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Accepting and Working with Voices: The Maastricht Approach

Dirk Corstens, Sandra Escher, Marius Romme and Eleanor Longden

Over the past three decades in Maastricht, the Netherlands, psychiatrist Marius Romme and researcher Sandra Escher have developed a new approach to hearing voices[1] which emphasises accepting and making sense of the experience. This framework, sometimes referred to as 'the Maastricht approach,' has grown progressively more influential in Europe, North America, Australasia, and elsewhere, and has led to voice hearers organising themselves into networks in order to empower themselves, challenge stigma, and find new and constructive ways of working towards recovery (Corstens et al., 2014; Longden, Corstens, & Dillon, 2013; Woods, 2013).

This approach contends that people hearing voices (hereafter referred to as 'VHs' for 'voice hearers') can learn to cope with the experience and benefit from psychosocial interventions. It is based on three central tenets: that the phenomena of hearing voices: a) is more prevalent in the general population than was previously believed, and as such should not be considered a symptom of illness in and of itself; b) can be understood as a personal reaction to life stresses, whose meaning and psychological purpose can be deciphered and; c) is more accurately considered as a dissociative experience rather than as a psychotic symptom. In addition to

[1] In the professional literature, voice hearing is usually referred to as *auditory* or *verbal hallucinations*. We will, however, use the term 'voices' throughout this chapter, which we feel is more consistent with the ways in which voice hearers themselves describe their experiences.

emphasising the importance of understanding voices' subjective meaning, a specific treatment model for working directly with a person's voices – emphasising their dissociative nature – has been developed by adapting the Voice Dialogue method (Stone & Stone, 1989).

The History of the Maastricht Approach and the Hearing Voices Movement

Beginning with one patient who insisted that her voice hearing experiences should be taken seriously, Romme and Escher worked in close collaboration with VHs to conduct research projects and organise meetings for VHs and professionals (see James, 2001). In this regard, early work found that bringing together patient and non-patient VHs highlighted the relative lack of difference between the experiences of these two groups at the point at which voices first emerged. In contrast, a striking difference was that the non-patients were more likely to have a subjectively meaningful framework for their voices and to be able to cope with them successfully. Sharing the stories of non-patient VHs, as well as patients who had recovered, generated considerable hope for distressed VHs and these narratives were widely shared in conferences, media work, and network meetings within the Netherlands.

Effectively, accepting and making sense of voices became a new paradigm, constructively creating new treatment approaches and ways of recovery.
Starting in the UK but ultimately moving internationally, this has led to the development of collectives of VHs (known as 'Hearing Voices Networks') who created and elaborated ways of supporting one another outside of statutory mental health services. These activities, in turn, led to and became embedded in what is known today as the International Hearing Voices Movement (see Longden et al.,

2013). Today, there are Hearing Voices Networks in 32 countries across the world, whose activities are supported and coordinated via Intervoice (www.intervoiceonline.org), the organisational body of the International Hearing Voices Movement. In addition to this administrative role, an important function of Intervoice is to disseminate hopeful messages, promote training and research, and offer practical support for distressed individuals trying to make sense of their experiences.

Relevant Research Findings

Since Romme and Escher's (1989, 1993, 2000) initial work, substantial empirical support has been provided for the Maastricht approach's key propositions. For example, the recognition that voice hearing specifically, and psychosis generally, is robustly associated with trauma and adversity has moved from 'heresy to certainty' (Read 2013, p.249; see also Longden, Madill, & Waterman, 2012; Read & Bentall, 2012; Read et al., 2005; Read et al., 2014; Varese et al., 2012). Correspondingly, the potential for non-pharmacological interventions has been increasingly acknowledged (e.g., British Psychological Society: Division of Clinical Psychology [BPS], 2014; Morrison et al., 2014; Read & Ross, 2003). Epidemiological data likewise confirms that hearing voices is by no means the sole province of the mentally ill, but is rather part of the spectrum of human difference and diversity (see Beavan et al., 2011; McCarthy-Jones, 2012). In turn, the phenomenological differences between voice characteristics in non-patients, patients with non-psychotic diagnoses, and patients with a formal diagnosis of schizophrenia have been shown to be surprisingly small (see Johns et al., 2014; Longden et al., 2012; Moskowitz & Corstens, 2007; McCarthy-Jones, 2012). In general, however, non-patient VHs feel less powerless and

are less afraid of their voices. Relatedly, an important factor for determining clinical need appears to be a person's *reaction* to their voices, and the ways they cope (or otherwise) with the underlying problems and conflicts that are implicated in voice onset and maintenance (e.g., Andrew et al., 2008; Romme, 1992; Romme et al., 2009; see Moskowitz et al., chapter XXX, this volume). For example, in their own research, Romme and Escher observed that for 70% of voice hearing patients and 50% of non-patients, voice onset was clearly connected to threatening or traumatising daily life experiences (Romme & Escher, 1989; Honig et al, 1998; see also Corstens & Longden, 2013). Similarly, for a group of 80 voice hearing children, 85% linked voice onset to trauma or stressful events, such as sexual and physical abuse, chronic emotional neglect, bullying, loss of a loved one (and being denied appropriate forms of bereavement), and parental divorce (Escher et al., 2004). Many, however, were able to cope with their voices without needing professional treatment. Correspondingly, the notion that voice hearing can be understood as a dissociative phenomenon (Moskowitz & Corstens, 2007) is increasingly well-evidenced, with a recent meta-analysis demonstrating a large, significant effect (r = .52) across 19 studies assessing, patients with psychosis and non-psychotic diagnoses, and non-patient VHs (Pilton et al., 2015).

