

# **PART TWO**

## **ABSTRACT BOOK**



17 September

**Morning programm:  
Plenary session from 10.15 hours till 13.00 hours**



*Elisa Carter MBA*

Chair: *Elisa Carter*, MBA (NL)

CEO of GGzE Eindhoven en de Kempen (Mental Health organization, clinical, polyclinic and outreach care)  
Member of the advising board (RvZ) for the ministry of Health Care Netherlands  
Member of the board of commissioners for healthcare research (Bestuur ZoNMW)  
Shortly after I had accepted the CEO position at the mental health institute Maastricht I met Professor Marius Romme. We had one hour to get acquainted.

We exchanged briefly each others' career, some insights on the national health care policy and the goals for mental health services in Maastricht. I was inspired by his passionate approach and logical reasoning while explaining his research on hearing voices. This inspiration helped me to focus on another way to organize the care in such a way that we can meet the demands of service users effectively.

Hearing voices has been regarded by psychiatry as “auditory hallucinations” and as a symptom of schizophrenia. Traditionally the usual treatment for voice hearing has been major tranquilizers and specific medication administered to reduce hallucinations and other symptoms. However not everyone responds to this treatment.

Ideally, most professionals would see all interventions as cooperate ventures between professionals and service user, but the perception of users is often different. Nearly always, the professional is in a position of power over the service user.

In a culture where the person with a mental health problem expects the work done by a professional to be akin to arranging a ceremony with supernatural significance, the power is not located in either the user or the professional. In this context therefore, professional help for a mental health problem would be perceived by the user in a very different way to how therapy is perceived by the West. This illustrates the way culture is involved in the nature of an intervention.

Professionals who understand the individual and collective power of self- help and self- management by the people who hear voices use talking therapies and exploring the meaning of the voices. These professionals interlink the use of family involvement, culture and community support systems. Their interventions goes beyond the diagnose, the symptoms, race and gender. To enforce this new approach in the institute I gained enormous support from professor Marius Romme and doctor Sandra Escher. Fortunately the head of the department mister Jo Maas and the psychiatrist Dirk Costens embraced the transition and the new movement was on the way.

My introduction in 1998 to the first hearing voices group in Manchester, founded by professor Marius Romme in 1988 inspired me to be persistent in the movement of the changing scene today, the move towards organizing services to meet needs.

Services to asses self-help.

Services organized on demand of service users.

## 10.15 Opening



*Prof. Wilma Boevink (NL)*

**Wilma Boevink**, born 1963, social scientist, Professor of Recovery at the Hanze University of Groningen, an active member of the Dutch user-movement in psychiatry and board member of the European Network of (ex-) Users and Survivors of Psychiatry (ENUSP). Working in Utrecht at the Trimbos-Institute (the Dutch Institute of Mental Health and Addiction). She is the leader of a user-led training and consulting company in the area of recovery, empowerment and experiential expertise of persons with psychiatric disabilities. Since 2006, Chair of Stichting Weerklank, the Dutch organisation of people who hear voices and have psychotic experiences. Publications include *Samen werken aan herstel. Van ervaringen delen naar kennis overdragen* (Working Together on Recovery: From Sharing Experiences to Implementing Knowledge), co-author, 2002; *Stories of Recovery: Working Together towards Experiential Knowledge in Mental Health Care*, editor, 2006; *Lijfsbehoud, levenskunst en lessen om van te leren. HEE-gesch(r)ift* (Survival, life-art and lessons to learn - TREE-document), author, 2009



## 10.30 5 Voice hearers tell their recovery story



*Eleonor (UK)*



*Ami (S)*



*Irene (NL)*



*Peter (UK)*



*Olga (DE)*



## 11.30 What do voices hearers need to recover?



*Prof. Dr. Marius Romme (NL)*

**Marius Romme** was full professor of social psychiatry at the University of Maastricht until 1999 and thereafter visiting professor at the city university of Birmingham. He is founder and chair of Intervoice. Over 25 years he has together with Sandra Escher studied the hearing voices experience. Their main publications were 'Accepting Voices' and 'Making Sense of Voices' (Mind 1993 & 2000 translated in 10 languages). Marius Romme also developed a systematic way of analyzing the relationship between the characteristics of the voices and what has socially and emotionally happened with the voice hearer: "The construct"

### **Abstract:**

In this presentation I will describe the last study "Living with Voices" in which 50 voice hearers report their

recovery. These stories form the evidence base of the accepting and making sense approach for people hearing voices, to recover from their problems and take their lives in their own hands again. Also when already treated within psychiatry for long time without a positive effect. This study shows that what people need to recover is the exact opposite of what they get as the consequence of the disease concept in Mental health and the general prejudices. It seems very hard to believe that voices really make sense and therefore it is hard to really listen to what voice hearers have to tell. This now a day's need an intense training period because we were all trained not to listen.

What do voice hearers need to recover:

- Meeting someone who takes interest in the voice hearer as a person; giving hope
- Meeting people who accept the voices as being real; but also accepting the voices oneself as one's reality.
- Recognising the personal aspects of their voices and tell their story over and over again.
- Changing the power structure between themselves and their voices
- Making choices
- changing the relationship with the voices.
- Recognising one's own emotions and accept them.

What do voice hearers get : a diagnostic label that explains nothing about what they experience; they get messages of no hope and to adept to their disease; they are asked to be the passive victim of their illness not being able to change anything of their disease with their own capacities; They are told to have to take medicines over long periods, which reduce their emotions in such a way that they don't learn to cope with them. Choices are made for them according to their disease not according to their dreams or wishes. They are told that social or emotional events have hardly any influence on their disease origin or prognosis. They are not asked what has happened in their lives. The relationship with their emotions is denied; information about alternative approaches is not given. They are not really listened too.

The purpose and result of recovering from the distress with voices is not to get rid of them, but to change their relationship with them as well as with the problems that lay at their roots. These stories show the need and necessity for emancipation. Too many people in our society and too many professionals working in the mental health field still see those amongst us who hear voices as being different, as not being a normal person. It might be compared with the general attitude towards homosexuality many years ago. Homosexuals changed public opinion by organizing themselves, using political pressure and the media in their fight for recognition. This battle is yet to be won by voice hearers who also need to go public and fight for their acceptance as full citizens. However, acceptance starts with accepting oneself and that is what becomes apparent from the stories in this book and therefore being supported in their self acceptance is important.

## 12.00 Why relationships matter: The crucial role of the therapeutic alliance in helping people with psychosis



*Prof. Dr. Richard Bentall (UK)*

*Prof. Bentall* holds a Chair in Clinical psychology at the University of Bangor, Wales, UK. He is particularly well known for his work on psychosis, delusions and hallucinations and has published extensively in this area. He also has an interest in differences between human and animal pedagogy and the treatment of chronic fatigue syndrome. In 1989 he was awarded the British Psychological Society's 'May Davidson Award' for contributions to the field of clinical psychology. He has edited and authored several books, most notably the recent *Madness Explained*, which was winner of the British Psychological Society Book Award 2004.

### **Abstract:**

At the end of the Second World War, the only recognised form of psychotherapy for psychosis was intensive psychoanalysis, which was regarded

as costly and (even according to some psychoanalysts) of limited efficacy. The post-war years saw a period of intense therapeutic innovation following two separate traditions: a technical tradition (behaviour modification) which placed its faith in psychological theory, and an interpersonal tradition (associated with Carl Rogers) which emphasized the importance of therapeutic relationships. It is widely assumed that the technical approach triumphed and in the present era of cognitive behaviour therapy (CBT) we now place our faith in particular psychological techniques. In this paper I will ask whether this faith is justified. CBT for psychosis is clearly a positive development, but its effectiveness has sometimes been over-stated by enthusiasts. Recent research has emphasized that non-CBT therapies can also be effective, and that the quality of the therapeutic alliance is an important determinant of outcome. Although further technical innovations may lead to improvements in psychological treatments for psychosis we neglect the interpersonal aspects of treatment at our peril.

## 12.30 Childhood trauma and psychosis: The power of relationships to harm and to heal



*Dr. John Read (NZ)*

### **Biography:**

After twenty years working primarily with people diagnosed 'schizophrenic' as a clinical psychologist and manager of mental health services, John Read took up an academic post in the Clinical Psychology programme at the University of Auckland, New Zealand, in 1994.

He has published over 50 research papers - predominantly in the areas of the relationship between adverse life events and psychosis, public attitudes towards 'mental illness' and the influence of the pharmaceutical industry in mental health.

John is the coordinating editor of 'Models of Madness: Psychological ,

Social and Biological Approaches to Schizophrenia' (Routledge, 2004) which has been translated into Swedish, Spanish, Russian and Chinese. He is a member of the Executive Committee of the International Society for the Psychological Treatments of Schizophrenia ([www.ipsps.org](http://www.ipsps.org)). John is also the Editor of the journal 'Psychosis: Psychological, Social and Integrative Approaches' (<http://mc.manuscriptcentral.com/rpsy>) which publishes first-person accounts of psychosis and of experiences with mental health services, as well as more traditional research.

