Postponing orders
- Substituting different orders and learning to express anger

- Anticipating the voice
- Talking to somebody about the voices

Trevor Eyles, a professional therapist working with these techniques in Denmark, says that he feels it is important at the outset of working with a voice hearer to reassure their voices that he does not intend to get rid of them.<sup>5</sup> Not only is this an intentionally different approach to traditional drug treatment, it illustrates an important aspect of working with voice hearers which is that it also means working with the voices. Corstens and colleagues describe how people found their experience of talking with voices.

These individuals experienced it as a safe way to enhance understanding of their voices through the provision of normalising frameworks and insight into the underlying reasons for voice emergence, ultimately acting as a catalyst for establishing more productive relationships between hearer and voice. Furthermore, the approach can improve social functioning for voice-hearers who are trapped in destructive communication patterns with their voices. (Corstens, Longden, & May, 2012, p. 8)

Medium-term techniques include normalising, which concerns showing how hallucinations and paranoia are normal responses to a range of stressful and traumatic experiences, rather than part of an incurable illness, and enhancing coping strategies. These include re-authorising lives by de-authorising the voices so they are less powerful. By personalising the voices people have been able to see them as less mysterious and hence less powerful. It is also during this phase that Romme and Escher (2000) believe that HVN groups can be most supportive. In the long term, people may need support in maintaining what they have achieved in order to enhance each individual's recovery.

While social workers may aspire to professional therapeutic roles, they are commonly employed to administrate the delivery of particular welfare services and within clinically orientated interdisciplinary teams they are often expected to take on the role of the Approved Mental Health Professional (AMHP). This may restrict the extent to which social workers feel that additional therapeutic skills can be used in practice. Triseliotis (1987) recognised this as an issue in respect of family therapy, but what made social workers different was their adaptation of clinically developed methods to the reality of people's daily lives. Social workers transformed family therapy into 'working with families', taking a method of practice that might normally only be used in clinical settings into people's own homes. The use of therapeutic knowledge in administrative interactions also distinguishes social workers from other welfare administrators who normally follow procedures without regard to the personal circumstances of the service user.

Social workers may be employed in a range of mental health settings – early intervention teams, community mental health teams, housing associations,

voluntary organisations or user-led projects – and their roles and resources will vary accordingly. However, this model of social work's relationship with clinical knowledge can also be applied to voice hearing. Making use of new therapeutic approaches in the daily administrative interactions with voice hearers will impact on their lives and change their experience of mental health services. A change in social work practice in any of these setting also changes the service.

## Conclusion

The Kraepelinian construct of psychosis resulting from illnesses has retained its dominance in psychiatry despite the evidence to the contrary. People being brought up in poverty are more likely to experience psychosis and both race and gender are factors in social causation and social construction (Read, 2004). The implications in terms of working to alleviate material deprivation and to counter racism and sexism are well known. There is also evidence to show the importance of expressed emotions and the impact of family communication skills on the prevention of psychosis (Tienari et al., 2004) and again this is another area in which mental health professionals can contribute their skills. Helping people to deal with the psychosocial impact of material deprivation, oppression and family life are all important roles in social work, but in helping people who are hearing voices something more is required, listening to voice hearers.

Psychiatrists and other mental health professionals continue to ignore what people tell them and instead to treat their stories as evidence of hallucinations and to diagnose them with schizophrenia. Despite the causal relationship between childhood trauma and psychosis, voice hearers are commonly disbelieved and even told that their memories of abuse are delusions. The Hearing Voices Network is challenging this mistreatment of people who are struggling to cope with the results of their traumatic experiences. Social workers can be part of that radical challenge, but social work education must be able to prepare them adequately to challenge the existing medical and pharmaceutical regimes.

## Notes

1. Emil Kraepelin (1856–1926) is credited with the hypothesis that psychotic experiences are symptoms of diseases. Although still unproven, this hypothesis is treated as true within western bio-medical psychiatry.
2. Former president of the International Society for the Psychological Treatments of the Schizophrenias and other Psychoses.
3. Talking on *Emancipatory Approaches to Hearing Voices* at Bradford, 12 December 2011, Marius Romme described trying to stop voice hearers from hearing voices like trying to make a homosexual into a heterosexual.
4. *Taking a Stand*, BBC Radio 4, 6 February 2001.
5. Trevor Eyles during his presentation to the ISPS conference, Preston, 7 December 2010.