Assessment: The Maastricht Hearing Voices Interview

Traditional psychiatry tends to view voices as pathological phenomenon, with little typically offered to VHs who seek help beyond medication. The alternative approach of the Maastricht model is based on helping people make sense of their voices and learning to cope and relate with them. A clinical strategy particularly associated with this endeavour is The Maastricht Hearing Voices Interview (MHVI; Romme &

Escher, 2000), a specialised assessment instrument for systematically exploring the links between voice content/characteristics and the psychosocial circumstances of the VH, both during and prior to voice emergence. By emphasising environmental rather than biogenetic influences in the origin and onset of distressing voices, it is consistent with the original diathesis-stress model, proposed by Zubin and Spring (1977), which did not insist on a genetic or biologically-cased vulnerability. This approach differentiates between acute stressors (circumstances that directly precipitate the start of voice hearing), and developmental events that create vulnerability for emotional crisis (psychological predisposition). As a tool to structure information gathering, the MHVI encourages the VH to explore their own experiences and establish some emotional distance from the voices, which in turn can highlight important information for clinical intervention. A brief summary of the MHVI structure is presented below.

1) **The Nature of the Experience:** Establishing whether the person actually hears voices, or if the experience is better characterised as intrusive thoughts. Voice location is also explored (if they are heard inside the head or externally through the ears), as well as the presence of other unusual sensory experiences and how these may relate to the voices.
2) **Characteristics of the Voices:** Factors like name, age and gender (if known/applicable), frequency, duration, speaking tone, and ways in which the different voices may relate both to one another and the VH.

3) **Personal History of Voice Hearing:** The VH's circumstances when each voice appeared for the first time, and how the voices may have developed since then in terms of content and influence.[2]

4) **Triggers:** Particular places, situations and/or emotions that trigger the voices, and how each voice responds to these.

5) **What do the Voices Say?** The content of each voice, preferably in whole sentences or exact words.[3]

6) **Explanations for the Origin of the Voice(s):** The person's own perspectives on why they are hearing voices.

7) **Impact of the Voices on Daily Life:** The effect of voice hearing on the VH's personal goals. Strategies used by the voices (e.g., giving advice, commanding, 'blackmailing', threatening punishment) are also examined, as well as the impact of these on the VH.

8) **Balance of the Relationship:** The ways in which the VH relates to and communicates with the voices.

9) **Coping Strategies:** Existing coping responses, broadly categorised into three themes: cognitive, behavioural, and physiological.

10) **Childhood Experiences:** Significant developmental events, particularly exposure to adversity, loss, and unmet emotional needs.

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[2] It is also possible that trauma produces a dissociative state, so that individuals do not remember what was happening at the time the voices began. We recommend using the Dissociative Experiences Scale (Bernstein & Putnam, 1986) before the MHVI in order to get some indication of the severity of dissociation.

[3] It is important to be aware that VHs may feel so ashamed or guilty by what the voices express that they feel unable to articulate it. The voices themselves may also forbid the VH to talk about them, or the individual might actively avoid attending to voice content. We have often observed that the more control the person has over the voices, the easier it is to discuss them.

11) **Treatment History:** What support the VH has received, and how effective it has been.
12) **Social Network:** An inventory of the presence/absence of supportive social contact.

An experienced interviewer generally takes 90 minutes to conduct the MHVI, although it is also possible to use it in clinical practice in a more extensive form (e.g., over several sessions). Before beginning the process, it is important to allow time to develop rapport by showing a broader interest in the person and their problems, combined with positive examples of other VH's experiences of coping and recovery (e.g., Romme et al., 2009), in order to help motivate the person to talk about the voices.

When the interview is concluded, the interviewer writes a report summarising the information in an accessible way. The VH is then asked to read the report and comment on it in order to discuss possible omissions or misunderstandings. Participating in this way can be a first step in reducing the types of emotional and cognitive avoidance that are so common amongst VH, and encouraging the VH to discuss new strategies for dealing with voices and emotions, as well as identifying practical and interpersonal issues that may be hindering recovery. We have often found that the interview process alone can have a therapeutic effect, because it helps VHs become more aware of the meaning of their voices, the relationship with their emotions and important psychosocial issues, and to increase motivation to try other coping strategies. However, we emphasize that the *systematic* use of the interview is necessary in order to structure the process and become aware of important aspects of the voice hearing experience.

Formulation: Making the Construct/Breaking the Code

Hearing voices is typically the end result of a sequence: 1) *trauma* leads to 2) *overwhelming emotions* which provoke 3) *dissociation* or *repression*. It is at this point that 4) *coping fails* and 5) *hearing voices* starts (for comparable sequences in the context of delusions, see Garfield, 2009). When this pattern is *deconstructed*, the individual's experiences can then be *reconstructed* as a sign of specific underlying problems and conflicts (i.e., when coping fails, the voices take over). In children we often find a shorter sequence, as voice hearing for them is often a direct response to traumatic experience as part of a dissociative reaction. Typically, the voice is 'protecting' the child. For example, during years of sexual abuse, a voice may offer emotional support. However, it is also not uncommon that the voice resembles the characteristics of the abuser; thus the voice can be viewed as a 'warning signal' on the one hand, expressing the dangerous and threatening behaviour of another person and, on the other, serves to split off overwhelming feelings of fear and annihilation.