### **Abstract:**

Recent research demonstrating a causal relationship between childhood abuse and neglect, bullying and witnessing inter-parental violence and later psychosis, including voice-hearing, will be summarized. The difficulty biological psychiatry has integrating this research, and the role of the drug companies in this process, will be discussed. It will be argued that only by asking about abuse and neglect can mental health workers establish a useful therapeutic relationship with people who experience psychosis and who have been abused or neglected as children.

18 September

**Morning programme:  
Plenary session from 10.00 hours till 13.00 hours**



*Elisa Carter MBA*

Chair: Drs. *Ivonne van der Padt* (NL):

she is a social psychiatric nurse (community mental health nurse) and head of the department of Higher professional education for social psychiatric nursing in Amsterdam (de Hogeschool van Amsterdam).

She is an active member of the professional association of social psychiatric nursing (V&VN-SPV) and was one of the editors of the journal *Social Psychiatry* the specialist journal for Social Psychiatric Nurses, published by the association.

The journal has published several articles about hearing voices by Sandra Escher and Marius Romme.

She is –as is Marius Romme -co-writer and editor of the book *Social psychiatry*. The new edition (spring 2010) contains a chapter about the Maastricht Hearing Voices Interview. This chapter is included in the new edition in order to educate

student social psychiatric nurses towards another attitude and conception on hearing voices and recovery. The professional Master on nursing in social psychiatry who will be developed and hopefully start in the fall of 2010 (also at the Hogeschool van Amsterdam) will provide a training to be able to work with the Maastricht Hearing Voices Interview. The training will be developed under supervision of Sandra Escher and Marius Romme. Ivonne is known to disseminate social psychiatry as an essential body of thought in today's approach of psychiatric problems people experience and the working alliances one creates to support people with their recovery.



## 10.00 5 voice hearers tell their recovery story



*Marlene (AU)*



*Jeanette (NL)*



*Flore (NL)*



*Antje (Germ)*



*Astrid (NL)*



## 11.00 Attitude through Terminology: Psychiatry as a profession at war with itself



*Prof. Dr. Jim van Os (NL)*

### **Abstract:**

Japan was the first country to abandon the confusing and mystifying 19th century term of “mind-splitting disease” (schizophrenia), replacing it with a scientifically more valid concept. Revisions of DSM and ICD are forthcoming. Should the rest of the world follow Japan’s example and similarly develop a new system of representation of psychosis?

The discussion about re-classifying and renaming schizophrenia and other psychotic disorders is clouded by conceptual confusion. First, it is often misunderstood as a misguided attempt to change societal stigma by changing the name. This is not the case, however, as renaming schizophrenia may be more correctly conceived as an attempt to change iatrogenic stigma occasioned by the use of misleading, mystifying and, ultimately, stigma-inducing terminology. Second, it is misunderstood as a purely semantic discussion, whereas in actual

fact it touches on the very core of psychiatry: which concepts should be used to represent and communicate about psychiatric nosology? In other words: the discussion is about an entirely new concept of classifying psychotic disorders. Third, it is seen as a discussion about a single diagnostic category: schizophrenia, that has a population prevalence of 0.5%. In actual fact, however, it is about the total morbidity force of psychosis and its current myriad of diagnostic categories in DSM and ICD with an estimated prevalence of 3.5%. Fourth, it has been suggested that the debate is political. This is not the case however, as solid scientific evidence pointing to the absence of nosological validity of diagnostic categories that nevertheless invariably are subject to paradoxical psychiatric reification, lies at the heart of the argument. Fifth, there is much confusion about the scientific distinction between what constitutes a syndrome (a group of symptom dimensions that cluster in different combinations in different people and for which one or more underlying diseases may or may not be found) and a disease (a nosologically valid entity with specific causes, symptoms, treatment and course).

Is it argued that both scientific and societal developments point to a syndromal system of classification combining categorical and dimensional representations of psychosis in DSM and ICD. It is proposed to introduce, analogous to the functional-descriptive term “Metabolic

Syndrome”, the diagnosis of “Salience Syndrome” to replace all current diagnostic categories of psychotic disorders. Within Salience syndrome, three subcategories may be identified, based on scientific evidence of relatively valid and specific contrasts, named Salience syndrome with affective expression, Salience syndrome with developmental expression and Salience syndrome not otherwise specified. It is argued that the concept of “salience” not only has scientific validity, but also has the potential to make the public recognise psychosis as relating to an aspect of human mentation and experience that is universal, thus potentially reducing stigma and exclusion.

## 11.30 The need for organisational changes in mental health services to create conditions for recovery



*Ron Coleman (UK)*

*Ron Coleman* has been active in the field of mental health since 1991, when affecting his own recovery from mental illness, he used his experiences to develop his ideas for recovery centered treatment of others. Since then he has went on to write numerous books and papers on the subject and was influential in the development of the Hearing Voices Network in the UK. He is a founder member of INTERVOICE and has been instrumental in nurturing and supporting the development of our organisation. Ron and his partner Karen are particularly well known for their work on Recovery and Psychosis and also specialise in ‘Self harm, Personality disorder, Risk training, Person Centred Planning’ and mental well being. Ron has set up Working to Recovery Ltd, a training and consultancy organisation.

### **Abstract:**

Abstract Ron Coleman Keynote Organisations as Vehicles of Recovery

If recovery is to become a reality for the many then organisations need to become vehicles of the recovery process this requires a change in the mindset of organisations and the development of a recovery platform that is value based.

Organisations being what they are must however believe it is in their best interests to make this move to recovery based services before they will do so.

Helen Glover in her discussion paper Uncovering Recovery Gives the following reasons as to why recovery based practice should be both adopted and developed she writes.

“Recovery issues do not solely pertain to the individual who experiences distress or illness but to the whole community including:

- Policy makers,
- Commissioners,
- Organisations that provide services,
- Practitioners,
- Those that use services,
- Those that play a significant role in the lives of people who experience mental illness / distress, and
- The general community at large.

While the interplay between these stakeholders appears hierarchical, it must be remembered that all players have a responsibility to look seriously at their role within recovery orientated service development and delivery.

This developing discussion is intended to facilitate understanding of recovery–orientated service delivery. It helps us to recognise how all stakeholders can interplay to provide what we understand as recovery practices. It also attempts to provide a value base for which recovery practice can be developed and delivered.”

Reasons to adopt and develop recovery practice

- Services will be responsive to the needs of people with mental illness/distress
- Services, in being responsive, will be effective and efficient
- Services will have staff that feel valued and supported in their work
- Services will have staff that feel fulfilled in their work with people with mental illness / distress
- Service users will feel actively involved in their care
- Service users will inform and be fully informed on all issues pertaining to their recovery
- As planning is central to recovery practice, service users, significant others, and service providers will have prepared for contingencies and crises
- Recovery practice is forward and future focussed
- Service users, their significant others and service providers will develop collaborative partnerships in their work towards recovery.
- Coercion and control of people’s actions will not dominate practice
- Evidence based knowledge and value based knowledge will co exist
- An articulated value base will underpin each service’s/organisations practice
- Feedback will not be feared, but sought and embraced in the continual development of responsive and accessible services
- Partnerships between all key stakeholders, including community members and groups, will be active and visible
- People will move beyond the need for intensive service delivery
- Service users will be educated about recovery processes and the applicability to their lives
- The diversity of knowledge, experience and values of all stakeholders will be upheld
- Within a recovery framework, providing diagnosis and prognosis is secondary to developing meaning and understanding
- Inviting people to create a society where inclusion is a reality, and develop meaning to what is happening for them.
- A relationship based on equality where the mutuality of knowledge and experience is respected is more aligned with recovery relationships and outcomes.”

Can we imagine our organizations making the changes required to implement a service system that adopts the above elements? For too many of us the answer will be no but does this mean we should just give up and go home? Again I would argue that the answer to this question is no. Rather than give up we should start looking at each of these 20 reasons given by Glover and seek to find ways in which they can be implemented in our own individual practice as well as within our organizations. Let us explore these reasons individually and look at what is already being done and also what could be done individually and organizationally to change the current ways of working.

## 12.00 Survival techniques: an exploration of hearing voices, self harm, eating ‘disorders’ and dissociation as the consequence of surviving childhood trauma



*Jacqui Dillon (UK)*

*Jacqui* is the Chair of the National Hearing Voices Network, England, a user led charity which works to promote acceptance and understanding of the experiences of hearing voices, seeing visions, tactile sensations and other sensory experiences. She is an international speaker and trainer specialising in hearing voices, ‘psychosis’ and trauma. Jacqui is a member of the campaign co-ordinating committee for CASL – the Campaign to Abolish the Schizophrenia Label. She is a published writer.