## References

- Alanen, Y., Lehtinen, K., Rakkolainen, V., & Aaltonen, J. (1991). Need-adapted treatment of new schizophrenic patients: Experiences and results of the Turku Project. *Acta Psychiatrica Scandinavica*, *83*, 363–372.
- Barnes, H. (1999). Exclusion and mental health—the relationship context of mental health practice. *Social Work Education*, *18*(4), 401–415.
- Barnes, H. (2001). A comment on Stroud and Pritchard: Child homicide, psychiatric disorder and dangerousness: A review and an empirical approach. *British Journal of Social Work*, *31*(3), 481–492.
- Bebbington, P., Bhugra, D., Brugha, T., Singleton, N., Farrell, M., Jenkins, R., . . . Meltzer, H. (2004). Psychosis, victimization and childhood disadvantage: Evidence from the second British National Survey of Psychiatric Morbidity. *British Journal of Psychiatry*, *185*, 220–226.
- Bentall, R. (2006). Madness explained: Why we must reject the Kraepelinian paradigm and replace it with ‘complaint-orientated’ approach to understanding mental illness. *Medical Hypotheses*, *66*, 220–233.
- Bentall, R. (2009). *Doctoring the Mind. Why Psychiatric Treatment Fails*. London: Allen Lane.
- Bola, J. (2005). Medication-free research in early episode schizophrenia: Evidence of long-term harm? *Schizophrenia Bulletin*, *32*(2), 288–296.
- Bola, J. R., & Mosher, L. R. (2003). Treatment of acute psychosis without neuroleptics: Two-year outcomes from the Soteria Project. *The Journal of Nervous and Mental Disease*, *191*(4), 219–229.
- Carter, A. (2004). *A New Approach to Working with Voice-Hearing*. Norwich, UK: Social Work Monographs.
- Coffey, M., & Hewitt, J. (2008). ‘You don’t talk about the voices’: Voice hearers and community mental health nurses talk about responding to voice hearing experiences. *Journal of Clinical Nursing*, *17*(12), 1591–1600.
- Coppock, V., & Dunn, B. (2010). *Understanding Social Work Practice in Mental Health*. London, UK: Sage.
- Corstens, D., Longden, E., & May, R. (2012). Talking with voices: Exploring what is expressed by the voices people hear. *Psychosis*, *4*(2), 95–104. DOI: 10.1080/17522439.2011.571705.
- Corstens, D., Escher, S., & Romme, M. (2008). Accepting and working with voices: The Maastricht approach. In A. Moskowitz, I. Schäfer, & M. Dorahy (Eds.), *Psychosis, Trauma and Dissociation: Emerging Perspectives on Severe Psychopathology* (pp. 319–332). Chichester: Wiley-Blackwell.
- De Chávez, M. (2012). Foreword. In M. Romme, & S. Escher (Eds.), *Psychosis as a Personal Crisis: An Experience-based Approach* (pp. xiii–xvi). London, UK: Routledge.
- Escher, S., Morris, M., Builks, A., Delespaul, P., Van Os, J., & Romme, M. (2004). Determinants of outcome in the pathways through care for children hearing voices. *International Journal of Social Welfare*, *13*, 208–222.
- Fisher, H., Craig, T., Fearon, P., Morgan, K., Dazzan, P., Lappin, J., . . . Morgan, C. (2011). Reliability and comparability of psychosis patients’ retrospective reports of childhood abuse. *Schizophrenia Bulletin*, *37*(3), 546–553.
- Golightley, M. (2008). *Social Work and Mental Health* (3rd ed.). Exeter, UK: Learning Matters.