Because hearing voices can initially feel very shocking and distressing, people easily become overwhelmed and ashamed. In Western culture, hearing voices is also closely associated with mental instability. Because of this societal ideology, many VHs don't relate their voices to their life history at all. Making sense of voices thus acknowledges their connection with overwhelming experiences. It requires an open, empathic attitude combined with a systematic approach to observing and gathering significant information: in effect, to decipher the relationship between the voices and life events and break the defensive 'code' (i.e., what the voices say may not adequately represent their purpose), which in patient VHs often involves destructive communication patterns and an exaggerated, negative way of expressing individual

emotional problems. This search for meaning leads to a dynamic psychosocial formulation that Romme and Escher (2000) have called 'the construct', which is effectively an understanding of the purpose of the voice negotiated between the interviewer and the VH. Two key questions are explored from the information in the report in order to formulate the construct: *Who or what do the voices represent?* and *What problems do the voices represent?*

Who or What do the Voices Represent? Traumatic events often involve other individuals, as well as powerful emotions that the survivor finds difficult to cope with. How the voices relate to the VH often resembles the identity and the characteristics of significant individuals related to the trauma in either a literal or metaphorical way, and significant actors in an emotionally overwhelming event will often influence voice characteristics (see Leudar and Thomas, 2000, particularly their comments about William James's notions about the social self). For example, the voice might have the same name or characteristics (gender, age) as the perpetrator, and the way it speaks may resemble the person involved in the trauma. In some cases, the voice may partly be a direct re-experiencing of the original traumatic events (McCarthy-Jones & Longden, 2015). Alternatively, voice content may only thematically reflect the words said by the original aggressor(s). The voice relates to life history, and while the VH may not be wholly aware of this, it is often something that they can easily recognise when the connection is worked out with them. Sometimes collaborative imagination is needed in order to discover the 'who' behind the voices: for example, the tone and content of a voice may not be congruent (e.g., a female voice repeating the words of a real-life male perpetrator). Nevertheless, voice hearing can often be understood as a reaction to social problems, sometimes as a mirror of overwhelming situations, on the basis of the vulnerability of the individual.

The identity, content, and characteristics of the voices and their origin can thus often indicate who or what they represent.

In stating this, we also acknowledge the intricacies of the concept of representation. It is not our contention that voices 'are' (for example) the literal perpetrators; rather that they embody the VH's memories, feelings and beliefs about negative events (and as such are only an indirect representation of other people). In turn, this includes aspects of the VH that may have identified with individuals who have harmed them (e.g., a voice that says "you're bad, you deserved it" can be seen as a part of the person which has internalised and believed this message). As such it is still possible to learn to relate to seemingly negative and abusive voices in an empathetic way. In this regard there are numerous examples within the Hearing Voices Movement of survivor testimony (including individuals diagnosed with psychosis/schizophrenia) wherein extremely aggressive voices have been reappraised by the VH as aspects of themselves which have been profoundly wounded, and thus in the greatest need of compassion and care (e.g., Coleman, 2011; Dillon, 2011; Longden, 2013; Romme et al., 2009).

What Problems do the Voices Represent? This question goes to the circumstances that lie at the root of the voice hearing experience: generally problems, conflicts and traumatic events that were so overwhelming they exceeded the individual's coping capacity. Resilience in the face of trauma exposure is strongly influenced by childhood experiences, in which we learn how to cope with life stressors, regulate and tolerate emotion, and adapt to internal and external conflicts. Many VHs have been emotionally inhibited in childhood by their caregivers or other significant adults (e.g., teachers). Consequently they may have extremely low self-esteem; and the more vulnerable a person is, the more difficult it becomes to learn to

endure and negotiate stressful events. Thus, in addition to trauma and abuse, other root problems can include such adversities as severe workplace conflict, domestic tension, sexual identity confusion, loyalty conflict, etc.

The Construct in Clinical Practice

The Maastricht approach promotes the idea that voices make emotional sense in the context of the VH's life. However, it also acknowledges that not all individuals accept this perspective in regard to their own voices. One concept which we often use to demonstrate how negative emotional experiences can be related to protection is the concept of the 'Inner Critic' (Stone & Stone, 1989), in which the 'Inner Critic' becomes a 'negative voice' that helps the person adapt to her environment and the expectations of her caregivers (for further discussion of relating this framework to voice hearing, see the later section on Talking With Voices).

It can often be useful for clinicians to preface the construct process by describing positive examples of the method (e.g., Romme et al., 2009), including drawing from their own practice to show how the process can be safe and accessible. Clinicians should also be open and authentic from the outset about their intentions – for example, by acknowledging that they believe strong connections often exist between voices and overwhelming experiences, and that they would like to explore this hypothesis with the VH.

Essentially, devising a construct requires an open, empathic working attitude combined with a systematic, collaborative approach to observing and gathering significant information. Consistent with best-practice guidelines for psychological formulation (e.g., BPS, 2011), the process should always honour the perspective and preferences of the VH, and not coerce them to accept the 'professional viewpoint' as

the most accurate and useful. The opinions of the VH should never be attacked, but rather respectfully explored. For example, if someone tells us they are hearing the voice of evil spirits, we would not tell them they are wrong but rather try and understand what this belief means to them and what function it may be serving. Indeed, in this regard, developing a construct is not an isolated activity led by the professional, but rather results from active collaboration with the VH. In our experience, it is possible to still work therapeutically with unresolved emotional issues whilst not coercing a VH to accept a psychosocial perspective (for example, we have seen instances in which VHs have been supported to seek religious counselling for what they believed were demonic voices, whilst therapists simultaneously provided support around trauma experiences).