### **Abstract:**

“Survival techniques: an exploration of hearing voices, self harm, eating dis-order and dissociation as the consequence of surviving childhood trauma”

Hearing voices, self harm, eating ‘disorders’ and dissociation when viewed objectively, are frequently classified as symptoms of serious mental illnesses and disordered personalities that require treatment, eradication and cure. This convenient societal solution to the complex problem of endemic childhood abuse requires that victims of abuse endure further insult to injury and become the problem to be dealt with. By tracing the roots of so called ‘symptoms’ back to their origins in traumatic childhood events and having the courage to bear witness to painful truths, a more accurate, humane and respectful picture emerges which reframes ‘symptoms’ as essential survival techniques. The mark of a responsible society and responsive services is the willingness to share collective responsibility for these experiences, to honour them, support them and learn from them at all levels.

## 12.30 Hearing voices, a common human experience



*John Watkins (AU)*

**John Watkins** has practiced as a mental health counsellor and educator for more than twenty-five years. He has a particular interest in researching and promoting holistic approaches to understanding and treating mental illness and regularly conducts training courses and workshops based on holistic principles. His previous books include *Living With Schizophrenia* and *Hearing Voices: A Common Human Experience*.

**Abstract:**

Though hearing voices is often considered a classic sign of madness it is, in fact, a rather common human experience. While “voices” are a prominent symptom of some psychotic disorders, they occur in numerous other contexts in a wide variety of forms. Many well-adjusted individuals have had at least one memorable voice experience and some people have them regularly. Although some voices are distressing or even disabling, others are sources of comfort, reassurance, and guidance. Benign inner voices – often an integral component of non-ordinary states of consciousness, mystical and paranormal phenomena, near-death experiences, and shamanic healing practices – may serve as a medium for creative inspiration, the call of vocation, extrasensory communication, and spiritual revelation. Venturing beyond conventional treatments whose sole aim is symptom eradication opens up the possibility of working creatively with inner voice experiences to foster personal growth, healing, and recovery.

## Afternoon programme for 17 and 18 September from 14.00 hours till 17.00 hours

**Masterclasses, presentations and discussion groups** by voice hearers, researchers and professionals.

### 17 September afternoon programme

#### Master classes

##### The importance of the 3 stages of voice hearing and paranoia



**P. Bullimore (UK)** Founder of Paranoia Network, England, “I spent over ten years in the psychiatric system in England often forcibly detained under the mental health act. I was given a diagnosis of chronic schizophrenia and was told I would never work again I spent years experiencing violent voices and extreme paranoia and would spend years in a drug induced state the medication never worked so with the help of a very good worker and the hearing voices network I was able to come of my drugs and learn more about my experiences and use more holistic approaches. I still hear voices daily but understand them more, I am now run the Sheffield Hearing Voices network I am chair of a training and consultancy agency called Asylum Associates and

recently founded the International Paranoia Network, I spend 70-80 hours per week travelling the world delivering training on hearing voices and paranoia.”

#### **Abstract:**

The presentation will look at how hearing voices and paranoia is often seen as an illness when it is a common human experience and how psychiatrist’s views are very subjective and based on no evidence. I will look at the 3 stages of paranoia and how it is different from the 3 stages of hearing voices I will also look at working with unusual beliefs and paranoia from a common sense and holistic approach. The presentation will look at positive interventions that can be used during the three stages of hearing voices and paranoia and ways of coping with each experience’s. If the 3 stages are implemented during the onset of person’s experiences of hearing voices and paranoia they are positive tools that should be used by early intervention How we can find a person’s dominant voice buy using protection strategies and the importance of protection strategies to help an individual deal with an increase in their voices and paranoia while finding and challenging the dominant voice.

## Adopting a non-judgemental and tolerant acceptance to voice hearing



**E. Longden (UK)** is a psychology undergraduate and former trustee of the Hearing Voices Network, currently working in an Early Intervention in Psychosis team. As a past user of psychiatric services, she has a strong interest in promoting tolerance, awareness and positive explanations for mental health issues and for the last four years has worked in both clinical and academic capacities to endorse creative, enabling approaches to experiences such as voice hearing, unusual beliefs and self-injury. Eleanor was part of the group who established the award-winning Bradford Self-Injury Service and has worked closely with Dr. Dirk Corstens in developing and promoting the innovative Voice Dialoguing technique in the UK.

### **Abstract:**

Voice hearing is meaningful, even if these meanings are painful and difficult to face. While attempts to eradicate voices are considered a ‘cure response’ by conventional mental health services, understanding, accepting and integrating the emotional and personal significance of one’s voices is the recovery response. During this session I will discuss the responsibility workers have to adopt a non-judgemental and tolerant acceptance towards their client’s experiences, and in doing so help promote practical healing and emotional growth.

## Making sense: a systematic method to exploring the function of the voices



*Dr. D. Corstens (NL)*

**Dirk** is a Social psychiatrist and psychotherapist working at the RIAGG Maastricht. Since 1992 as a collaborator of Romme and Escher participating in research, treatment and education on voice hearing. Leads a treatment facility for voice hearers in Maastricht. Currently preparing a PhD on courses for voice hearers and professionals and the voice dialogue method for voice hearing. Speaker at several international conferences and workshops about hearing voices.

### **Abstract:**

The so-called ‘construct’ is a mean to restore the relationship between life history and voices. Often this relationship is lost because

emotions that gave rise to the voices are difficult to bear. Voices represent situations that were too threatening to the person. To voice hearers their voices seem to speak in a strange code of which the original meaning became unclear. Making the construct helps to break this code. Several items from the Maastricht Hearing Voices Interview are used to elucidate the persons from the past and problems that the voices are representing. The way how to work with the construct is explained, several examples will be presented and how it can help to establish a more productive relationship with the voices.

## Owning our experience; taking back power



*Ron Coleman (UK)*

*Ron Coleman* is a Mental Health Trainer and Consultant specialising in Recovery and Psychosis. Following his role as national co-ordinator of the ‘Hearing Voices Network’ he used his experiences of recovery to design Workbooks and Training packages, to enable voice hearers to gain ascendancy over the negative aspects of the voice hearing experience. Ron’s own route to recovery after spending 13 years in and out of the psychiatric system has given him many insights into the numerous difficult issues facing today’s mental health services. He is now back in his homeland of Scotland after 20 years of self imposed exile!

### **Abstract:**

In this session we will explore how we can use voice profiles as a means to understanding the voices that a person is hearing. We will also explore at least one other tool (Power Circles) showing how we can utilize these two techniques together in such a way as to help us as workers engage in a constructive way with the person and their voices.



# Presentations around the theme: “Meaning” in hearing voices

## The sources of meaning in voice hearing



*Prof. I. Leudar (UK)*

*I. van Leudar*, School of Psychological Sciences, The University of Manchester, Ivan Leudar was born in Czechoslovakia but lived most of his life in the U.K. He is now a professor of analytical and historical psychology at the University of Manchester. His recent publications include *Voices of Reason, Voices of Insanity* (2000, Routledge, with Phil Thomas), *Conversation Analysis and Psychotherapy* (2008, CUP, with Annsi Perakyla et al) and *Against Theory of Mind* (2009, Palgrave/MacMillan, with Alan Costall). His work on hearing voices aims to document voice hearers’ own understanding of their experiences and it focuses on methods they use to endow these experiences with meaning. His current projects investigate

voices in everyday life and especially in bereavement. One aim is to normalise these experiences by documenting their variety in both contemporary world and through studies of historical cases. He is currently working on a book that might be entitled *Historical Psychology*.

### **Abstract:**

Psychiatry and cognitive clinical Psychology attempt to provide explanations for voices in a natural science paradigm, for example as results of faulty reality testing, which are caused by specific brain dysfunctions. In doing this, however, both lose the essential aspect of these experiences, that they are meaningful. On the rare occasions that they note what the voices mean to the hearer they see the meanings as pathogenic - there is for instance, a long tradition in Psychiatry to consider voices as a source of delusions. The result is that such approaches, despite much research effort, throw very little light on the experiences of hearing voices. In all of my research I treat the experiences of hearing voices as meaningful and enquire into the sources of their meaning. In this respect my work is of course not unique – one influential contemporary approach for instance sees voices as representing abuse in the person’s past, another considers that the experiences serve to retain for a time the deceased person in the world of the bereaved person. Clearly, however, these sorts of meaning are only some of many possible. The talk will summarise our past research on voices - the principles that guide it and its results. To anticipate the talk: (i) our historical research documents resources for understanding hearing voices provided by cultures very different from our own. (The ancient Greek poet Hesiod, for instance, was able to think of the voice he heard as that of Muses and

make use of it in his poetry). (ii) Our method is to work with as wide a variety of individual voice hearers as possible and to elucidate the meanings of voices for them, and their sources. (iii) Our findings indicate that voice-talk is typically linguistically simple yet meaningful because the words and sounds of voices are always understood in the settings that are formulated for the voices by the voice hearers. Such settings usually integrate the concrete occasion, somewhat broader field of voice hearer's ongoing activities as well as his or her biography. The voices are, however, not just understood in the context formulated for them, they can also change the current experience by bringing in and making relevant information from other times and places in the person's life. Case examples will be provided to document some of the methods voice hearers use to make voices meaningful in this way.

