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The Hearing Voices Approach

Paul Baker

I am from Manchester in the North West of England. I have been a mental health activist for the over thirty five years now. By training and profession I am a community development worker and my work and presentation reflects this perspective.

Although I have a great deal of experience in working alongside people diagnosed with mental health problems and with mental health professionals, the work I have been involved with has been carried out mostly outside of formal mental health service provision.

Today I am going to share with you three examples of overcoming institutional thinking and systems that have succeeded through combining innovation and partnership with local communities and communities of interest.

I am going discuss the following:

- The Hearing Voices Approach
- Open Dialogue and
- Trialogues

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I will consider why and how the philosophies, practices and outcomes of these approaches should be implemented universally as part of the deinstintitionalization agenda.

Who are the people in this picture?

Anybody want to guess?

They are my colleagues and friends.

They all hear voices.

They have all been diagnosed with schizophrenia.

They have all recovered and no longer regard themselves as having schizophrenia.

Like me they are all involved with he international Hearing Voices Movement (HVM) since 1989. The movement is a prominent mental health service-user/survivor movement that promotes the needs and perspectives of experts by experience in the phenomenon of hearing voices, also known as auditory verbal hallucinations within psychiatry.

The main tenet of the HVM is the notion that hearing voices is a meaningful human experience and this is why the term hearing voices is used rather than hallucinations. It is crucial that we recognize that importance of language in our work.

The Hearing Voices Movement questions, critiques, and reframes traditional biomedical understandings of voice-hearing, develop coping and recovery frameworks, redefine the ownership of power and expertise and promote political advocacy for the rights of those who hear voices.

Formed in the 1987 it is an international social movement made experts by experience (voice-hearers, family members) working in partnership with experts by profession (academics, clinicians, activists).

The Hearing Voices Movement is organized into local and national networks. It began in the Netherlands and the UK and now there are 29 National Networks throughout Europe, North America, Australia, and New Zealand. There are also emerging initiatives in Latin America, the Middle East, Africa, and Asia

The movement holds an annual world congress, the Sixth World Hearing Voices Congress was held in Melbourne, Australia, 2013 and was organised by people who hear voices. It attended by 800 delegates. This year the conference is being held in Thessolonika, Greece.

At these events and in all of its work the Hearing Voices Movement seeks to combine the experience of voice-hearers and professionals in developing ways of working that draws on the value of peer support and that help people to live peacefully and positively with their experience.

The main finding of the Hearing Voices Movement and the challenge for mental health services is that reducing and reifying voice-hearing to a pathological phenomenon is not beneficial in helping people to learn to cope with their voices.

On the contrary effective practice for supporting distressed individuals should involve trying to understand the voice-hearer's frame of reference, supporting them to change their relationship with their voices and promoting the valuable role of peer support for decreasing social isolation and stigma.

The core values of the Hearing Voices Movement are as follows

- a normalizing belief that hearing voices is a natural part of the human experience
- voices themselves are not viewed as abnormal or aberrant
- voices are conceptualized as meaningful and interpretable response to social, emotional, and/or interpersonal circumstances
- diverse explanations for voices are accepted and valued
- it respects that people may draw on a range of explanations to make sense of their voices
- voice-hearers are encouraged to take ownership of their experience and define it for themselves
- in majority of cases voice-hearing can be understood and interpreted in the context of life events and interpersonal narratives

- A process of accepting voices is regarded as more helpful than attempting to suppress or eliminate them.
- This process involves accepting the voices as a real experience, honoring the subjective reality of the voice-hearer
- Recognizing that voices are something that the voice-hearer can—with support—deal with the experience successfully
- Peer support is seen as a fruitful means of helping people to make sense of and cope with their voices.
- Mutual support groups with emphasis on group ownership rather than following a predetermined structure
- Online support forums are an increasingly common feature
- One-to-One peer work is used as a means of promoting change
- Embraces principles of Intentional Peer Support

The Hearing Voices approach accords with the type of psychosocial causal explanations and treatments favored by many service-users and their families, psychological perspectives on voice-hearing and the general drive toward recovery-oriented mental health practice.

Over the last year there has been a growing body of empirical research that supports this approach including the following:

- there is increasing evidence for a continuum model of voices and similar experiences
- the robust associations between voices and traumatic; adversarial life events in both clinical and nonclinical populations
- voice content is psychologically significant and meaningful
- greater levels of emotional suppression are associated with more frequent and troublesome voice-hearing experiences
- the commonality in structural voice characteristics between psychotic patients, non-psychotic patients, and nonclinical groups

- comparable patterns of functional activation in clinical and nonclinical voice-hearers
- links between voice-hearing and mental health problems being primarily determined by an individual's interpretation of and/or emotional response to their voices
- the development of relational approaches to voice-hearing within cognitive behavioral therapy

Paradigm shift an understanding of voices as a meaningful experience that can direct personal change and recovery creating a shared identity, a new language, and practice of hope and situating voices as an intelligible human experience is reassuring, reduce shame, and stigma promotes a positive a positive therapeutic alliance.

