

Do you hear what I hear?

Some thoughts on “voices”

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Hallucinations

- According to the DSM hallucinations are a sensory perception that has the compelling sense of reality of a true perception but that occurs without the external stimulation of the relevant sensory organ.
- Types include auditory, gustatory, somatic, tactile, or visual.
- Auditory are the most common type

Auditory Hallucinations

- Involves the perception of sound
- The most common description is of voices
- Some sources distinguish between those “located” inside vs. outside the head but this distinction does not appear to be critical
- Some people will have apparent insight and describe “false” voices

Understanding Voices

- A currently accepted theory, supported by research holds that voices are actually the individuals own thoughts that are misperceived as being heard rather than thought.
- When people hear voices they are often found to be sub-vocalizing, in effect saying the things they hear to themselves.

What do they mean?

- Traditionally voices are seen as indications of psychosis.
- Research on hallucinations has found that they are actually much more common than most of us would suspect.
- They occur in a variety of people many of whom don't have a diagnosed psychiatric disorder

A common experience?

- Although not classified as hallucinations dreams typically involve both visual and auditory as well as other sensory modality experiences that have “the compelling sense of reality of a true perception but that occurs without the external stimulation of the relevant sensory organ”

Hallucinations in the General Population

- The incidence of psychotic symptoms in the general population is about 100 times greater than the incidence of psychotic disorders
- The experience of hallucinations at one point in time is not a good predictor of later hallucinations
- Hanssen et al 2005

You heard what?

- In a survey of 375 college students 71% reported some brief, occasional experiences of voices while awake.
- In another study of 586 college students 30-40% reported hearing voices, and almost 1/2 reported it happened at least once a month
- Reports of hallucinations were not related to measures of psychopathology

Are you listening?

- Two studies report large portions of college students report “psychotic” symptoms such as hearing their thoughts spoken out loud
- A study of 17,000 adults (excluding those with obvious physical or mental illness) found 8% men and 12% of women report at least one hallucinatory experience.

Oh shut up!

- A study of people who responded to a TV request for people who heard voices found 76 of 173 people responding were not in psychiatric treatment
- Other studies report rates of 25% of a group of “normal” people, 10% of men and 15 % of women in a large community sample and an annual prevalence rate of 4% in whites

How we typically respond

- In most psychiatric settings hallucinations are responded to as if
 - Diagnostic of psychosis
 - All or nothing: if present no further questions are needed
 - A problem symptom requiring treatment with medication
 - The patient is responding to internal stimuli

An alternative understanding

- The individual patient (and everyone else in the world) is attempting to make sense of their own experience. It is likely that they hear the voice and try to explain why they hear the voice. They may come up with an explanation that we think is strange but it makes sense to them.

What is it like

- If given a chance and an accepting response many people with voices will describe their experience. We tend to shut this down when we respond to the presence as a symptom of an illness and an indication that more medication is all that is needed to take it away. Consider how you would feel if you reported an experience and others said that is just a sign you are sick.

Can you tell me about them?

- If we enquire in an empathetic way the patient may be able to describe the experience with voices.
- This includes many characteristics
 - Number, Identity, Social position, Gender, Volume, Power, Knowledge, Occurrence, Content, Beliefs about origin and mechanism

Emotional Reactions

- The emotional reaction is the result not of experiencing the voices but what the individual thinks about this experience.
- This is the critical pathway to understanding how the patient will be affected by the voices and when and how we can help.

Patient Example 1

- The patient hears a voice he describes as a powerful, male, threatening and critical in content. It is often quite loud and frequently commands that the patient do things.
- He believes the source of the voice is the devil and that if he doesn't comply with it then the devil will harm him.
- The devil is very powerful, and knowledgeable and can be anywhere, the fact that he has picked our patient to talk to means bad things about the patient. He finds the voice very frightening

Patient Example 2

- The patient reports she has many voices but the most common one is her deceased grandmother. Her grandmother was her primary care provider growing up.
- The voice often comments on her situation and usually provides helpful advice. She finds that when the voice is not there she is more lonely and frightened and the voice is usually comforting and helpful.

Response to typical treatment

- Assume we give both patient 1 and 2 treatment with an antipsychotic medication and both respond with a reduction of reported experience of the voices.
- Patient 1 may well be relieved but not change his assessment of the voice or it's implications.
- Patient 2 may well be distressed by the loss of the voice she found helpful

What can we do?

- If we begin by simply listening to the and trying to understand their experience we can begin to build a helping relationship. This alone may have considerable impact on their mental status.
- We can work toward an open dialog about the experience of the voice and how to deal with it.

Some tools

- There are some things that may help people manage voices. These can be offered as suggestions for them to try, not because they must get rid of the voices (which is unlikely to work) but because we want to help them manage distress

#1 Use your voice

- Remember the sub-vocalization idea
- If the individual uses their own voice the hallucination may disappear for a time.
- They can:
 - Sing or hum a song
 - Count under their breath
 - Read aloud (softly)

#2 Distraction

- To the extent that all of us have limited capacity to think about many different things at once focusing attention can serve as a tool to manage hallucinations
 - They can
 - Focus on stimuli outside themselves (music, movies, the snow)
 - Engage in an activity that requires full attention
 - Change environments, go to another room, take a walk

#3 Affirmations

- This sort of self talk can have a positive effect on mood which may indirectly effect the experience of voices, and moderate the emotional impact of voices.
 - They can
 - Repeat positive self affirmations
 - List positive characteristics others have noted
 - (staff may provide some of these)

#4 Ear plugs

- Some people report that wearing an ear plug (often in only one ear) often seems to relieve voices. Staff can explain that this works for others and encourage them to try it.
 - They can
 - Try an ear plug in one or both ears and determine if it seems to help. If so they could be used ad lib

#5 Time out

- Some people report that voices are worse when the environment is loud or distressing. They may find some time spent relaxing is helpful. Long periods of isolation may worsen voices and should be avoided.
 - They can
 - Use a relaxation tape or CD or perhaps a relaxation room, special chair etc

#6 Headphones

- Similar to 4 & 5 the use of headphones with an ipod or similar device will provide relief to some people. They may find some content more helpful than others so if possible allow a choice.
 - They can
 - borrow or use their own walkman or ipod to listen to material that they find helpful

#7 Responding to the voices

- While we tend to see responding to them as a problem it may be helpful. The effort is most likely to work if it addresses the concerns and beliefs about the voices. Thus telling them to shut up or prove it or simply saying who cares what you say may be helpful depending on their beliefs.
 - They can
 - Respond to the voices in a personally meaningful way that supports their relative power, knowledge etc in relationship to the voice

No Safety Behavior Please!

- The 7 techniques or variations of them may be helpful but need to be used in context. Both staff and patients need to understand that the use of these methods is a way to be more comfortable as the voices can be unpleasant or annoying but that it is not “necessary” to get rid of the voices.

What are safety behaviors and why are they a problem?

- Safety behaviors are things someone does to get relief where they believe that if they did not do them some disastrous consequence would follow. A classic example is the panic patient who takes a Xanax and believes it saves his life. The problem is that such behaviors actually reinforce the belief in the danger of the symptom and the magical belief that the coping response was all important in preventing a disaster. This perpetuates the disorder and distress associated with the symptom

The final goal

- The final goal in working with voices is to reduce the distress and interference with function they cause. It is not to get rid of them (which may be impossible in many cases).
- We want the patient to learn that the voices like any other experience affects us based on how we evaluate it.