## Meaning of voices in a student population



*J. Turner Baker (UK)*

**Johanna Turner Baker**, currently working as a part time research assistant at the University of Manchester and as a therapeutic horticulturist in schools around Manchester.

### **Abstract:**

In this talk I will be presenting three cases chosen from ongoing research on hearing voices in a student population. During the study I have been interviewing in depth students who reported hearing voices.

In this talk I will focus on instances where the interviewees simply hear their own name called. This experience is fairly common and seems too simple for comment. Yet, the meaning voice hearers ascribe to such voices can vary and be quite complex and personally significant. The talk focuses on and documents the methods that voice hearers use to endow these experiences with meaning. The main

source of meaning is contextualisation of the experience in a variety of contexts, that include the physical here-and-now, the extended present and person's biography. These experiences happen as part of people's day to day lives, so I will look at how hearing one's name called might alter their experience at the time.

I will also report on social resources that people use to explain these 'unusual experiences'. These include medical, psychological and spiritual representations of hearing voices. The point of the research is to normalise the experience – none of the informants had any diagnosable psychological problems.

## Hearing voices in bereavement



*J. Hayes (UK)*

**Jacqueline Hayes**, currently working on a PhD at the University of Manchester and training as a therapist. Has had personal experiences of hearing voices and worked closely with people who hear voices in therapy work and in supported housing.

### **Abstract:**

In this talk I will present some recent research concerning hearing voices in bereavement. This is based on an ongoing study of detailed narrative interviews with a variety of bereaved participants. First I will look briefly at how these experiences have been traditionally understood in psychiatry and psychology. There is little research on the subject to-date but what is there shows that these are

relatively common experiences in a bereavement, rich with emotion and meaning, but often kept private due to significant stigma. I will then show through the use of case studies drawn from the current study how the bereaved make meaning and sense of their experiences – by reference to their former everyday life with the deceased, and their loss. Further I will show that these voices often are embedded in a family of related experiences denoting the continued presence of the deceased including visions, smells, touch and dreams. I will ask the questions – what functions do these experiences have in the bereavement? And, what role do they have in coping with the loss? And finally I will show that in making sense of these experiences, participants draw on a variety of sources of meaning – from personal biography, to psychology, psychiatry, religion and spirituality. The result is that by studying hearing voices through such illuminating personal accounts, rather than within a medical framework, the experiences are normalised.

## Voices and inspiration, voices and emotions



*T. Gerritsma (NL)*



*T. Rivas (NL)*

### **Abstract:**

In 2007 *Tilly Gerritsma*, a ‘highly sensitive person’ from the Netherlands, wrote an autobiographical book about hearing voices, “Gek genoeg gewoon”, together with psychologist, philosopher and psychical researcher *Titus Rivas*, MA, who included a comprehensive overview of the relevant literature.

Tilly’s own experiences with the phenomenon of hearing voices began when she heard a voice that said “Faith” and “Trust” to her - in English - which made her realise that she was not alone any longer. She felt supported by the voice and assumed that it came from the ‘other side’. This particular belief was reinforced by the convictions of a sympathetic psychic healer. Tilly decided to accept the phenomenon and did not consult a psychologist about it. She opened herself completely to the experience, but, after a while, she found out that it also had a chaotic influence on her life. It was as if her sensitivity was increased to such an extent that there was an overkill of information. Therefore, she decided to take charge of her own mind again. Thirteen years later, Tilly’s thinking about this event has become broader in that she believes the voice might also have been produced by her own subconscious mind. By then, she had read a lot of books about psychology, psychiatry and spirituality. Tilly actually had been in need of emotional support when she started hearing the voice. Tilly went through a difficult period in her life with major problems with her sons and she felt desolate. The voice healed her emotional trust. However, she believes her ‘emotional balance’ had not been completely restored yet, and that’s why other voices tried to flood her with unwanted information. Independently, she took several important steps to improve her inner balance and she’s grateful that her voices made her more aware of her emotional problems. Tilly wishes to stress that voices can be positive as well as negative. In the positive sense, voices can often be wise counsellors and helpers. Even persons who suffer from negative voices can sometimes be helped

by positive ones. In her own life, the influence of her positive voice was transformed into inspiration which helped her take a different look at all kinds of issues. Since then, she has also had many experiences with telepathy which made her realise that everyone is connected. Based on the available literature, Titus Rivas endorses a the legitimacy of a psychogenic and spiritual interpretation of Tilly's experiences, and those of others with a similar story.

## Achieving full recovery through becoming aware of meaning



*L. Govers (I)*

### **Abstract:**

**Lia Govers**, born in the Netherlands in 1952. Living in Italy since 1972, now with her Italian husband and son. In Holland she qualified as a primary school teacher, while in Italy she became a working student and graduated in pedagogy, but never used this study for a job. She always worked with her knowledge of the languages in offices, in an industry or like a free lance translator. Before 1999 she suffered for at least 4 years a 'delirious paranoid schizophrenia', but with the help of years of a psychodynamic psychotherapy she is fully cured nowadays and this all really thanks to a human psychiatric approach, during all these years. Since half 2002 she does not take psychopharmakon any more.

Since half 2006 she was invited to write her autobiographic story (Translated title: 'Can a motherbond not be regained?'), that now has been published in Holland, soon will be published also in Italy and probably within 1 year in an English version too.

For *Intervoice* she has only written one chapter for the 2009-book that Ben Gray is editing. In Italy she already appeared in public several times, mostly to give testimony that recovery from 'schizophrenia' is possible, but also to fight against the stigma hanging around (ex) mental illness. In January 2009 she wrote, together with her psychiatrist, an Italian article for the psychiatric review 'Psichiatria di comunità', around the possibility of recovery from 'schizophrenia'.

After the summer of 2008 she contacted the international ISPS and gave them already all the possible technical details about her recovery from 'schizophrenia' through talking therapy she posted in English inside a psychoanalytic site.

At the Conference she would like to talk about her recovery through a human psychiatric approach, about the factors that helped her mostly in the 9-10 years she was followed, but also about the clear phenomenological meaning of the so-called 'schizophrenic' fantasies. All the things she discovered before and during her psychotherapy and extra during her writing process ended in a great, deepgoing and freeing awareness-process. On the WMHO-site there has been posted also an article about her recovery in the beginning of 2008.

## Emanuel Swedenborg and his experiences



*Dr. S. Jones (UK)*

**Simon Jones**, psychologist, UK I am a researcher interested in the history of hearing voices, the causes of hearing voices, and strategies that help people cope with voices. I received his Doctorate from Durham University in the UK.

### **Abstract:**

Emanuel Swedenborg and his experiences: Considering the extraordinary voices and visions of Emanuel Swedenborg: psychospiritual crises and the meaning of hallucinations. Emanuel Swedenborg (1688-1772) initial career was that of a man of science, and he spent the first half of his life working in the fields of chemistry, biology, and geology, as well as physiology and mathematics. However, at the age of 50, after a series of vivid dreams, and night-time hallucinations, he developed day-time hallucinations which he experienced for over 30 years, until his death. These experiences and their theological meaning became Swedenborg's focus for the

rest of his life. Swedenborg wrote down many of his experiences, and left us detailed reports of his hallucinations. He reported how he saw and talked with angels and spirits, experienced visions of Heaven and Hell, and also underwent a range of other hallucinatory experiences. I firstly examine what exactly Swedenborg experienced, and how this compares to hallucinations experienced by people today. I then go onto examine how Swedenborg's experiences were understood by his contemporaries, and people of subsequent generations.

I then show that attempts by 19th- and 20th-century psychiatrists to explain Swedenborg's experiences as being due to either schizophrenia or epilepsy are likely to be misplaced. Instead, I argue that although Swedenborg experienced extensive hallucinations, he wasn't mentally ill. I also note similarities between Swedenborg's experiences and near-death experiences. Finally, I address what might have caused his hallucinations. I suggest that the combination of a psychospiritual crisis which he underwent, his nutritional intake, as well as his habit of undertaking slow meditative breathing, may all have contributed to the formation of his experiences. I conclude that the example of Swedenborg who, after the onset of his hallucinations, was able to learn Hebrew and make presentations to the Swedish parliament, illustrates that it is quite possible to experience hallucinations without the need to consider them a medical or mental illness.

