Angels at our tables: A summary of the findings from a 3-year research project into New Zealanders' Experiences of Hearing Voices

Vanessa Beavan[1], John Read[2] and Claire Cartwright[3]

Rationale and objectives of the research

In 2003, researchers at the University of Auckland began developing a project to investigate the experience of hearing voices in the general New Zealand population. The idea for the project was based on international research suggesting that hearing voices is a relatively common experience, reported by approximately 5 to 10% of the general population. Findings from these international studies also demonstrated that voices could be experienced in many different ways, from positive and enriching to negative and distressing.

The New Zealand study had 4 main objectives.

1. To map the range of hearing voices experiences in the general population. This included investigating topographical characteristics such as content, form and identity of voices, as well as the impact the experience has on people's lives.
2. To explore voice-hearers' own explanatory models and analyse how these relate to the ways in which their voices are experienced.
3. To increase knowledge about effective ways of managing voices. This included identifying coping strategies that voice-hearers use and evaluating their effectiveness, as well as exploring voice-hearers' experiences with mental health agencies and other support services.
4. To seek out and describe the essential structure of the phenomenon of hearing voices, in an attempt to provide a definition of this phenomenon that will fit across the range of different voice-hearing experiences.

Research methodology

Through local and national media sources such as television, radio, newspapers and flyers, members of the New Zealand public were invited to participate in the study, on the condition that they were over the age of 18 and had heard voices that no one else can hear. Approximately 250 voice-hearers made contact with the university and all were sent a Hearing Voices Questionnaire. A total of 154 completed questionnaires were returned. Fifty of the 154 questionnaire respondents were selected for an interview, which explored their experiences in more depth. The following summary of findings is based on both quantitative data from the questionnaires and qualitative data from the interviews.

[1] PhD candidate, Psychology Department, The University of Auckland
[2] Senior Lecturer, Psychology Department, The University of Auckland
[3] Lecturer, Psychology Department, The University of Auckland

Participant demographics

Table 1. Participant demographics

Variable		Questionnaire Respondents	Interview Respondents
Gender	Male	51 (33%)	20 (40%)
	Female	102 (66%)	30 (60%)
Age	Range	19-84	19-84
	Mean	48	49
Ethnicity	Pakeha	130 (84.4%)	40 (80%)
	Maori	19 (12.3%)	8 (16%)
	Other	4 (2.6%)	2 (4%)
Contact with Mental Health services	Yes	84 (54.5%)	28 (56%)
	No	69 (44.8%)	21 (42%)

Topographical characteristics of voices

Participants identified a vast array of voice experiences. Most participants reported hearing more than two voices, but about a third had only ever experienced one or two voices. In terms of the location of the voices, the vast majority of participants heard voices inside or inside and outside of their heads, and only about one person in ten heard voices outside their head only. A small number of participants heard voices all the time, many heard voices every day and many more heard voices less than once a week. Some voices talked non-stop for long periods of time, but most talked for less than half-an-hour at a time.

Voices were reported to manifest in many various forms. Most frequently they were reported to act as a helpful guide. This was followed by voices commenting on the person's thoughts or actions and voices telling the person what to do. About a quarter of all questionnaire respondents heard voices talking or arguing with each other. Overall, participants tended to have little control over their voices. However, most participants did not find their voices to be significantly intrusive.

The vast majority of questionnaire respondents reported that they could identify who or what their voices were. More in-depth questioning during the interviews revealed that voices could be identified as belonging to one of eight categories. These categories, in order of prevalence, were: Deceased persons and spirits, Unspecified entities, Living people, Parts of the self, Spirit guides, Gods and prophets, Animals, and Aliens. Of note is that of the questionnaire respondents who reported being able to identify their voices, only about 60% were completely convinced of the accuracy of their judgement. Thus, it seems that although many voice-hearers can readily recognise their various voices and relate them to certain entities, they are not always sure if the voice actually belongs to that entity.

In terms of voice content, participants reported that their voices said a vast array of different things to them. As the graph below shows, almost half of the questionnaire respondents reported that their voices said mostly friendly or helpful things to them. Only a quarter of respondents heard mostly negative or unhelpful voices.