The utility of the construct method has been assessed by Corstens and Longden (2013), who report on its application with 100 VHs. Within this sample, the average length of voice hearing was 18 years, 80 were diagnosed with schizophrenia/psychosis, and adverse childhood experiences were reported by 89 individuals. The query *who or what do the voices represent* was formulated in 78 cases (most commonly disowned aspects of self or an abusive family member) with *what problems do the voices represent* being apparent in 94 of cases (most frequently low self-worth, anger, and shame/guilt). Whilst the conclusions that can be drawn from this work are limited by its uncontrolled observational design, it serves to add to a rapidly growing literature about the possibility of seeking meaningful links between psychosocial events and the content of so-called psychotic symptoms (BPS, 2011; 2014). As Fowler, Garety and Kuipers (1998) describe it, “[s]uch links often provide indications of long-standing unresolved difficulties and associated negative self-

evaluations…which may be closely intertwined with processes maintaining delusional beliefs and voices and may underpin aspects of the emotional reaction" (p.127).

An Example: Maureen, aged 30

The identity of the voices**:** The voices are all female: Ina (perceived age 7), Anna (age 19) and Johanna (age 30).

The content/characteristics of the voices**:** Ina persistently speaks about the abuse Maureen experienced as child and will cry or shout if Maureen does not listen to her. Anna accuses Maureen of being "weak" and "worthless", and of failing to defend herself against other people. She attacks Maureen and tells her to kill herself because she is "such a wimp." Johanna is a positive voice who is helpful and supportive. She often gives advice, such as not listening to the other voices and looking for coping strategies.

Triggers**:** Ina is triggered by visits to Maureen's parents, as well as by thoughts and emotions that relate to sexual experience. Triggers for Anna are when Maureen has to be assertive but feels unable to do so, when Maureen visits her family, or when she interacts with men. Johanna is most active when the other voices, especially Anna, are aggressive and Maureen feels afraid of them, or when Maureen fears that she will end up obeying Anna's destructive commands.

The history of the voices**:** Ina appeared when Maureen was 7 years old, the age when she began to be sexually abused by an uncle. This abuse lasted for five years. Anna first came when Maureen was 19 years old, the point at which Maureen wanted her parents to help her to officially accuse the uncle and have him prosecuted. Though they initially agreed, her parents then changed their minds and withdrew their

support, just before legal proceedings were scheduled to begin. It was then that the voice of Anna came. Johanna appeared when Maureen first began therapy.

***Childhood history*:** In addition to the sexual abuse, Maureen was brought up in a very controlling, authoritarian manner. Her parents discouraged the expression of strong emotions, like anger, and consequently she did not learn how to be assertive or to advocate for her needs.

Who do the voices represent? Ina and Anna do not reflect real people, but embody Maureen's own beliefs, emotions and memories related to the sexual abuse. Johanna represents the part of Maureen that is trying to help herself.

Ina is 7 years old, the same age as Maureen was when her uncle began abusing her. This voice shouts and cries, and embodies the overwhelming fear and despair that were repressed during the actual abuse. The traumatic events are almost 'frozen' in the voice and repeat themselves endlessly with little alteration (including the fact that the voice has never aged).

Anna is the same age as Maureen was when she was betrayed by her parents and denied an opportunity to seek justice. Maureen consequently experienced an overwhelming sense of guilt, shame, and rejection. The content of this voice reflects Maureen's emotional confusion, as well as internalised anger for not feeling able to 'stand up for herself.'

Johanna is the same age as when Maureen began therapy. This voice reflects the therapist who created a safe place for Maureen to express her experiences and needs, as well as the part of Maureen that is trying to cope and survive.

What problems do the voices represent? Maureen agreed that all the information gathered in the construct related to her difficulties in coming to terms with the feelings of guilt and shame related to the sexual abuse. Maureen's therapist

subsequently focussed on helping Maureen acquire more control over the voices by helping her schedule time for them during the day. The next issues discussed were learning to talk about the abuse, recognising the related somatic complaints as signals of stress and anxiety, and dealing with Maureen's guilt and confusion about her own 'contribution' to the abuse and her belief that she had 'let it go on for so long.' The grooming techniques of the perpetrator were also explored. Later Maureen's own choices regarding sexuality and sexual identity, and accomplishing her life goals, were emphasised.

Recovery

Recovery is a personal process within a supportive environment – learning to express one's own personal story and be validated for who one is. For many VHs, self-help groups, supporting others, and learning to communicate about one's voices can be an important step. In turn learning to accept the voices, finding positive ways to communicate with them, and viewing them as warning signals of emotional problems, can indicate therapeutic avenues for solving emotional and social difficulties (Romme et al., 2009). In our experience, this process often results in the person's relationship with their voices becoming more positive. VHs can learn to have pride in their experiences and to give their voices a personal and positive meaning. Other VHs learn to cope with them effectively and create a fulfilling life of which the voices become a part. They learn to no longer be dominated by their voices and to make their own choices.

Recovery, ultimately, is about dealing with life and its problems. Voices can challenge this process, but can also be an important part of understanding and integrating one's emotional conflicts. Within this process, support from family,

friends, other VHs, and professionals is needed. For professionals, we believe it is our task to facilitate such an environment by individual, community, social and political support.

Recovery Plan

One important function of the construct is its use in developing a recovery plan, which is focussed around three main goals: 1) identifying the most troubling aspects of the voices and selecting and practicing appropriate coping strategies, 2) improving the VH's ability to tolerate and process painful emotions, and 3) dealing with historical events that have been difficult to integrate and accept, working through associated painful emotions, and moving towards the future (see also Longden et al., 2013).