# Presentations around the theme: Trauma and hearing voices

## Hearing voices and emotional neglect



*Prof. J. Read (NZ)*

### **Biography:**

After twenty years working primarily with people diagnosed ‘schizophrenic’ as a clinical psychologist and manager of mental health services, John Read took up an academic post in the Clinical Psychology programme at the University of Auckland, New Zealand, in 1994. He has published over 50 research papers - predominantly in the areas of the relationship between adverse life events and psychosis, public attitudes towards ‘mental illness’ and the influence of the pharmaceutical industry in mental health.

John is the coordinating editor of ‘Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia’

(Routledge, 2004) which has been translated into Swedish, Spanish, Russian and Chinese. He is a member of the Executive Committee of the International Society for the Psychological Treatments of Schizophrenia ([www.isps.org](http://www.isps.org)). John is also the Editor of the journal ‘Psychosis: Psychological, Social and Integrative Approaches’ (<http://mc.manuscriptcentral.com/rpsy>) which publishes first-person accounts of psychosis and of experiences with mental health services, as well as more traditional research.

### **Abstract:**

Early research on childhood trauma and psychosis focused on sexual and physical abuse. More recent research has begun to include neglect with similar, or even stronger findings. Attachment theory, with its focus on internal representations of relationships and on affect regulation, may be a useful paradigm to help us understand how neglect in childhood can lead to psychosis later in life.

## Trauma and psychosis: truth or myth?



*Inez Myin-Germeys*



*Tineke Lataster*

### ***Inez Myin-Germeys en Tineke Lataster***

Over the last years, a number of papers have come out demonstrating an association between childhood trauma and the development of clinical and subclinical psychosis. However, two recent reviews concluded that there is still unclarity about the putative association due to several methodological problems in the available studies (Morgan & Fisher, 2007; Bentall et al 2008). For example, most studies were conducted in either chronic patients or in the general population, thus limiting the possible conclusions that can be drawn with regard to the causal role of trauma in the onset of psychosis. Furthermore, studies did not always properly assessed trauma. Also, control subjects were often lacking. Overall, there seems to be an association, however, evidence is still inconclusive.

In this workshop, we will offer two lines of evidence that might improve our understanding of the association between trauma and psychosis.

First, we will describe data from several large data-sets investigating whether traumatic experiences are associated with either sub-clinical or clinical psychotic symptoms. In addition, it will be investigated whether traumatic experiences are specifically associated with certain symptoms, such as hearing voices.

Second, we will explore a possible underlying mechanism. We will argue that traumatic experiences may increase the sensitivity to other stressors in daily life, as such increasing the risk to develop psychosis.

We would like to discuss these two lines of evidence with the audience and are aiming for an interactive workshop.

## Hearing voices as a reaction to abuse



*J. Mantle (UK) voice hearer, UK*

### **Abstract:**

Some difficulties encountered on the rocky road to recovery .... and why not to give up. Coming from a small island a hundred miles from the south coast of England, I had been finding it difficult to find other voice-hearers willing to share their experiences and was feeling very isolated. I had begun working with a therapist who was keen to help me deal with the many upsetting consequences of hearing voices. He was the first person I had met who was happy to look at the voices in a non medical way. He gave me a new diagnosis - chronic post traumatic stress disorder. He encouraged me to get as much help from as many sources as possible, and as a result I started attending conferences in England (though this has proved difficult financially, since I am unwaged). I have managed to attend about one conference a year since 2005, and these have been a great help in my battle to manage the voices better. I have been inspired by meeting other service

users who are determined to overcome their problems and who challenge their unhelpful diagnoses.

But .....I have always wanted to hear more about the difficulties other people experience in learning to live with these experiences, as I know that I am not the only one who has struggled. If we only talk about people who have made complete recoveries, those of us who are still trying (and sometimes failing) can be left feeling somewhat discouraged. That is why I would like to give a workshop where we can discuss some of the difficulties encountered on the rocky road to recovery and ways of overcoming them, and not only talk about the 100% success stories (inspiring though these are.)

This will include the information about myself, life, education, career, loss of career as a result of prejudice in the workplace which I have given you in my introduction to myself (Page 1) I will then introduce various themes which will include the challenges of:

Understanding the origins and possible causes of voices

Hearing voices as a result of trauma (abuse, etc)

Managing command voices and self-harm

Command voices and suicide. Hearing voices and over-activity

## Hearing voices related to severe abuse



*L. v.d. Giessen (NL)*



*W. v. Stalen (NL)*

### **Abstract:**

Together with my foster daughter we should like to present her. Her mental disfunctioning was caused by severe abuse of all kinds during the first half of her life. It took about thirteen years to overcome dissociation, psychosis etc, etc. We want to emphasize that hearing voices and psychotic episodes should not automatically lead to the diagnosis schizophrenia. That medication sometimes is necessary during a certain period of time and that the buddies should work together with the experts. We also want to talk about physical examination of the client. Many of the so called psychiatric clients suffer from neurological or other physical defects, but they are treated in the psychiatric department. Last but not least we want to focus on the idea that it becomes time to research what the effects are if a patient want to get rid of the medication.

## Relations between emotion regulation, traumatic events and hallucination-proneness in non- clinical participants



*Frank Larøi*

### **Biographical information:**

*Frank Larøi* works as a lecturer and researcher in the Cognitive Psychopathology Unit, University of Liège (Belgium). His research interests include examining cognitive and emotional mechanisms involved in hearing voices in the general population.

### **Abstract:**

Previous studies have shown that the presence of traumatic events is an important variable in the development of psychotic symptoms both in clinical and non-clinical populations. However, few studies have explored possible underlying mechanisms involved in this relationship. In the present study, the influence of emotion regulation strategies, in particular, maladaptive regulation strategies, was investigated as a possible mechanism implicated in the relation between hallucination-proneness and the presence of traumatic events. One hundred

and seventeen non-clinical participants completed 2 emotion regulation measures, in addition to a questionnaire assessing the presence of various traumatic events and a questionnaire assessing hallucination-proneness. Results showed that the presence of traumatic events was associated with hallucination-proneness. Furthermore, the use of maladaptive emotion regulation strategies was related to the presence of traumatic events. Interestingly, this was not the case for recent traumatic events. In addition, hallucination-proneness was related to a greater presence of maladaptive emotion regulation strategies. There was also evidence of the opposite effect concerning adaptive emotion regulation strategies, that is, lower hallucination-proneness scores were related to a greater use of these types of strategies. These findings suggest that hallucination-proneness is related to the use of maladaptive emotion regulation strategies in the face of traumatic events.

## Auditory hallucinations: Psychotic symptom or dissociative experience?



*Dr. A. Moskowitz (UK), Ph.D.  
University of Aberdeen*

*Andrew* is a clinical psychologist, trained in the United States, with clinical and research experience in post-traumatic, psychotic and personality disorders, currently employed as a Clinical Senior Lecturer in the Department of Mental Health at the University of Aberdeen in Scotland. In addition to teaching medical students, he provides individual and group psychotherapy, and works regularly with persons hearing voices. Andrew is the lead editor of an important new book on the connections between trauma, dissociation and psychosis, and has written extensively on interpreting psychotic symptoms, including voices, from a trauma/dissociation perspective.

### **Abstract:**

While auditory hallucinations are considered a core psychotic symptom, central to the diagnosis of schizophrenia, it has long been recognized that persons who are not

psychotic may also hear voices. There is an entrenched clinical belief that distinctions can be made between these groups, typically, on the basis of the perceived location or the ‘third-person’ perspective of the voices. While it is generally believed that such characteristics of voices have significant clinical implications, and are important in the differential diagnosis between dissociative and psychotic disorders, there is no research evidence in support of this. Voices heard by persons diagnosed schizophrenic appear to be indistinguishable, on the basis of their experienced characteristics, from voices heard by persons with dissociative disorders or by persons with no mental disorder at all. On this and other bases outlined in this talk, it is argued that hearing voices should be considered a dissociative experience, which under some conditions may have pathological consequences. In other words, while voices may occur in the context of a psychotic disorder, they should not be considered a psychotic symptom.