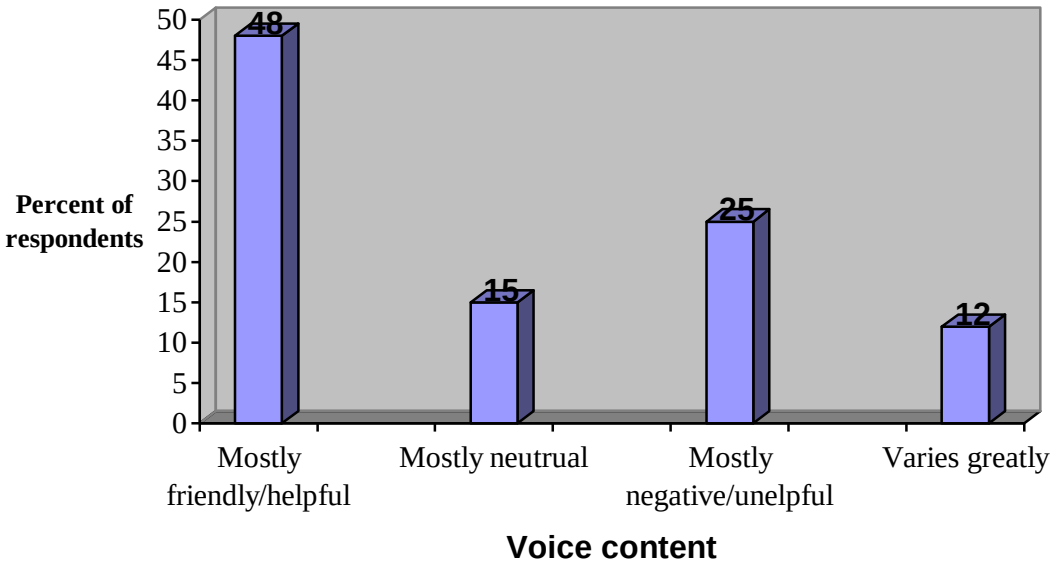

Figure 1. Types of voice content reported by questionnaire respondents

The qualitative data from the interviews provided more information about the types of positive, negative and neutral things that voices would say. For example, in terms of positive voice content, interview participants described hearing advice or guidance, helpful information, nice things about themselves, encouraging and comforting words, and positive emotional sounds, such as giggling. Examples of negative voice content included unhelpful advice or guidance, distressing information, criticisms of themselves or others, commands to hurt themselves or others, and negative emotional sounds such as screaming or crying. Other types of voice content, which tended to be more neutral or ambiguous in nature, included neutral comments, repetitive words or phrases, calling the person's name, messages for others, premonitions and music.

The first voice-hearing experience

The majority (66%) of questionnaire respondents reported hearing voices for the very first time before the age of 26, with a quarter of all respondents reporting hearing voices before age 6. Over 90% of questionnaire respondents could recall their first experience. However the types of things the voices said and how they made people feel varied greatly across participants. Although only 18% of questionnaire respondents reported that their first voices were mostly nasty or aggressive, 27% reported feeling very distressed by the first experience. This suggests that, in some cases, the experience of hearing voices itself may trigger a negative emotional reaction, perhaps because of the fear and stigma surrounding the experience.

Over half (57.8%) of the questionnaire participants from the present study identified a significant event taking place shortly before their first voice-hearing experience, and in the vast majority (81%) of cases the event was negative. This finding is similar to previous research reporting that between 58% and 70% of participants identified a traumatic event preceding the onset of their voices (Honig et al., 1998; Romme & Escher, 1989). These findings suggest that for many people the onset of voice experiences occurs within the context of, and may be directly associated with, significant and often traumatic life events.

