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How to set up a Hearing Voices Group

Background Information

Abstract

This pilot qualitative study looks at the processes and challenges involved in setting up and running a Hearing Voices Group for long term users of the Wexford Mental Health Services. Service users attending the Rehabilitation Service who had reported hearing voices, which they found distressing and frightening were identified. They reported feeling powerless and were unable to exert any control over their voices. There is increasing evidence to suggest that group based interventions are beneficial to voice hearers.

Background

Hearing voices is a phenomenon that is widely experienced among people who use mental health services. It is considered a first rank symptom of schizophrenia¹. It is estimated that 25% of people diagnosed with affective psychosis and 80% of those diagnosed with schizophrenia hear voices². Voice hearing is also much more common among non psychiatric populations than one might expect^{2,3,4}. In a survey in 1991 of 15,000 members of the general population, Tien (1991) found that there was a prevalence rate of 2-3%³. In the general population only one third of those who reported hearing voices reported distress or impairment of functioning. In fact, many people who hear voices find them helpful or benevolent^{5,6} have drawn together various explanations given for the phenomena of hearing voices. These have included left temporal lesions⁷, speech related cognitive deficits⁸, middle ear infection⁹, psychoactive substances, tuberculosis (often speculated to have caused Joan of Arc's voices¹⁰), migranes and spiritual experiences. Whatever the origins of the voices, it is now known that a key determinant of the level of distress associated with such experiences concerns the meaning attributed to it by the person, the extent to which they have a positive view of the voice and the extent to which they feel they are in control of it².

The experience of hearing critical, malevolent voices can be a very distressing, debilitating and a stigma inducing experience¹¹ and often leads to high levels of depression and suicidality¹². Previously professionals were trained to avoid discussing the specific content, meaning or characteristics of voices with their clients¹³, under the assumption that doing so will ‘encourage’ them. Medication was used to remove the symptoms⁵. Within the last ten years however there has been considerable interest in the phenomenology, processes and coping mechanisms of people suffering from psychosis, using a broadly Cognitive Behavioural Therapy approach^{14,15}. The fact that a significant number of people experiencing distressing auditory hallucinations do not respond to medication coupled with the finding that people who have active coping skills to deal with their voices fare better in terms of distress and functioning⁵ have precipitated new ways of thinking about the experience of auditory hallucinations. Empirical evidence has shown that coping skills enhancement has been shown to be superior to problem solving when managing auditory hallucinations and there are increased benefits of using focusing, as compared to distraction techniques, for chronic auditory hallucinations¹⁶. A key aim of interventions now entails helping the voice hearer to come to an understanding of the experience, one that fosters the development of effective management skills and personal growth¹⁶.

There has been increasing support for the use of cognitive therapy within a group setting for the treatment of auditory hallucinations¹⁷. Some of the conditions for effective group work include: having a clear structure, clear boundaries, a here and now focus on specific issues, and an attempt to reduce anxiety at an early stage of the group work^{18,19}.

Yalom and Leszcz²⁰ have argued that many of the ‘therapeutic factors’ that can be successfully facilitated from within a group setting can also be experienced by voice hearers in a group setting. The Gloucestershire Hearing Voices Network²¹ has carried out pioneering work in the development of an Integrative Approach to group work for psychosis, emphasising the person’s ongoing ability to cope, learn and develop their competency^{22,23}. This approach emphasises a reduction in isolation by increasing social interaction, learning to overcome the distress of symptoms (especially by sharing coping strategies) and being collaborative in the content of sessions.

Method

Information in relation to the Hearing Voices Group was circulated to the various Mental Health Service teams, inviting referrals. Eleven referrals were received. Nine people met the criteria for participation in the group and were felt to be people who could gain from participation. Two were not voice hearers and were excluded. Each client gave their consent to participate in the group. The only inclusion criteria was that participants would need to have been hearing voices over the past year, which they experienced as unpleasant or distressing and which were generally non responsive to psychotropic medication. Those with pseudohallucinations or illusory experiences were excluded.

The purpose of the group was explained and participants were asked to complete a number of questionnaires, which would be used to inform the structure and content of the group and also to establish a baseline of functioning for each participant. The main focus of the questionnaires focused on the degree to which the voice hearer believed the voices were in control, whether or not the voices were a positive or negative force and in turn the degree of distress experienced by the person.

The following instruments were used: Topography of Voices or Voices Rating Scale, An adaption of Voice Power Differential scale²⁴, WHOQOL-BREF, Perceived Stress Scale, Irritability, Depression and Anxiety Scale (IDA), Intervention specific questionnaire

Of the nine people selected, four were female and five were male. The age range was from 27 years to 49 years. One person had studied to masters level but the majority of participants had left school early without completing any formal examinations. One person had a dual diagnosis of schizophrenia and learning disability. Two people were attending community based courses, two were attending a mental health day centre and the remainder were unemployed. Three service users were inpatients, two were living in supported accommodation and three were living independently in the community. All of the participants had a long history with the psychiatric services,

ranging from 3 to 30 years, with problems relating to schizophrenia, depression, substance abuse and self harm. All participants were on antipsychotic medications. No one had participated in a Hearing Voices Group previously.