# Presentations around the theme: Education

## 10 session course teaching behaviour strategy



*Prof. R. Buccheri (USA),  
DNSc., ARNP, Professor, USF School  
of Nursing, San Francisco,  
USA, San Francisco,*



*Louise Trygstad,  
DNSc, RN, CNS, Professor Emerita,  
USF School of Nursing*

### **Abstract:**

Two nurses who have been working with people who hear voices for 15 years. They are the experts and have taught us what we know about voices including what helps and what does not help. We have led a “Managing Voices and Negative Thoughts” support group for 11 years. The purpose of our 15-year research program has been to empower people to better cope with their distressing voices. Our theory based 10-session course teaches people behavioral strategies (e.g., talking to others, relaxation techniques) to manage their distressing voices including commands to harm. Participants practice a strategy twice a day for a week and then the following week learn and practice a new strategy. Attendance at the course was found to be associated with a reduction in negative characteristics of voices (i.e., frequency, self-control, clarity, tone, distractibility, distress), intensity of voices, and levels of anxiety and depression. Immediately after attendance at the course, the prevalence of commands to harm self decreased from 44% to 24% and remained at 24% for one year after completion of the course. The prevalence of commands to harm others decreased from 21% to 16% immediately after

the course and was 17% one year after completion of the course. We are currently testing a revised 12-session version of the course that includes more anxiety reduction and peer providers. Hearing voices, especially those that command harm to self and others can be extremely distressing. Some people feel powerless to resist acting on those commands. So it is not surprising that hearing commands to harm can increase anxiety, depression, suicide, and violence towards others. The purpose of this research project was to empower people to better cope with and manage their distressing voices and harm commands. Our 15 year research program has developed a 10-session Behavioral Management of Persistent Auditory Hallucinations Course by learning from clients who experience auditory hallucinations, building on existing research and theory, and using a multidisciplinary team of expert clinicians and scholars to develop and test the course. Each of the 10 classes teaches a different behavioral strategy (e.g., talking with others, relaxation techniques). Participants practice the strategy twice a day for a week and then the following week learn and practice a new strategy. Statistically significant improvements in negative characteristics of auditory hallucinations (i.e., frequency, self-control, clarity, tone, distractibility, distress), anxiety, and depression were found. Some improvements were maintained for one-year (i.e., frequency, self-control, clarity, distractibility), a reduction in anxiety was maintained for 9 months. Immediately after the course, command hallucinations to harm self decreased from 44% of participants to 24% and remained at 24% for one year. Commands to harm others decreased from 21% of participants to 16% immediately after the course, and were 17% after one year. Persons with lower levels of anxiety prior to starting the course improved more than those with higher anxiety levels. We have published our experience and findings and taught many nurses to teach the course. Both patients and nurses report the course is helpful. Our current study offers the course worldwide. We are working on incorporating more anxiety reduction strategies and using peer providers. (References available)

## Recovery based working with voices



*Jim Chapman, RMN,  
MA, PGCert. Senior Lecturer,  
Clinical Skills Division,  
Birmingham City University, UK*



*Professor Mervyn Morris,  
Centre for Community Mental Health*

**Jim Chapman** is senior lecturer at Birmingham City University and co-ordinates a module entitled ‘Recovery Based working with Voice Hearers’. He is interested in how students acquire new skills and begin to make use of them in their routine clinical practice. Through the module, Jim has encouraged students in Birmingham to challenge their existing beliefs about ‘schizophrenia’ and helped them to begin to work with voice hearers in the way advocated by Marius Romme and Sandra Escher, and others. Jim is currently extending this work to other parts of the UK. He continues to work clinically with voice hearers within the local mental health trust.

**Mervyn Morris** is Professor of Community Mental Health and Director of the Centre for Community Mental Health at Birmingham City University, focussing on service redesign and developing alternative approaches through user expertise, particularly in the area of psychosis. He has worked extensively with European project partners, and for the World Health Organisation, and is Professor II at UC Buskerud, Norway. Mervyn is also Chief Executive of a mental health NGO.

Mervyn has been an advocate of research and user experience around voice hearing for many years and has worked with Marius Romme and Sandra Escher for many of those years. With their collaboration a module at Birmingham City University was created, ‘Recovery-based Working with Voice Hearers’, which is based on the pioneering work of Romme and Escher. Mervyn has also collaborated on papers related to voice hearing, including “Determinants of outcome in the pathways through care for children hearing voices” with Sandra Escher, and ‘The harmful concept of schizophrenia’ with Marius Romme.

**Abstract:**

Evaluation of module for qualified mental health nurses and other mental health workers, which introduces and equip students with the skills to work with voice hearers in a recovery focused way, qualitative research into how well they had embedded this approach into their everyday practice. Students at Birmingham City University have been taking a module entitled Recovery Based working with Voice Hearers as part of their BSc Honours degree in Mental Health Studies. Over the last 8 years, approximately 147 students have completed the module, which is designed to equip students with the skills and knowledge to work constructively with voice hearers, closely following the model as advocated by Romme & Escher. It is believed that this is the only university-based credit bearing module in existence in the UK, if not the world. Traditionally there has been a problem in the UK with the transfer of knowledge and skills in post-qualifying courses into mainstream practice. The reasons for this are complex, but include staff not feeling fully competent to use their new found skills in practice, staff not being offered enough time to use and develop these skills, and staff not feeling totally faithful to the new approaches they have been exposed to. We were curious to see how students undertaking this module had attempted to implement the work into their routine practice, and if they had encountered similar difficulties, so we invited all previous participants to take part in this research project. All 147 previous students were invited to take part in the research, and 48 agreed to this. The project comprised of four focus groups of around 12 people in each group. They were asked a series of open ended questions that established how well they thought they had implemented the work of R&E into their everyday practice. The data from the focus groups was tape recorded, and is in the process of being analysed and put into themes. It is envisaged that this process will have been completed for the conference in September, and the authors hope also to publish the findings in relevant mental health journals.

## A training model in interviewing voice hearers about their experience



*Dr .S. Escher, (NL)*

### **Biography:**

**Sandra Escher** was first trained at the School of Journalism in Utrecht, before she began to work at the University of Maastricht, department of Social Psychiatry. She became also a senior staff member at the Community mental Health Centre in Maastricht in 1987. Since that time she works together with Marius Romme on the hearing voices project. With Romme she wrote two books which have been translated into several languages. With him she developed the Maastricht Interview for Voice hearers. Sandra organised eight annual well attended congresses and helped voice hearers to write their presentations. In 1999 she became an honorary research fellow at the University of Central England

in Birmingham. Sandra began a 3-year follow-up on 80 children hearing voices. On this research she got her M.Phil and PhD in Birmingham and she got a PhD at the University of Maastricht. At present she is co-director of Intervoice.

### **Abstract:**

Interviewing people with psychotic experiences

Most people assume that they have the skills to interview someone. If it is true, is this also true for the interview with someone with psychotic experiences? What conditions do you need here? What outcome can one expect? Is there a need to systemize the interview and if so why? In the Maastricht interview 14 items are distinguished: the experience itself; the characteristics of the voices; the triggers; influence of the voices; trauma; relation with the voices and their believe are in a systematic way discussed. This interview give the professional support and creates a learning situation for voice hearers.

In this presentation the goals and elements of the Maastricht interview will be discussed.

## An introduction course in working with voices



*J. Schnackenberg (G)*



*Suzanne Engelen (NL)*

### **Abstract:**

**Joachim Schnackenberg** (Germany) is a trained psychiatric nurse and a qualified social worker. He currently works as a mental health social worker in a community psychiatric team in North London. He has got many years of unique experience in the successful application of the Making Sense of Voices or Experience Focussed Counselling approach in both acute care settings, as well as in community psychiatric settings. He also works as a trainer, supervisor and counsellor for an international training company, the efc Institute, based in Hanover, Germany. The efc Institute trains, informs and supports professionals, voice hearers and laypersons in the application of the individualised recovery approach to voice hearing as advocated by Romme & Escher and the recovery movement.

**Suzanne Engelen** (NL) is a voice hearer. She studied social work and mental health sciences at Maastricht University. She's a member of Weerklank (Dutch hearing voices network) and now works mainly as a recovery teacher (based on her own experience) for the TREE (Dutch based recovery project) project. She is also involved in several other recovery orientated initiatives, such as the efc Institute.

### **Abstract:**

#### **The three part basic training programme in Experience Focussed Counselling with voice hearers**

This workshop will briefly discuss and introduce the three level training programme in Experience Focussed Counselling in Germany. There will be an opportunity to discuss the merits and potential difficulties of this programme.

Despite the success of the hearing voices movement, propelled by the exchange between experts by experience and by profession, its clear recovery focussed credentials and successes have to date had very little impact on a practical level within mainstream psychiatry.

As a result, the need for a more formalised training approach has become clear in recent years. To address the need for training, Joachim Schnackenberg, in collaboration with Professor Dr Romme & Dr Escher and in discussion with the German hearing voices network, developed a three part training programme in Experience Focussed Counselling. This provides a formalised qualification and confidence in the application of this new approach for professionals, voice hearers and laypersons. In this context, Experience Focussed Counselling represents the individual recovery focussed approach, born out of the hearing voices movement and initially formalised by Romme & Escher.