Explanatory models

Participants identified an extensive range of explanatory models for their experiences of hearing voices. These were grouped into three major categories: biological, psychological and spiritual. Explanations in the biological category included references to brain dysfunction and the effects of both prescription and recreational drugs. Explanations in the psychological category included references to interpersonal trauma, abnormal cognitive processes and different aspects of the self. In the category of spiritual explanations, participants talked about being in communion with external entities, having psychic abilities, being more open to mystic or spiritual experiences, as well as general references to spirituality, such as intuition and the existence of a spiritual realm.

A hierarchical cluster analysis was performed on the 16 explanatory model items from the questionnaire to establish which types of explanations tend to go together. This analysis distinguished psychological and biological explanations from explanations that touch on the mystical, the parapsychological and the spiritual, showing that people who tend to endorse psychological and/or biological explanations do not tend to endorse spiritually-based explanations, and vice versa.

This analysis also demonstrated that people who hold biological explanations also tend to hold psychological explanations, and vice versa. Observations from the interviews may help to account for this finding. Firstly, some participants referred to their voices as a symptom of mental illness, related to brain dysfunction or chemical imbalance, but also understood their mental illness to be caused by interpersonal trauma, such as sexual or emotional abuse in childhood. This is consistent with research into the neurodevelopmental effects of early trauma on the brain (Read, Perry, Moskowitz & Connolly, 2001). Secondly, some participants clearly delineated two sets of voice experiences, one caused by a temporary state of altered consciousness through the ingestion of drugs and one related more to psychological processes such as interpersonal trauma or different levels of consciousness. Finally, some participants who believed their voices to be due to negative early childhood experiences or life stresses also wondered about whether the association between voices and mental illness might apply to them.

Consistent with previous research (Angermeyer & Klusmann, 1988; Angermeyer, Klusmann, & Walpuski, 1988; Jones, Guy, & Ormond, 2003), the present study found that the least favoured category of explanations was biological. Of the various psychological explanations, the most frequently endorsed was "The voices are a consequence of traumatic or stressful life events." Indeed, about three-quarters of all

questionnaire respondents held some notions of a causal link between traumatic events and hearing voices. This finding is consistent with the growing number of studies demonstrating an association between trauma history and hallucinations, in both clinical and non-clinical samples (Ensink, 1994; Escher, 2005; Hammersley et al., 2003; Honig et al., 1998; Kilcommons & Morrison, 2005; Morrison & Peterson, 2003; Offen, Waller, & Thomas, 2003; Read, Agar, Argyle, & Aderhold, 2003; Ross et al., 1990; Whitfield, Dube, Felitti, & Anda, 2005).

However, spiritual frames of reference were also very commonly reported. For example, the most frequently (42.9%) endorsed explanation from the questionnaire was "I am having a spiritual experience." This supports findings by previous authors who have drawn attention to the significance of spiritual understandings and called for a more holistic approach to understanding and working with voices (Chadwick, 1997; Jones et al., 2003; Romme & Escher, 1989).

The impact of voice experiences

Voice-hearers expressed a whole range of emotional reactions to their voices, from fear and anger to reassurance and amusement. This finding is consistent with previous studies describing a vast array of emotional reactions reported by both psychiatric and non-psychiatric samples, and both within and across participants (Cheung, Schweitzer, Crowley, & Tuckwell, 1997; Close & Garety, 1998; Johns, Hemsley, & Kuipers, 2002; Leudar & Thomas, 2000; Miller, O'Connor, & Di Pasquale, 1993). Overall, data from the questionnaires show that positive experiences tended to be more common than negative ones, although only a minority of participants reported feeling always happy or content in response to their voices. A reasonably large number of participants reported experiencing a very mixed reaction to their voices. Further probing in the interviews revealed that this would usually be due to the participant experiencing different types of voices. This is consistent with previous research showing that when voice-hearers identify multiple voices, they can experience positive feelings towards some and negative feelings towards others (Belofastov, 2004).