Coping With Difficult Voices. Voices can command, demoralize, and be destructive, often intruding and trapping the VH in isolation, passivity and destructive activities. Many voices become threatening when the VH tries to disobey them, yet they also tend to grow more dominant and controlling when the individual sets no limits. Supporting VHs is a creative endeavour, comparable with family therapy. Yet while voices have their own (albeit limited) repertoire of strategies to assert control, the VH can develop new techniques to address the voices and learn to set their own limits.

Acquiring more control through anxiety reduction and decreasing voice frequency and intrusiveness are important first goals. Providing reassuring information can reduce anxiety levels considerably, as creating hope in a situation that appears devastating empowers the VH. Temporarily prescribing medication may also be helpful in reducing anxiety. However antipsychotic medication does not always

have a lasting impact on voices (see Corstens et al, 2013). They also reduce the person's intensity of affect, which may be useful in the short-term but may diminish recovery prospects in the long-term (Harrow, Jobe & Faull, 2014; Wunderink et al., 2013) because coping with emotion is not learned. However, benzodiazepines can be successfully prescribed short-term to diminish anxiety. When chronic low mood triggers the voices, antidepressants may also help.

Creating 'space' and boundaries is something the VH can achieve by setting time for listening to the voices instead of trying to avoid them. We differentiate between 'listening' to, 'obeying' to and 'hearing' the voices. 'Listening', which we feel is the optimal approach, involves being receptive, reflective and asking mainly neutral questions while not reacting strongly. This can be practised in therapy sessions with the VH. Time-limited listening should be coupled with dismissing and boundary-setting for the voices at other times of the day. Which we call 'hearing'. VHs can also negotiate with the voice(s) about this in a dialogical way: 'I will listen to you and be there for you 10 minutes every day (e.g. between 18.30 - 19 h) and I ask you not to bother me outside that timeframe (or twice a day etcetera)'. In turn, obeying the voices is usually not a helpful option, unless it is the VH's own informed choice (for example, some voices are considered a useful source of guidance and support; Jenner et al., 2008). 'Hearing' the voices we consider (emotionally of dialogically) neglecting the voices and hear them somewhere in the background, like street noises. To learn to neglect the voice(s) is an important strategy for learning to cope with the voice(s), but not as the only one. Often VHs get the advice to neglect (the content of) the voice(s). But then this often has the opposite effect, like 'don't think of a black cat'. In combination with 'listening', 'hearing' becomes a useful strategy - to engage and focus combined with disengagement. Making one's own choices, resisting voice commands,

and keeping a diary about the voices, are all means to acquire more distance between the voices and the VH. Discussing the ways in which the VH interprets their voices (e.g., as paranormal, spiritual or religious experiences) is often not very productive, unless it occurs as a sort of Socratic dialogue, as is done in cognitive behavioural therapy. The VH's interpretations can, however, suggest underlying emotional themes. Finally, the VH should be supported to learn to give up the role of 'victim' and take responsibility for their own life and recovery (Coleman, 2011). This process can often be stimulated when the 'code' is broken and the meaning of the voices in relation to one's life history is made clear. Further self-help suggestions for VHs are provided by May and Longden (2010) and Smith, Coleman and Good (2003).

Accepting the Past and Processing Associated Emotions. Certain feelings, such as anger, guilt and shame, along with issues related to sexuality, may be severely repressed in VH; and it is often the case that the voice's emotions reflect the hidden emotions of the individual. Creating a compassionate, supportive social environment can be extremely valuable, whether within a formal Hearing Voices Network, a peer-support group, or other social relationships that can increase the capacity to work through traumatic memories, along with associated feelings of anxiety, guilt and despair. Practising expressing difficult emotions in social situations, as is done in assertiveness training, or support with socialising, can help VHs with the process of expressing painful feelings. Participating in peer-support groups is often particularly welcomed, because stigma is minimized and positive acceptance as someone who hears voices (instead of as a psychiatric patient) can increase self-esteem (Dillon & Hornstein, 2013). In these networks, VHs help other VHs, supporting further integration in a social environment.

As discussed previously, VHs have often been exposed to adverse events. They may re-experience traumatic memories, partly in their voices but also in (other) dissociative complaints such as depersonalisation, derealisation, numbing (often interpreted as so-called 'negative symptoms'), amnesia, re-enactments, and nightmares/insomnia. As such, finding ways to safely contain and process distress is extremely important (e.g., Boon et al., 2011; Herman, 1992; Ross & Halpern, 2009). Many people who are identified as 'psychotic' are denied access to psychotherapeutic intervention, on the false premise that discussing voices, or other 'psychotic symptoms', will cause deterioration. However, it is likewise important that psychotherapy is conducted by experienced practitioners who are used to dealing with trauma and with strong transference reactions.

Talking with Voices

Voices are a personal reality. While an aim of many VHs and professionals has been to try to eliminate the voices, our experience has taught us that a more realistic objective is to learn to accept, and cope with, them. Inspired by the practice and method of Voice Dialogue (Stone & Stone, 1989), and guided by an experienced Voice Dialogue therapist, Robert Samboliev, we developed a method to communicate directly with voices. This approach is similar to that used in the dissociative disorders field in the treatment of persons with dissociative identity disorder (DID), where an emphasis is placed on making contact with split off parts of the personality in order to achieve therapeutic change.