The efc Institute provides 2-day workshops for every one of its three levels in basic training, as well as support and supervision in applying the newly learned skills in practice. The training workshops of the efc Institute are primarily run by Joachim Schnackenberg, Suzanne Engelen and Senait Debesay, an expert by profession, with a strong commitment to recovery focussed practice. Professor Romme & Dr Escher remain part of the team and are particularly available for level three training and any specialised issues.

The positive result of the formalisation of training in Experience Focussed Counselling can best be evidenced by an increasing number of requests for formalised training of entire mental health staff teams in different parts of Germany.

## An introduction course in accepting voices



*Dr. J. Gerritsma (NL)*

### **Abstract:**

In this presentation we will first enquire what good learning objectives are.

Well defined learning objective show relevant competencies the participant must have gained at the end of a course.

Second we will issue the outline of an introduction course in accepting voices.

We will discourse the competencies the different health workers in the field and voice hearers must have in order to accept voice hearing.

Several teaching en learning vehicles are proposed to help the participants on their way to master these skills.

[www.jaapgerritsma.nl](http://www.jaapgerritsma.nl)



# Presentations around the theme: Recovery

## Recovery is reshaping our clinical and scientific responsibilities



*M. Amering, Medical University of Vienna*

Voice hearers have been an essential force among the pioneers of the recovery movement, who have created the concepts and a language for recovery. As authors of the groundwork for the movement they have developed and impacted not only alternatives, but also international mental health system transformation efforts and specific models of recovery-oriented practice.

From their work we do know that much of recovery is lived outside clinical settings, but also that important challenges concern the roles and responsibilities of clinicians in supporting and assisting people with mental health problems in their efforts towards making full use of their health and resilience, and achieving their goals in life.

Self-determination and individual choice of flexible support and opportunities, promoting empowerment and hope, and assistance in situations of calculated risk are the new indicators of the quality of services. In contrast to a deficit model of mental illness recovery-orientation includes a focus on health promotion, individual strengths, and resilience. A shift from demoralizing prognostic scepticism towards a rational and optimistic attitude towards recovery, and broadening treatment goals beyond symptom reduction and stabilization require specific skills and new forms of co-operation between practitioners and service users, between mental health workers of different backgrounds, and between psychiatry and the public. New rules for services, for example, user involvement on all levels and person-centred organization of care, as well as new tools for clinical collaborations, for example, shared decision-making and psychiatric advance directives, are being complemented by new proposals regarding more ethically consistent anti-discrimination and involuntary treatment legislation and participatory approaches to evidence-based medicine and policy.

Recovery demands all our best efforts in terms of human rights, patients' rights, scientific and clinical responsibility and service in the interest of those of us who might become patients and those who have. We learn from those who are using services, those who have used services (ex-users), and those who define themselves through overcoming harmful experiences in the support system (survivors). Co-operations between people with and without lived experience of mental health problems and of mental health services have been successful but need more support as do those who work on the development of alternatives outside the traditional system.

The USAmerican National Coalition of Mental Health Consumer/Survivor Organisations notably captures their commitment to enriching the field with the ‘full range of lived experiences’ in their proposition ‘We are the evidence!’. This bodes well for the emerging evidence-base for recovery-orientation including an urgent call for a partnership approach which allows all experiences and all forms of evidence to be used at all levels. Co-operative and co-ordinated efforts with (ex-) service users, carers, their spokespeople and public health advocates offer formidable chances to reduce stigma, discrimination and social exclusion, which are currently seriously limiting efforts towards recovery. While the task appears huge, the combination of the wisdom and energy of the user movement and the current need of many clinicians and academics in psychiatry world-wide to overcome reductionistic and uninspired conceptual **frameworks, might just work in favour of substantial changes now.**

### **Publications:**

*Amering M & Schmolke M (2009) Recovery in mental health. Reshaping scientific and clinical responsibilities. London: Wiley-Blackwell.*

*Amering M, Schrank B, Wallcraft J (2009) Handbook of Service User Involvement in Mental Health Research. London: Wiley-Blackwell.*

## **Who else needs to recover? The professional?**



*K. Taylor (UK)*

**Karen** is an RMN with 16 years experience in the NHS in England with both older people and adults of working age. Karen has personal experience of designing, implementing and managing innovative community care services. After leaving the NHS, Karen managed the company ‘Keepwell Ltd’ for 2 years, where she ran a psychosis resolution service based on recovery and co-authored the workbook, ‘Working to Recovery’. Karen has also been involved in introducing Recovery Training into Australia, New Zealand, Palestine, Denmark and Italy as well as throughout the United Kingdom. Based in Scotland, Karen is Director of ‘Working to Recovery Ltd, alongside Ron Coleman

### **Abstract:**

This workshop will explore through discussion what we mean by recovery , I will challenge the notion that recovery is something just consumers need to do and show that recovery is something all of us experience, in order for our consumers to recovery staff, family members & society needs to recovery too. My own years of practice as both a psychiatric nurse & then as a consultant/trainer will inform this discussion

## The TREE program; Towards Recovery, Empowerment and Experimental Expertise



*Prof. W. Boevink (NL)*

### **Abstract:**

The TREE programme: recovery, empowerment and experiential knowledge of persons with severe mental suffering  
Wboevink@trimbos.nl

In the Netherlands, long-term mental health care users in cooperation with Trimbos-institute, developed the TREE-programme. TREE stands for working towards recovery, empowerment and experiential knowledge by and with user/survivors of psychiatry. This programme combines the strategies and methods of user initiatives which are thought to account for their success. These are among others: self-determination, self-help and mutual support, the creation of new roles based on

positive labelling of psychiatric experiences, giving meaning to experiences of distress oneself instead of accepting 'the doctors' view'.

The TREE-programme aims at enabling users/survivors to manage their own lives and to counter their marginalization in society. To this end, the programme enables its participants to exchange experiences and offer mutual support. It also encourages them to develop knowledge and to use such knowledge by making it available to others. Last but not least, the programme promotes user led change within mental health care organisations in the direction of recovery-based services.

Users/survivors can take part as a member of a self-help group, as a student of one of the courses, a volunteer or as a paid experiential expert. The programme offers the opportunity to:

- communicate with others about experiences that are overwhelming;
- create some distance from these experiences and reflect upon them (develop your own narrative);
- make a we-story out of several I-stories (experiential story);
- make the experiential narrative useful for knowledge dissemination to fellow users of psychiatry, mental health care professionals and others;
- participate as a (paid) trainer or lecturer in training programmes (thus creating jobs).

The underlying principle is that an important element in recovering from long-term mental illness is to develop and pass on narratives. To make and to tell a narrative enables us to overcome whatever it is we are overwhelmed with, for instance a psychosis, because it enables us to recover our sense of self. Through the story telling we grow from being a disorder to becoming a person trying to deal with life. And it enables us to learn to formulate what it is we need to recover. To develop your own narrative and compare it with the narratives of other users of psychiatry is the beginning of building experiential knowledge. A collective story is

made out of several individual narratives. To this end we look for underlying principles, for what we have in common and for what distinguishes us from one another. And finally the experiential story is transformed and used for knowledge dissemination in training programmes and courses.

In the TREE programme participants develop, transform and disseminate experiential knowledge. They perform these tasks themselves, as volunteers or in paid jobs in the mental health care organisations where the programme is implemented. If necessary they hire others, mental health care professionals perhaps, as prostheses to enable them to perform their tasks. The programme consists of:

- self-help groups and working groups;
- one day training, courses and group discussions for fellow users of psychiatry;
- training programmes for professionals;
- consultancy and coaching in organisations that wish to implement the programme.

The programme is for and with longterm users of psychiatry. They often struggle with multiple and complex problems in several domains of life and most of them have impressive patient careers in psychiatry.

As a consequence they face dependency, lack of self-confidence and self-esteem, loss of control over their lives, loss of meaningful identity and greater social vulnerability. There are no other criteria to enter the programme than to have (the courage to have) some curiosity in what the programme is about. The programme is open to all users of long-term mental health care. There are no criteria, no demands, no examination and one can use it as often and as long as one likes.

In the lecture some examples will be given of how to develop user knowledge, how to disseminate and implement it.

In the Netherlands the TREE-programme, or parts of it, is becoming more and more popular among people with psychiatric disabilities themselves as well as among care providers. Several mental health care organisations have started to facilitate their users to implement the programme. A nationwide operating team of experiential experts is now hired frequently to provide for kick off meetings, support fellow users in their recovery and in making recovery narratives, coach persons with psychiatric disabilities to become experiential experts, train fellow users and professionals, give lectures, design new programme parts and guide the implementation of the programme.