Two factors seem to be particularly important in helping to explain the emotional impact that hearing voices can have on an individual. Firstly, a logistic regression analysis found that voice content was the only significant predictor of emotional impact, suggesting that what the voices say will be the most important factor in determining how a person feels about hearing them. However, the impact that voice experiences have on voice-hearers also seems to be mediated by beliefs about the origin of the voices. In particular, questionnaire respondents in the present study who tended towards a more positive emotional response to their voices were significantly more likely to endorse spiritual explanations for their experiences. They were also significantly less likely to endorse explanations that viewed voices as pathological phenomena, the result of negative actions by self or others or deficits in the person.

In terms of more enduring effects of voice experiences, it was of note that 58% of all interviewees expressed concerns related to the stigma associated with being a voice-hearer. This stigma was often connected with mental illness and the fear of being

labelled mad. As a result many voice-hearers reported not telling anyone about their voices, but feeling that they would benefit from sharing their experiences with others, including family, friends, and other voice-hearers, on the condition that they would be received in an accepting and non-judgmental way.

Coping strategies

There appear to be no sure-fire coping strategies that work for all voice-hearers. Instead, the evidence suggests that voice-hearers should be encouraged to develop and test out their own selection of techniques that help them successfully manage their voice experiences. The beliefs a person has about themselves and their voices appear to be a significant factor in the choice of strategies, as well as in their effectiveness. Strategies that give control to the voice-hearer, such as setting limits and selective listening, appear to be particularly effective in the long-term, but only when the person has developed a sense of self-efficacy and empowerment over their voices.

To achieve this, some voice-hearers may find it helpful to draw on the positive dynamics played out in their other relationships. Some voice-hearers may feel more empowered through developing an understanding of voice-phenomena, by reading literature or talking to knowledgeable people. Other voice-hearers may benefit from a therapeutic context which addresses self-esteem and self-efficacy and/or provides a safe environment in which the person can test out the power and omnipotence of their voices. While the person is developing these skills they may find it helpful to use some more simple distraction techniques. Although individual differences should be taken into account, techniques that switch the person's attention away from the voices to some more soothing or inspiring activity, such as singing, humming, listening to music, prayer and mediation, appear to be effective for most people who use them.

Help and support for voice experiences

One of the most striking findings from the results about help and support was that although over half (54.4%) of the questionnaire participants reported having been in contact with mental health services, only a fifth (22%) reported that this contact was for reasons at least somewhat related to their voice experiences. Statistical analyses revealed that people who had been in contact with mental health services for their voice experiences were significantly more likely to report negative content and emotional reaction, both at onset and in general, hearing voices commenting on them, feeling angry, frightened, confused and sad, believing that their voices were punishment, a symptom of mental illness and/or a consequence of trauma. They were also significantly more likely to hear voices that were more intense in terms of frequency, duration and intrusiveness.

Information from the interviews showed that about the same number of people found interventions from mental health services helpful as those who found them unhelpful. In terms of unhelpful experiences, participants referred to having a lack of control over their own recovery process. In particular, participants did not appreciate being forced to take medication that they found unhelpful and/or unpleasant. This finding indicates the

importance of people working with voice-hearers to create an environment of collaboration and self-determination. Participants also indicated the need for a holistic approach to working with voices. In particular, they emphasised the importance of integrating cultural, spiritual and contextual factors into therapeutic work. These factors continue to be neglected, despite calls by prominent authors and organisations that pharmacotherapy alone is insufficient (British Psychological Society, 2000; Leibman & Salzinger, 1998; Westacott, 1995).

Participants from the present study also stressed the need for more information and education about voice-related phenomena. The benefits of information appear to be multifactorial. Firstly, some participants found that learning more about voice phenomena, from psychological, spiritual and cultural perspectives, helped them to better understand and contextualise their experience. Secondly, some participants thought that practical advice about coping strategies from these perspectives would also be helpful. Thirdly, a number of participants reported wanting to have more information about other voice-hearers' experiences. Some were keen to access research literature, such as the findings from the present study, while others referred to the potential benefits of meeting with other voice-hearers in an informal setting to share information and experiences. Finally, some participants referred to the benefits of educating other people about voice phenomena. As Baker (1995) suggested, sharing knowledge with friends and family can be helpful because it may demystify the experience and allow others to be more supportive.