The Hearing Voices Movement has a dual focus in that it is as concerned about the human rights, emancipation, and societal change re. issues of systemic adversity, abuse, and injustice that research implicates in the origins of distressing voices and support, treatment, and healing for instance:

- Voice profiling – creating a construct e.g Maastricht Interview schedule
- Voice dialoguing – talking to voices
- Peer Support Groups
- Trauma-informed practice

> Twenty-five years after the Hearing Voices Movement first created the space for people to discuss voices, 'the voice-hearer' has become established as an identity people can adopt, inhabit, and mobilize in order to lay claim to a view of voice-hearing as meaningful in the context of people's lives. The challenge, perhaps, for the next quarter century is for the mental health professions fully to recognize this claim and its potentially radical implications. (WOODS, 2013, p. 263).

Open Dialogue: A family and social network approach to psychosis care

The Open Dialogue approach is an innovative approach to people experiencing a mental health crisis and their families/networks, and a system of care, developed at Keropudas Hospital in Tornio, Western Lapland, Finland over the last 30 years.

In the 1980s psychiatric services in Western Lapland had one of the worst incidences of 'schizophrenia'. Now they have the best documented outcomes in the Western World. For example, around 75% of those experiencing psychosis have returned to work or study within 2 years and only around 20% are still taking antipsychotic medication at 2 year follow-up.

Open Dialogue is not an alternative to standard psychiatric services, it is the psychiatric service in Western Lapland. It is a comprehensive approach with well-integrated inpatient and outpatient services.

The Approach involves working with families and social networks, as much as possible in their own homes, Open Dialogue teams work to help all those involved in a crisis situation to be together and to engage in dialogue.

It has been their experience that if the family/team can bear the extreme emotion in a crisis situation, and tolerate the uncertainty - in time - shared meaning usually emerges and healing is possible.

Open Dialogue has drawn on a number of theoretical models, including systemic family therapy, dialogical theory and social constructionism

- de-emphasizes pharmaceutical intervention and instead establishes a dialogue with the patient,
- provides immediate help, and organizes "a treatment meeting" within twenty-four hours of the initial contact.
- sees psychosis as "happening between people, not within a person."

- putting attention on helping improve the social relationships surrounding the person in crisis as the key to recovery.
- addresses the problems in the network of relationships surrounding a person who is "in crisis," rather than assuming the problem is inside the person's head.

Objectives

- Help the social network – including changing attitudes of providers – rather than just focusing on achieving change in the person in crisis.
- The problem the process seeks to resolve is seen as being between people and in the broader social context, not in the pathology of the individual.
- Achieves treatment outcomes — avoiding hospitalization, lowering use of medication, and getting people through crisis

Social Networks and Families

Clients are not compelled to include family members if they are against it - safety and abuse issues are given priority.

However, separation from an abusive family is not always considered the best strategy, because by removing oneself you may lose the opportunity to confront and challenge the abuse.

At a "first break" there is an opportunity to bring family dynamics out into the open and achieve power shifts in relationships.

Someone who engages with an abusive family member directly, and successfully overcomes emotional dependency or fear, might then have stronger resources to transform deeper problems.

When you separate from your family, you might carry unresolved feelings and patterns that shape the rest of your relationships and life, and find you haven't really separated at all.

Open Dialogue Meetings

The aim of the meeting is defined as that of dialogue, in which the patient can find voice, thus reducing the person's sense of isolation.

The approach emphasizes the process of finding language for the psychotic experience that previously was inexpressible and creating a shared understanding of the crisis within a network.

The use of ordinary words and creation of joint meanings tends to generate a collaborative set of relationships and to open up an avenue to people's own knowledge, skills, and capabilities.

Outcomes

The results consistently show that this way of working reduces hospitalization, lowers use of medication, and leads to less reoccurrence of crisis when compared with psychosis treatment as usual. For example:

- A five-year follow-up study (Seikkula et al. 2006), 83% of patients have returned to their jobs or studies or were job seeking, thus not receiving government disability. In the same study, 77% did not have residual psychotic symptoms.
- The Open Dialogue patients were hospitalised less frequently, and three per cent of these patients required neuroleptic drugs, in contrast to 100 per cent of the patients in the comparison group.
- At the two-year follow-up, 82 per cent had no, or only mild non-visible psychotic symptoms compared to 50 per cent in the comparison group.
- Patients in the Western Lapland site had better employment status, with 23 per cent living on disability allowance compared to 57 per cent in the comparison group.
- Relapses occurred in 24 per cent of the Open Dialogue cases compared to 71 per cent in the comparison group (Seikkula et al., 2003).
- A possible reason for these relatively good prognoses was the shortening of the duration of untreated psychosis (DUP) to 3.6 months in Western Lapland, where the network-centred system

has emphasized immediate attention to acute disturbances before they become hardened into chronic conditions.