In the Voice Dialogue method (designed for working with non-patients who do not hear voices), every person is viewed as consisting of many individual selves or sub-personalities, each with its own personal history, physical characteristics,

emotional and physical reactions, and ways of perceiving the world (Stone & Stone, 1989). These selves are organised in opposites, called *primary* and *disowned* selves. Voices, more specifically ego-dystonic voices, could be interpreted as disowned (or dissociated) selves, relating to difficulties in tolerating emotions, and other adverse experiences in the VH's life. In Voice Dialogue practice, the facilitator (not referred to as a 'therapist') makes contact – talks – with the sub-personalities in an exploratory way by asking ordinary questions, similar to those we would ask when we want to get to know someone to whom we've just been introduced. Questions like 'what is your role?' or 'what would happen if you weren't there?' can evoke a good understanding of a specific sub-personality and create an energetic contact. Exploring the sub-personalities, initially the primary and then the disowned, creates space in the person and a kind of *meta-position* that is called an 'Aware Ego' (similar, in some ways, to mindfulness) – an operating ego of sorts that bridges the tension between the opposite selves, and makes the person aware of the different selves she contains. In this regard change is not the aim but a by-product, in which awareness can help create distance and choice. In the process of Voice Dialogue, this awareness supports a more conscious use of the capacities one has.

The theory of Voice Dialogue offers an easily understood explanatory model of voices as different sub-personalities or selves, and its accepting and non-pathologising attitude presents a non-judgemental way for VH to relate to their voices (their first book was called 'Embracing our Selves'; Stone & Stone, 1989). The interpretation of the primary selves as protective, although manifesting in a harsh and rigid way, offers a comparative and positive image of voices.

In our 'Talking With Voices' approach, we question the voices directly (asking the VH to let the specific voice speak 'through' him/her by repeating its

responses verbatim) or indirectly (the VH paraphrases what the particular voice has said) and try to discover their aims and original protective functions (which in many cases have become suppressed and distorted when the VH didn't know how to cope). The facilitator tries to help the VH recognise and acknowledge the original positive, protective function of the voice, and change their attitude to it in order to create a more peaceful and constructive relationship (see Corstens, Longden, & May, 2012; Corstens, May, & Longden, 2012; Moskowitz & Corstens, 2007; Moskowitz, Corstens & Kent, 2011).

Future Directions for the Maastricht Approach

The Maastricht approach rejects the conception of voice-hearing as a meaningless pathological symptom, instead emphasizing the need to place the experience within interpersonal contexts, support VHs to develop more positive and empowered relationships with their voices, and discover ways to cope with both the voices themselves and the underlying emotional vulnerabilities and conflicts which they might embody. Thus it encourages and facilitates recovery models and psychosocial interventions, wherein the focus is not on clinical 'cure' and voice elimination, but on healing, restitution, and emotional exploration. The approach is much valued amongst VHs themselves, as evidenced by the global dissemination of the Hearing Voices Movement in the past two decades, and in this regard its practices and philosophies require little substantiation beyond the fact that voice hearers find them beneficial and choose to be involved. However, a similar anecdotal approach cannot be applied to therapeutic interventions intended for clinical use, and there is a need for more rigorous evaluations of the effectiveness and utility of this approach, both within and outside publicly-funded services. This includes investigations that uncover how

strategies like the construct might effectively contribute to recovery and treatment planning; understanding indications and contraindications of Talking With Voices for patients with and without comorbid psychosis; and in what instances a strongly psychosocial approach may feel unacceptable for individual VHs. To address this issue, a clinical trial utilizing a multiple baseline case series design is currently underway (UK Clinical Trials Gateway, 2015), with other initiatives for assessing feasibility and acceptability in preparation.

On a more theoretical level, the issue of dissociation as an explanatory framework for voice hearing needs further elaboration. In clinical practice there is often a distinction made between the dissociated parts of the personality in DID, where amnesia is common, and voices that can be experienced inside or outside the person (or both), with the absence (usually) of amnesia. But is this simply a different level of dissociation, or are the aetiological processes different? And what might voice content tell us about the degree of dissociation? As Corstens et al. (2014) have noted: "Within HVM [Hearing Voices Movement] conferences, there has been a move toward people describing embodied experience of voices and voices as 'parts' of the voice-hearer themselves. These are multisensory experiences that the word 'voice-hearing' does not adequately capture. The HVM also needs to be aware of, and responsive to, people's experience of visions and other sensations above and beyond auditory phenomena." (p. S.292)

A final consideration is the extent to which the Maastricht approach could be developed through greater integration with complementary therapeutic techniques. For example, models for working with complex trauma and structural dissociation (e.g., Ross & Halpern, 2009), compassion-focused therapy (e.g, Gilbert, 2009), and related approaches like Acceptance and Commitment therapy (e.g., Hayes, Strosahl &

Wilson, 1999) and mindfulness (e.g., Chadwick, Taylor & Abba, 2005), inform how to cope with voices and reflect many attitudes and strategies inherent in the Maastricht approach. As emotionally overwhelming life events/traumas play a pivotal role in the Maastricht framework, there is also a strong need to understand the impact of trauma-focused therapies on outcome. An important recent study from van de Berg et al. (2015) demonstrated positive effects of both prolonged exposure and Eye Movement Desensitisation and Reprocessing (EMDR) for patients with PTSD and psychosis. Though this is encouraging, specific outcome research for traumatized VHs is also needed, considering ~~as well as~~ as well how EMDR may impact other aspects of voice hearing, such as ~~e.g.~~ the relationship between voices and the VH, coping with voices and recovery issues.