Overall, participants in the present study called for a model of intervention that accepted their voice experiences as real, took an holistic approach incorporating contextual, cultural and spiritual factors, and worked more generally with voice-hearers, their families and the public to provide information about voice phenomena and normalise the experience. These findings support the development of consumer-based organisations, such as the Hearing Voices Network, which encourage the sharing of experiences and support for voice-hearers, voice-focussed training for clinicians, and the provision of information to all interested parties. These organisations are currently having success in the UK, Continental Europe and North America (INTERVOICE conference, 2006). Although there are currently some relatively small-scale efforts towards groups and workshops for voice-hearers and clinicians in New Zealand (Lampshire & Loretto, 2004; Pearson, 2004), the findings from the present study suggest the potential benefits that could be made from a more national-level organisation modelled on the Hearing Voices Network.

Bringing it all together: good voices and bad voices

After interviewing 50 voice-hearers, the researcher felt intuitively that, in general, participants tended to identify the overall experience of hearing voices as either a valued blessing or an unwanted curse. In particular, the researcher noted that participants who valued their voices tended to have more spiritual beliefs, a more positive emotional reaction and less contact with mental health services. This was in contrast to people who experienced mostly unwanted voices. This latter group of participants tended to have

more biological and/or psychological understandings of their voices, have a more negative emotional reaction to them, and increased contact with mental health services.

Several statistical analyses were run in order to test out the researcher's intuitive conceptualisation. Firstly, the hierarchical analysis of beliefs about voices showed that participants tended to endorse either spiritual explanations or bio-psychological explanations. A second analysis demonstrated that a number of topographical characteristics and beliefs about voices were significantly related to participants' emotional reaction to their voices. Finally, a third analysis demonstrated that many of these same variables could significantly predict whether or not a person came into contact with mental health services. The table below presents a summary of these findings, thus proposing a framework wherein voice experiences may be considered either a blessing or a curse.

Table 2. Characteristics of the two general types of hearing voices experiences.

Positive experiences: **BLESSING**	Negative experiences: **CURSE**
Onset Positive content Positive emotional reaction	Onset Negative content Negative emotional reaction
Positive content	Negative content
Positive emotional reaction Feeling reassured Feeling encouraged Feeling amused Not being bothered by the voices	Negative emotional reaction Feeling angry Feeling frightened Feeling confused Feeling sad
Can identify voices Believe voices are Gods, Spirits or guides More convinced of voice identity Less likely to view voices as own thoughts	Can't identify voices Believe voices are people they know Believe voices are people they don't know Less convinced of voice identity More likely to view voices as own thoughts
Form Voices act as a helpful guide	Form Talking or arguing with each other Commenting on self or others Giving Instructions
Decreased frequency Decreased duration Decreased disturbance in contact with other people Decrease in taking over thoughts Increased control	Increased frequency Increased duration Increased disturbance in contact with other people Increase in taking over thoughts Decreased control
Beliefs I am special/I have special abilities The voices come to support me I inherited it from my parents/ancestors The voice belongs to a deceased loved one I am having a spiritual experience Culturally normal experience	Beliefs The voices are punishment The voices are a result of my drug use I have a brain disorder Symptom of mental illness Consequence of trauma Consequence of difficult relationships Replay of conversations
	Contact with mental health services Contact with mental health services for voices Wanting help now or in the past

This is a simplified model. Voice experiences may be better conceptualised along a continuum, rather than forced into one of two categories. Further, some voice-hearers will have both positive and negative voices. However, the findings from the present study do suggest that overall, people tend to conceptualise the experience as a whole as either as a valuable and desirable blessing or a distressing and unwanted curse, and that certain topographical characteristics and beliefs are associated with these two different types of experience.

The essence of the voice-hearing experience

Although much of the work of the present study was concerned with seeking out significant differences in the types of experiences voice-hearers report, the phenomenological approach also required that the researcher seek out the essential characteristics that were common across experiences (objective 4). A model was developed which proposes that the essence of hearing voices is comprised of five components. These are that:

a) the content of the voices is personally meaningful to the voice-hearer
b) the voices have a characterised identity
c) the person has a relationship with their voices
d) the experience has a significant impact on the voice-hearer's life
e) the experience has a compelling sense of reality.