The aims of the group were:

- To provide safe place for people to talk about voices
- To reduce isolation/stigma
- To provide more information and greater understanding
- To develop better coping strategies
- To reduce stress
- To enable a greater sense of control and power over voices

Eight group sessions took place over a ten week period. All meetings took place in a training centre on the grounds of the hospital and lasted approximately one and a quarter hours.

The format adopted for the group sessions was loosely based on a number of approaches including elements of the normalisation approach of Romme and Escher²⁵, Coping Strategy Enhancement by Tarriers²⁶ and the Stress/Vulnerability Model by Zubin & Spring²². The overall approach used in each session consisted of a flexible client centred approach with a particular emphasis on respect for each person and the explanation or meaning they attributed to their voices. The techniques of traditional cognitive therapy, along with Socratic questioning, reflection, role playing, relaxation and summarizing were used throughout each session.

The group did provide a safe and structured place for people to begin to discuss something that previously was not encouraged or facilitated. This in itself helped to reduce people's sense of isolation and some of the stigma associated with hearing voices. In hearing about the experiences of others, individual experiences became more normalised. Different coping strategies that people had tried out were constantly highlighted, discussed and shared. Once people were helped to understand the links between stress and hearing voices, they were given practical skills, such as relaxation techniques, to help reduce their stress.

Description of voices from group attendees:

Unpleasant	Comforting
Violent	Frightening
Argumentative	Stubborn
Boring – same words over and over	Surprising
Broken record – saying the same thing	Short lived
Telling me to harm myself – repeating this	
Ongoing dialogue	
Loud	

How the voices made people feel and behave:

Content	Effect on me
‘Cut your wrists’ – feel like I have to do it	Feelings: Bad, Afraid, Upset Self conscious Uncomfortable
‘Get out’	Unable to cope Confusion
‘Kill people in a very violent way’	Physical: Headaches Nausea Drowsiness Not able to concentrate Behaviour: “stop you from talking” “Avoid people – feel they are talking about me or laughing at me” “Not being able to do what you want” Take drugs Take alcohol Thoughts: “I am evil” “I am powerless” “I cannot cope”

Coping strategies described by the group to deal with the voices:

Things that can help with the voices:

1. Listen to my walkman
2. Have conversations with others
3. Distraction
4. Playing sport
5. Cooking or baking
6. Responding to the voice
7. Answering back
8. Swearing at them
9. Ignoring them
10. Praying
11. Slow breathing, relaxation
12. Managing stress
13. Doing things you enjoy
14. Taking a drink of water

Things that don't help:

1. Taking drugs
2. Stress

Results

People varied in the extent to which they heard their voices daily or weekly, ranging from 15 times a day to once or twice a week. Most people found their voices very difficult to ignore and found the experience to be quite distressing. One person described it as more of a noise than a voice. Beliefs in relation to the voices included that it was the devil ordering the person to harm themselves or others, that they were powerful and that they were real. Others described a male voice, instructing them to commit suicide. Several participants described an ongoing running commentary.

People described getting headaches, feeling panicky and anxious due to the pressure and noise generated by the voices. One person specifically identified stress as a factor that made the voices worse. All of those assessed felt that the voices had been impacting negatively on their lives for some time, causing them distress, reducing their quality of life and preventing them from doing things they would like to do.

As this was a pilot project the sample size was too small to formulate any meaningful statistics. However participants completed feedback on their experience in relation to the group and all found it very helpful to be able to talk to others about their voices. One participant said *“it really gave me ten weeks of great freedom”*. Another said *“it showed me how my nervous reactions can be eased and helped”*. Another participant expressed a feeling of greater control over her voices.

Although it was envisaged that a CBT approach would be used there were a number of barriers to this approach. The ability to conceptualise or a willingness to do homework, are just some of the factors considered to be fundamental to the success of cognitive therapy. These abilities were by and large compromised in this group. The majority of participants had difficulties communicating, had literacy problems, were not fluent, were not used to initiating conversation and were used to responding only when asked. It was difficult for people to retain the key features of each session and very frequent repetition was required. Some participants were looking for definitive explanations for their voices. However with a hearing voices group the focus is on what the voice means to the person and how they cope with their experience. Some people struggled with this ambiguity. Motivation to attend the group attendance varied from week to week.

Conclusion

The Hearing Voices Group was set up with the aim of providing a structured and safe place for long term mental health service users to discuss and share their experiences of hearing voices. It was hoped that in doing so participants would come to understand their voices more and possibly identify triggers, to further develop their coping mechanisms and to feel less isolated and stigmatised as a result of their experiences.

Though the sample is small it was felt to have been beneficial to the service users. It is a viable way to provide an intervention to a very marginalised group of people, provided that a client centred and flexible approach is adopted.

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