Summary

The Maastricht approach to hearing voices offers an alternative to traditional attitudes in psychiatry. Voices are seen as meaningful phenomenon originating in the personal history of an individual who has been overwhelmed by threatening emotions. Systematically interviewing the VH with the MHVI, and formulating a construct in order to discover who and what problems the voices may represent, breaks the code of defence, promotes communication with the voices, and signals a path for a recovery plan that can lead to positive changes in the relationship between the voices and the VH. Several techniques to support individuals to take more control over their voices and their lives can be applied, including (for those who can engage with their voices) techniques derived from Voice Dialogue. Empowerment and recovery are key objectives. Ultimately, the psychotherapeutic attitude is embedded within a social psychiatric approach wherein support is promoted via positive information, an

encouraging attitude towards VHs, and international networks of VHs who discover the strength of mutual support and creative ideas.

References

Beavan, V., Read, J., & Cartwright, C. (2011). The prevalence of voice-hearers in the general population: A literature review. *Journal of Mental Health*, *20*(3), 281-292.

Bernstein, E. M. & Putman, F.W. (1986). Development, reliability and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174,* 727-35.

Bijl, R.V., Ravelli, A. & Van Zessen, G. (1998). Prevalence of psychotic disorder in the general population: results from the Netherlands mental health survey and incidence study. *Social Psychiatry & Epidemiology, 33, 587-596.*

Boon, S., Steele, K. & van der Hart, O. (2011). *Coping with trauma-related dissociation: Skills training for patients and therapists*. New York: W.W.Norton.

Boyle, M. (2002). *Schizophrenia, a scientific delusion?* (2nd ed). London: Routledge.

British Psychological Society (BPS) Division of Clinical Psychology. (2011). *Good practice guidelines on the use of psychological formulation*. Leicester, England: BPS.

British Psychological Society (BPS) Division of Clinical Psychology. (2014). *Understanding psychosis and schizophrenia. A report by the Division of Clinical Psychology*. Leicester, England: BPS.

Chadwick, P., Taylor, K.N. and Abba, N., 2005. Mindfulness groups for people with psychosis. *Behavioural and Cognitive Psychotherapy*, *33*(03), pp.351-359.

Coleman, R. (2011). *Recovery: An alien concept?* (3rd ed). Fife, Scotland: P&P Press.

Corstens, D., Longden, E., & May, R. (2012). Talking with voices: Exploring what is expressed by the voices people hear. *Psychosis: Psychological, Social and Integrative Approaches, 4*(2), 95-104.

Corstens, D., May, R., & Longden, E. (2012). Talking with voices. In M. Romme & S. Escher (Eds.), *Psychosis as a personal crisis: An experience based approach* (pp. 166–178). London, England: Routledge.

Corstens, D., & Longden, E. (2013). The origins of voices: Links between voice hearing and life history in a survey of 100 cases. *Psychosis: Psychological, Social and Integrative Approaches, 5*(3), 270-285.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. *Schizophrenia Bulletin*, *40*(S4), S285-S294.

Corstens, D., Longden, E., van Os, J., Rüdinger, B., & Bentall, R.P. (2013). The treatment of hallucinations: A comment. *Psychosis: Psychological, Social and Integrative Approaches, 5*(1), 98-102.

Dillon, J. (2011). The personal *is* the political. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 141-157). Basingstoke, England: Palgrave Macmillan.

Dillon J., & Hornstein, G.A. (2013). Hearing voices peer support groups: A powerful alternative for people in distress. *Psychosis: Psychological Social and Integrative Approaches*, *5*, 286–295.

Eaton, W.W., Romanoski A., Anthony J. C., et al. (1991) Screening for psychosis in the general population with a self-report interview. *Journal of Nervous and Mental Disease, 179, 689 -693.*

Escher, S. & Romme, M. (2000). Interview with a person who hears voices, to be used in conjunction with *Making Sense of Voices*. London: Mind.

Escher, S., Morris, M., Buiks, 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, pp. 208-222*

Fowler, D., Garety, P., & Kuipers, E. (1998). Cognitive therapy for psychosis: Formulation, treatment, effects and service implications. *Journal of Mental Health, 7*(2), 123-133.

Garfield, D. (2009). *Unbearable affect: A guide to the psychotherapy of psychosis* (2nd ed.). New York, NY: Karnac Books.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199-208.

Hagen R., Turkington, D., Berge, T., & Gråwe, R.W. (Eds). (2010). *CBT for psychosis: A symptom-based approach*. London: Routledge.

Harrow, M., Jobe, T. H., Faull, R. N. (2014). Does treatment of schizophrenia with antipsychotic medications eliminate or reduce psychosis? A 20-year multi-follow-up study. *Psychological Medicine, 22*(14), 3007-3016.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and commitment therapy*. New York, NY: Guilford Press.

Herman, J. L. (1992). *Trauma and recovery*. New York, NY: Basic Books.

Honig, A., Romme, M.A.J., Ensink, B.J. et al (1998). Auditory hallucinations: a comparison between patients and nonpatients. *Journal of Nervous and Mental Diseases, 186*(10), 646-51.

James, A. (2001). *Raising our voices: An account of the Hearing Voices Movement*. Gloucester, England: Handsell.

Jenner, J. A., Rutten, S., Beuckens, J., Boonstra, N., & Sytema, S. (2008). Positive and useful auditory vocal hallucinations: Prevalence, characteristics, attributions, and implications for treatment. *Acta Psychiatrica Scandinavica*, *118*(3), 238-245.

Johns, L., Kompus, K., Connell, M., Humpston, C., Lincoln, T., Longden, E., … Larøi, F. (2014). Auditory verbal hallucinations in persons with and without a need for care. *Schizophrenia Bulletin*, *40*(S4), S255–S264.

Leudar, I., & and Thomas, P. (2000). *Voices of reason, voices of insanity: Studies of verbal hallucinations.* London, England: Routledge.

Longden, E. (2013). *Learning from the voices in my head*. New York, NY: TED Books.