A model which attempts to define the essence of a phenomenon should also include descriptions of the relationships among the structural components of that phenomenon. Consistent with the quantitative data presented in Table 2, the qualitative data suggests that there is a consistent structural pattern in which voice content and identity are related in obvious ways to the relationship a person has with their voices, and that these factors are again related to the person's emotional response to their experience. Each experience, therefore, appears to happen according to a relatively pre-determined template. Over time a person will be able to predict how each of their voices is likely to behave and how this is likely to make them feel. In the case of distressing voices, beliefs and expectations about voices might feed into a vicious cycle of fear and helplessness. In the case of helpful voices, beliefs and expectations might feed into a positive cycle of ongoing support and encouragement.

The proposed model of the essence of hearing voices suggests a number of treatment implications that are consistent with suggestions made by previous authors. Firstly, a fundamental principle for people working with voice-hearers is the importance of acknowledging the reality of the experience to the voice-hearer (Romme & Escher, 1994). Secondly, a good starting point may be to ask the voice-hearer about the topographical characteristics of their voices, and in particular who they are and what they say (Wagner & King, 2005). This will likely lead on to a conversation about the impact the voices have on the person's emotional state. It is also important to know how the person understands their relationship with the voices and the significance and function of the voices in their life (van Laarhoven, 1994). It may be helpful to explore whether the person has experienced relationships like this before and whether the voices can be

understood within the context of these relationships (Morrison, Read, & Turkington, 2005).

Conclusion

The phenomenon of hearing voices is more complex than suggested by the psychiatric model of voices as a symptom of severe mental illness. Voice-hearers from the present study reported a diverse range of experiences and explanatory models and most had never been diagnosed with a psychiatric disorder. Overall, experiences tended to be described by participants as either negative or positive and each set of experiences incorporated a similar pattern of topographical characteristics, explanatory models and emotional reactions. However, some essential characteristics of hearing voices that occur across experiences were sought out and described. These included personally meaningful content, characterised identity, a relationship with the voices, an emotional response to the experience, and the sense that voices are real.

Not all voice-hearers in the present study reported wanting help specifically for their voice experiences, although many said they would like to see a change in the way this phenomenon is perceived. Specifically, they called for more information about voices and normalisation of the experience to reduce stigma, particularly with regard to its perceived association with severe mental illness. Those people who did report that they would like help for their voice experiences tended to emphasise the importance of a holistic approach incorporating psychological, cultural and spiritual factors.

While there are some significant limitations to the present study, it represents the first attempt to analyse and present such a large number of key components of the phenomenon of hearing voices from voice-hearers' perspectives. Future research investigating these key components in greater detail and with larger and more diverse samples will no doubt provide further evidence of the complexity of this experience. Hopefully, thereby, the stigma associated with this relatively common experience can be reduced and a greater range of responses will be available to those with the gift, or curse, or hearing voices.

References

Angermeyer, M., & Klusmann, D. (1988). The causes of functional psychoses as seen by patients and their relatives: I. The patients' point of view. *European Archives of Psychiatry & Neurological Sciences, 238*(1), 47-54.

Angermeyer, M., Klusmann, D., & Walpuski, O. (1988). The causes of functional psychoses as seen by patients and their relatives: II. The relatives' point of view. *European Archives of Psychiatry & Neurological Sciences, 238*(1), 55-61.

Baker, P. (1995). Accepting the inner voices. *Nursing Times, 91*(31), 59-61.

British Psychological Society (2000). *Understanding mental illness: Recent advances in understanding mental illness and psychosis experiences.* Leicester: British Psychological Society.

Chadwick, P. K. (1997). Recovery from psychosis: learning more from patients. *Journal of Mental Health, 6*(6), 577-588.

Cheung, P., Schweitzer, I., Crowley, K., & Tuckwell, V. (1997). Violence in schizophrenia: role of hallucinations and delusions. *Schizophrenia Research, 26*, 181-190.