- Gould, N. (2006). An inclusive approach to knowledge for mental health social work practice and policy. *British Journal of Social Work*, 36(1), 109–125.
- Gould, N. (2010). *Mental Health Social Work in Context*. London, UK: Routledge.
- Hammersley, P., Bullimore, P., Fiddler, M., & Read, J. (2008). The trauma model of psychosis. In T. Stickley, & T. Basset (Eds.), *Learning About Mental Health Practice* (pp. 401–416). London: John Wiley & Sons.
- Hammersley, P., Burston, D., & Read, J. (2004). Learning to listen: Childhood trauma and adult psychosis. *Mental Health Practice*, 7(6), 18–21.
- Hammersley, P., Langshaw, B., Bullimore, P., Dillon, J., Romme, M., & Escher, S. (2008). Schizophrenia at the tipping point. *Mental Health Practice*, 12(1), 14–19.
- Hornstein, G. (2009). *Agnes's Jacket. A Psychologist's Search for the Meaning of Madness*. New York, NY: Rodale.
- Johnstone, L. (2011). Can traumatic events traumatize people? Trauma, madness and 'psychosis'. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-Medicalizing Misery* (pp. 99–109). Basingstoke, UK: Palgrave Macmillan.
- Jones, H. (2010). *Mental Health Services, Hearing Voices Group Evaluation*. Nottinghamshire Healthcare NHS Trust, Retford.
- Karban, K. (2011). *Social Work and Mental Health*. Cambridge, UK: Polity Press.
- Karlsson, L. B. (2008). More real than reality: A study of voice hearing. *International Journal of Social Welfare*, 17, 365–373.
- Kisely, S., Campbell, L., & Preston, N. (2008). The Cochrane Collaboration. *Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders (Review)*. London, UK: Wiley.
- Langan, J. (2009). Mental health, risk communication and data quality in the electronic age. *British Journal of Social Work*, 39(3), 467–487.
- Longden, E. (2010). Making sense of voices: A personal story of recovery. *Psychosis*, 2(3), 255–259.
- Longden, E., Corstens, D., Escher, S., & Romme, M. (2011). Voice hearing in a biographical context: A model for formulating the relationship between voices and life history. *Psychosis*, 4(3), 224–234.
- McAuley, C., & Young, C. (2006). The mental health of looked after children: Challenges for CAMHS provision. *Journal of Social Work Practice*, 20(1), 91–103.
- Meddings, S., Walley, L., Collins, T., Tullett, F., & McEwan, B. (2006). The voices don't like it. *Mental Health Today* September, pp. 26–30.
- Moncrieff, J. (2008). The myth of the magic antipsychotic. *Mental Health Today* June, p. 18, 19, 22.
- Nathan, J., & Webber, M. (2010). Mental health social work and the bureau-medicalisation of mental health care: Identity in a changing world. *Journal of Social Work Practice*, 24(1), 15–28.
- Nelson, G., Lord, J., & Ochoka, J. (2001). *Shifting the Paradigm in Community Mental Health: Towards Empowerment and Community*. Toronto, ON: University of Toronto Press.
- Plumb, A. (1999). New mental health legislation. A lifesaver? Changing paradigm and practice. *Social Work Education*, 18(4), 459–478.
- Read, J. (2004). Poverty, ethnicity and gender. In J. Read, L. Mosher, & R. Bentall (Eds.), *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia* (pp. 161–194). London, UK: Routledge.

- Read, J., Fink, P., Rudegeair, T., Felitti, V., & Whitfield, C. (2008). Child maltreatment and psychosis: A return to a genuinely integrated bio-psycho-social model. *Clinical Schizophrenia and Related Psychoses*, 2, 235–254.
- Romme, M. (2009a). Important steps to recovery with voices. In M. Romme, S. Escher, J. Dillon, D. Corstens, & M. Morris (Eds.), *Living with Voices: 50 Stories of Recovery* (pp. 7–22). Ross-on-Wye, UK: PCCS Books.
- Romme, M. (2009b). The disease concept of hearing voices and its harmful aspects. In M. Romme, S. Escher, J. Dillon, D. Corstens, & M. Morris (Eds.), *Living with Voices: 50 Stories of Recovery* (pp. 23–38). Ross-on-Wye, UK: PCCS Books.
- Romme, M., & Escher, S. (2000). *Making Sense of Voices: The Mental Health Professional's Guide to Working with Voice-hearers*. London, UK: Mind Publications.
- Romme, M., Honig, A., Noorthoorn, O., & Escher, A. (1992). Coping with hearing voices: An emancipatory approach. *British Journal of Psychiatry*, 161, 99–103.
- Spandler, H., & Calton, T. (2009). Psychosis and human rights: Conflicts in mental health policy and practice. *Social Policy and Society*, 8, 245–256.
- Szasz, T. (1960). The myth of mental illness. *American Psychologist*, 15, 113–118.
- Tew, J. (2002). Going social: Championing a holistic model of mental distress within professional education. *Social Work Education*, 21(2), 143–155.
- Tew, J. (2011). *Social Approaches to Mental Distress*. Basingstoke, UK: Palgrave Macmillan.
- Tienari, P., Wynne, L., Sorri, A., Lahti, I., Läksy, K., Moring, J., . . . Wahlberg, K. (2004). Genotype-environment interaction in schizophrenia-spectrum disorder: Long-term follow-up study of Finnish adoptees. *The British Journal of Psychiatry*, 184, 216–222.
- Triseliotis, J. (1987). 'Family therapy' or working with families. *Practice*, 1(1), 5–13.
- Wilson, G., & Daly, M. (2007). Shaping the future of mental health policy and legislation in Northern Ireland: The impact of service user and professional social work discourses. *British Journal of Social Work*, 37(3), 423–439.