Lessons

- Meet clients in crisis immediately and often daily until the crises are resolved.
- Avoid hospitalization and its consequential stigma
- Preferably meet in the homes of those seeking their services
- Avoid the use of anti-psychotic medication wherever possible.
- Work in groups, because psychosis is a problem involving relationships.
- Include in the treatment process the families and social networks of those seeking their help
- Clinicians work in teams, not as isolated, sole practitioners
- Approach values of the voice of everyone in the process, most especially the person directly in crisis.

Trialogue Groups

- The creation of a community forum where everyone with an interest in mental health participates in an open dialogue
- A means of communication between service users, family members and mental health workers beyond role stereotypes
    - Service users, ex- service users, survivors
    - family and friends
    - mental health workers
    - Citizens
- The collective expertise creates learning, transformation and communication skills

- Respectful ground rules ensures open dialogue is possible
- The common denominator is an interest in mental health

Characteristics of open dialogue processes and participation

- The dialogue is based on give and take as opposed to one way communication
- All people concerned by the issue under investigation should have the opportunity to participate
- Participants are obliged to help other participants be active in the dialogue
- All participants have the same status within the dialogue arena
- Experience is the point of departure for participation
- At least some of the experience the participant has when entering the dialogue is seen as relevant
- It must be possible for all participants to have an understanding for the topics under discussion
- An argument can be rejected only after an investigation (and not for instance, on the grounds that it arises from a source with limited legitimacy)
- All arguments to enter the dialogue must be represented by the actors (participants) present
- All participants are obliged to accept that other participants may have better arguments than their own
- Among discussion issues can be the roles occupied by participants with no one exempt from such a discussion
- The dialogue should be able to integrate a growing degree of disagreement
- The dialogue should continuously generate decisions that provide a platform for joint action

- meets regularly in an open discussion forum
- located on "neutral terrain" outside any therapeutic, familial or institutional context
- aim of communicating about and discussing the experiences and consequences of mental health problems and ways to deal with them
- on an equal footing – as experts by experience and experts by training or both.

Well over 150 groups in Germany today

5000 people involved in Trialogue at any given time (Bock & Priebe, 2005)

Trialogues in Austria, Switzerland, France, Lichtenstein, Poland

Istanbul, Beijing, Buenos Aires et al.

Growing interest in english-speaking countries:

Mental Health Trialogue Network, Ireland www.trialogue.co

What is a mental illness?

Good and bad experiences with services

What helps?

The role of medication

Crisis management

Stigma and discrimination

Work and social inclusion

Power, powerlessness, and empowerment

The family doctor as a trialogue partner

Where are the professionals?

The “good” psychiatrist – different perspectives

When help has more unwanted than wanted effects

Diagnosis as a trap – being put in a box

Spirituality and mental health

Hopes for recovery and healing

Day clinics – why so few?

From aftercare to prevention – easy access to early help

Clinical and field trials – experimenting with patients

Silent users – who is helping them?

Features

Neutral setting

all expertise acknowledged on equal footing

no need for role compliance

Creative exchange and experiments with perspectives

Learning, information gathering, asking questions

Experiencing different interpretations of similar roles

Abundance of expertise in one room

Secure setting, rules, limits (time, communication style etc.) power balance?

Outcomes: This openness must continue

Communication in trialogue groups is clearly different from clinical and other encounters

Groups cherish and aspire to create:

- Mutual concern for each other
- good will
- openness and truthfulness

Clinical routine with role prescriptions, power balance and constant pressure to act is experienced as an impediment

Trialogue facilitates a discrete and independent form of communication and acquisition and production of knowledge

Common Themes

Partnership and shared responsibility

Relationships based on trust and rapport

Recognising expertise and strengths

Nothing about me without me

Reciprocity and equality

Authenticity and congruency

Shared interests and values

Implications

Professional boundary and control issues need to be considered

We are people first

We are visitors in people lives

We should aim to make ourselves redundant in people's lives

We should work with social networks

Whole life recovery is the objective

Recovery relationships are fostered by:

Being listened to

Feeling valued

Connectedness

Shared language

Continuity

Shared time

Reference

WOODS, A. The voice-hearer. *J Ment Health*, v. 22, p. 263-270, 2013.