Close, H., & Garety, P. (1998). Cognitive assessment of voices: further developments in understanding the emotional impact of voices. *The British Journal of Clinical Psychology, 37*(2), 173-188.

Ensink, B. (1994). Trauma: A study of child abuse and hallucinations. In M. Romme & A. Escher (Eds.), *Accepting voices* (pp. 165-171). London: MIND.

Escher, A. (2005). *Making sense of psychotic experiences.* Unpublished Unpublished doctoral dissertation, Maasstricht University, Maastricht.

Hammersley, P., Dias, A., Todd, G., Bowen-Jones, K., Reilly, B., & Bentall, R. (2003). Childhood trauma and hallucinations in bipolar affective disorder: Preliminary investigation. *British Journal of Psychiatry, 182*(6), 543-547.

Honig, A., Romme, M., Ensink, B., Escher, S., Pennings, M., & Devries, M. (1998). Auditory hallucinations: A comparison between patients and non-patients. *The Journal of Nervous and Mental Disease, 186*(10), 646-651.

Johns, L., Hemsley, D., & Kuipers, E. (2002). A comparison of auditory hallucinations in a psychiatric and non-psychiatric group. *British Journal of Clinical Psychology, 41*, 81-86.

Jones, S., Guy, A., & Ormond, J. (2003). A Q-methodolgical study of hearing voices: A preliminary exploration of voice hearers' understanding of their experiences. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 189-209.

Kilcommons, A., & Morrison, A. (2005). Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors. *Acta Psychiatrica Scandinavica, 112*, 351-359.

Lampshire, D., & Loretto, M. (2004). Hearing voices group. Auckland.

Leibman, M., & Salzinger, K. (1998). A theory-based treatment of psychotic symptoms in schizophrenia: Treatment successes and obstacles to implementation. *Journal of Genetic Psychology, 15*(4), 404-420.

Leudar, I., & Thomas, P. (2000). *Voices of Reason, Voices of Insanity: Studies of Verbal Hallucinations*. London: Routledge.

Miller, L., O'Connor, E., & Di Pasquale, T. (1993). Patients' attitudes towards hallucinations. *American Journal of Psychiatry, 150*, 584-588.

Morrison, A., & Peterson, T. (2003). Trauma, metacognition and predisposition to hallucinations in non-patients. *Behavioural and Cognitive Psychotherapy, 31*(3), 235-246.

Morrison, A., Read, J., & Turkington, D. (2005). Trauma and psychosis: Theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*(5), 327-329.

Offen, L., Waller, G., & Thomas, G. (2003). Is reported childhood sexual abuse associated with the psychopathological characteristics of patients who experience auditory hallucinations? *Child Abuse and Neglect, 27*, 919-927.

Pearson, A. (2004). Working with voices. Auckland: Keepwell Publications.

Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 1-22.

Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry: Interpersonal and Biological Processes, 64* (4), 319-345.

Romme, M., & Escher, A. (1989). Hearing Voices. *Schizophrenia Bulletin, 15*, 209-216.

Romme, M., & Escher, A. (1994). *Accepting voices*. London: MIND.

Ross, C., Miller, S., Reagor, P., Bjornson, L., Fraser, G., & Anderson, G. (1990). Schneiderian symptoms in Multiple Personality Disorder and Schizophrenia. *Comprehensive Psychiatry, 31*(2), 111-118.

van Laarhoven, J. (1994). Functional analysis. In M. Romme & A. Escher (Eds.), *Accepting Voices* (pp. 152-162). London: MIND.

Wagner, L., & King, M. (2005). Existential needs of people with psychotic disorders in Porto Alegre, Brazil. *The British Journal of Psychiatry, 186*, 141-145.

Westacott, M. (1995). Strategies for managing auditory hallucinations. *Nursing Times, 91*(3), 35-37.

Whitfield, C., Dube, s., Felitti, V., & Anda, R. (2005). Adverse childhood experiences and hallucinations. *Child Abuse and Neglect, 29*, 797-810.