Longden, E., Corstens, D., & Dillon, J. (2013). Recovery, discovery and revolution: The work of Intervoice and the hearing voices movement. In S. Coles, S. Keenan & B. Diamond (Eds.), *Madness contested: Power and Practice* (pp. 161–180). Ross-on-Wye, England: PCCS Books.

Longden, E., Madill, A., & Waterman, M.G. (2012). Dissociation, trauma, and the role of lived experience: Toward a new conceptualization of voice hearing. *Psychological Bulletin, 138*(1), 28-76.

May, R. & Longden, E. (2010). Self-help approaches to hearing voices. In F. Larøi and A. Aleman (Eds.), *Hallucinations: A guide to treatment and management* (pp. 257-279). Oxford: Oxford University Press.

McCarthy-Jones, S. (2012). *Hearing voices: The histories, causes and meanings of auditory verbal hallucinations.* Cambridge, England: Cambridge University Press.

McCarthy-Jones, S., & Longden, E. (2015). Auditory verbal hallucinations in schizophrenia and post-traumatic stress disorder: Common phenomenology,

common cause, common interventions? *Frontiers in Psychology*, *6*, http://dx.doi.org/10.3389/fpsyg. 2015.01071

Morrison, A. P., Turkington, D., Pyle, M., Spencer, H., Brabban, A., Dunn, G., ... & Hutton, P. (2014). Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: A single-blind randomised controlled trial. *The Lancet*, *383*(9926), 1395-1403.

Moskowitz, A. & Corstens, D. (2007). Auditory hallucinations: psychotic symptom or dissociative experience? *The Journal of Psychological Trauma, 6*(2/3), 35-63.

Moskowitz, A., Corstens, D., Kent, J. (2011). What can auditory hallucinations tell us about the dissociative nature of personality? In V. Sinason (Ed.), *Trauma, dissociation and multiplicity: Working on identity and selves*, pp. 22–35. London, England: Routledge.

Pilton, M., Varese, F., Berry, K. & Bucci, S. (2015). The relationship between dissociation and voices: A systematic literature review and meta-analysis. *Clinical Psychology Review.* Advanced online publication. Doi: 10.1016/j.cpr.2015.06.004

Read, J. (2013b). Childhood adversity and psychosis: From heresy to certainty. In J. Read & J. Dillon (Eds.), *Models of madness: Psychological, social and biological approaches to psychosis* (2nd ed.), pp. 249-275. Hove, England: Routledge.

Read, J., & Bentall, R.P. (2012). Negative childhood experiences and mental health: Theoretical, clinical and primary prevention implications. *British Journal of Psychiatry*, *200*(2), 89-91.

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, *4*(1), 65-79.

Read, J. & Ross, C.A. (2003). Psychological trauma and psychosis: another reason why people diagnosed schizophrenic must be offered psychological therapies. *Journal of the American Academy of Psychoanalytic and Dynamic Psychiatry, 31,* 247-268.

Read, J., van Os, J., Morrison, A. P. & Ross C. A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*(5), 330-350.

Romme, M. A. J. & Escher, A. D. M. A. C. (1989). Hearing voices. *Schizophrenia Bulletin, 15,* 209-216.

Romme, M., Escher, S., Dillon, J., Corstens, D., & Morris, M. (Eds.). (2009). *Living with voices: Fifty stories of recovery*. Ross-on-Wye, England: PCCS Books.

Romme, M.A.J., Honig, A., Noorthoorn, O. & Escher, A.D.M.A.C. (1992). Coping with voices: An emancipatory approach. *British Journal of Psychiatry*, *161: 99-103.*

Romme, M.A.J., & Escher A.D.M.A.C. (Eds.). (1993). *Accepting voices.* London: Mind.

Romme, M.A.J., & Escher A.D.M.A.C. (2000). *Making sense of voices: A guide for professionals working with voice hearers.* London: Mind.

Ross, C.A., & Halpern, N. (2009). *Trauma model therapy: A treatment approach for trauma, dissociation and complex comorbidity*. Richardson, TX: Manitou Communications Inc.

Smith, M., Coleman, R. & Good, J. (2003). *Psychiatric first aid in psychosis*. Fife: P&P Press.

Stone, H. & Stone, S. (1989). *Embracing our selves: The Voice Dialogue training manual*. New York: Nataraj Publishing.

Tien, A. Y. (1991). Distributions of hallucinations in the population. *Social Psychiatry and Psychiatric Epidemiology, 26*, 287-292.

UK Clinical Trials Gateway. (2015). *Making sense of voices*. Accessed from http://ukctg.nihr.ac.uk/trials/trial-details/trial details?trialNumber=ISRCTN54370851

Van den Berg, D.P., de Bont, P.A., van der Vleugel, B.M., de Roos, C., de Jongh, A., Van Minnen, A., & van der Gaag, M. (2015). Prolonged exposure vs. eye movement desensitization and reprocessing vs. waiting list for posttraumatic stress disorder in patients with a psychotic disorder. A randomized clinical trial. *JAMA Psychiatry, 72*(3), 259-267.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer W., … Bentall, R.P. (2012). Childhood trauma increases the risk of psychosis: A meta-analysis of patient-control, prospective- and cross sectional cohort studies. *Schizophrenia Bulletin*, *38*(4), 661-671.

Woods, A. (2013). The voice hearer. *Journal of Mental Health*, *22*(3): 263–270.

Wunderink, L., Nieboer, R. M., Wiersma, D., Sytema, S., & Nienhuis, F. J. (2013). Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy. *JAMA Psychiatry, 70*(9), 913-920.

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