Four implementation sites, throughout the country, with models of the TREE programme have been studied on its effect. Two sites were organisations for sheltered housing. One site was an ACT network organisation and one site consisted of two non-clinical, interdisciplinary teams of a large mental health care organisation. A randomized controlled (cluster) design was followed. In the first year of the study the TREE programme started in half the locations of the sheltered housing organisations. In the second year the other half follows. On the last two sites a randomized controlled trial design was followed. All respondents with an interest in the TREE programme were followed up to two years. Outcome indicators were identity, confidence in mental health, empowerment and connectedness.

Users of longterm psychiatry:

- have a DSM identity. They think of themselves as being their disorder;
- lack sources of hope and what is more: in MHC they can't find any either
- are not supported in (starting to work on) their recovery. There is no recovery oriented care in MHC in my country
- have forgotten about normal social roles and responsibilities. We notice this when we start a new group and ask them to listen to each other or to call us if he/she cannot be present during a meeting etcetera.
- lack information about nonmedical concepts of psychosis: users of longterm mhc do not know about how to learn to cope with voices for instance.
- are not stimulated in building selfesteem, on the contrary: longterm mental health care is a very stigmatizing part of our health care system (e.g. no respect for 30 years experience as a patient)
- When participating in the TREE programmes, they:
  - Develop colourful identities, e.g. from 'schizophrenic rehabilitant' to the leader and 'father' of the recoverygroup
  - Find the courage to start moving again, to act
  - Discover their talents
  - Find hope in stories of others
  - Develop pride
  - Develop as gifted & powerful story makers and presenters

In the lecture the quantitative results will be presented. In the lecture the results of the trial will be presented.

## The HARD project; a young people's recovery program



Presenters Ms Ros Thoma; Kelly Bayley, Kellie Commans & Matt Jones  
Ros Thomas has worked in Psychosocial Rehabilitation for many years and commenced at Gateway Community Health as the Young Peoples Psychosocial Rehabilitation Worker in 2002. Her role was to plan, develop, implement and evaluate a Youth specific Program. In the early 1990's Ros had to take up the challenge of adapting to change with the introduction of de-institutionalization. She drew on her experiences in the development of the Groovers Model. As mentioned, Ros will be presenting this workshop in conjunction with 3 participants of participants in the program.

### **Abstract:**

The HARD Project has developed out of the ongoing work of the Young People's Program (YPP) at Gateway Community Health in Wodonga, Victoria, Australia. The Young People's Program caters for people aged 16-26 of varied diagnosis, providing groups, individual and family support. The central component of the program is the Groovers Group, which focus's on clients experiences, promotes a sense of hopefulness, examines attitudes and perceptions, and shares information and knowledge in a positive, supportive and sometimes challenging environment. This provides an opportunity for all to make sense of their experience and identify their unique set of skills, experiences, and strengths and the values which they can use to aid their growth and recovery - like putting a jigsaw together. Groovers deliberately does not focus on diagnoses or labels, instead it uses people's strengths and experiences to create solutions and promote the active process of recovery.

## Using the media to improve our profile



*Douglas Holmes*

Using the media to improve our profile will examine how Douglas Holmes, voice hearer from NSW, Australia has used different media including Journalism, Public relations, Films, Internet, Mobile, Publishing, Magazines, Newspapers, Mass wire media and “Personal” Media to promote hearing voices in NSW & Australia.

I have been working on this project for at least 13 years since first hearing Pat Deegan speak publicly about her own experience with voices while attending the TheMHS conference [www.themhs.org](http://www.themhs.org) in Brisbane in 1996.

During the workshop I will show how I have built a large database through collecting people’s business cards and/or of email contacts.

The example I particularly want to focus on at the conference is how through the above technique I was involved in a major television promotion about Hearing Voices in Australia co-hosted by Andrew Denton in 2007 titled: Angels and Demons over 1,000,000 people were reported to have seen this show on the Australian Broadcasting Commission in May 2008 then similar numbers when it was repeated again in Oct 2009. The show also received a 2009 TheMHS Gold Award for broadcast media at the 2008 TheMHS Auckland conference [www.themhs.org](http://www.themhs.org).

The TV show created quite a bit of interest in Australia. I held a public forum in Sydney in 2008. 20 people came to the meeting and from that we formed a group of interested people who have started the NSW Hearing Voices Network with a healthy membership and the start of support groups and a network for voice hearers in NSW.

One other little side benefit that has come from this is that we applied for a grant in November 2008 from the Lord Mayor Clover Moore MP, Salary trust fund <http://www.clovermoore.com/main/?id=291> for \$13,000 and in April 2009 we received \$20,000 which has allowed us to turn to dream of having a web site [www.hvnnsw.org](http://www.hvnnsw.org) into a reality



# Discussion group theme medication

## How to spin an illusion?



*O. Runciman (DK)*

**Olga Runciman**, voice hearer, trainer and chair of HVN, Denmark, she says she was given the label of schizophrenia and spent ten years living within that context. Today she has not only recovered but have gone on to thrive. She has her own business working for change through education and information. She also works as a recovery coach at Slotsvænget a psychiatric halfway house and she is a part time university student studying to become a qualified psychologist. She is also the chairperson for the Danish Hearing Voices Network.

### **Abstract:**

How to spin an illusion, Why do consumers never get to hear about the non glossy side of

medication research and evidence? I believed that what I was taught about antipsychotics was based on sound, evidence based science. I believed the experts when they said we know how help the chemical defect in the brains of those they called mad. I believed and thus it never occurred to me to question the validity of the medical model of mental distress. That is until I became a victim of mental distress and discovered to my detriment the failings of the medical model and its medical treatment, for it incapacitated me.

Working as I do today with other voice hearers I have since found out that I am not alone in this experience that all around me in the many institutions are to be found victims of this biological model of distress who say this does not help yet they are never heard. They and my own experience has therefore led me to investigate the basis of the medical treatment of voice hearers and what I found out has shocked me. I see how powerful the pharmaceutical companies are in not only creating an extremely lucrative market based on mental distress but that this market is almost devoid of true scientific evidence.

In my presentation I will be looking at the history of antipsychotic medication, for without the historical perspective the present has little meaning. I will look at the evidence, or rather lack of, for a biochemical explanation of mental distress and hearing voices and why in spite of this lack of evidence the medical model of mental distress still dominates. I will also be looking at voice hearing and the pharmaceutical industry who are they really helping? Finally I ask, what can be done about it?

## Do neuroleptics work?



*Prof. Dr. A. J.M. Loonen (NL)*

**Anton J.M. Loonen**, MD, PharmD, PhD, is a clinical pharmacologist with specific expertise in the treatment of patients with a chronic psychiatric illness. He works as a clinician in the department for intensive long-term psychiatric care of Mental Hospital Geestelijke Gezondheidszorg Westelijk Noord-Brabant (GGZWNB) in Halsteren and in a private practice for sophisticated (neuro) psychiatric pharmacotherapy. He is a professor of pharmacotherapy in psychiatric patients, Department of Pharmacy, University of Groningen, Groningen, The Netherlands, and teaches neurobiology, scientific methodology, and pharmacotherapy to psychiatric residents, pharmacy students, and nurse practitioners. In addition, Prof. dr. Loonen

has authored more than 200 scientific and educational papers and book chapters and books on the methodology of clinical drug experimentation and on the neurobiological basis for the clinical effects of psychotropic drugs (both in Dutch). He is a member of the Collegium Internationale Neuropsychopharmacologicum, The European College of Neuropsychopharmacology, The American Psychiatric Association, and several Dutch professional organizations.

Prof. dr. Loonen studied pharmacy at the University of Amsterdam (1978) and Medicine at Radboud University of Nijmegen (1996). He took his PhD at the University of Amsterdam with research in the biochemical psychopharmacological field and received his training as a hospital pharmacist and clinical pharmacologist at the Groot Ziekengasthuis in 's-Hertogenbosch, The Netherlands. In addition, he has worked as a research coordinator in the psychiatric teaching hospital Reinier van Arkel in 's-Hertogenbosch and in the Delta psychiatric teaching hospital in Poortugaal, and as a clinician in the geriatric department of Delta hospital and in his current position.

### **Abstract:**

**How do antipsychotics work?** Antipsychotic drugs have therapeutic effects in psychotic disorders such as schizophrenia, delirium and in specific mood disorders such as acute mania or major depressive episode with psychotic features. All currently available antipsychotics induce their therapeutic effects (and an important part of their side effects) by inhibiting dopaminergic transmission in specific parts of the forebrain. The neurotransmitter dopamine is used by a set of neurons with cell bodies in the midbrain and with fibres running to the dorsal and ventral striatum, the prefrontal cortex and the (medial) temporal lobe. The striatum is part of a circuit that originates in the cerebral cortex, runs through the striatum and other sub-cortical nuclei to the thalamus and, from there, back to the cerebral cortex: the

CSTC circuit. The activity of this circuit determines the magnitude of the cerebral cortical output. The dopaminergic activity in the striatum in turn regulates this CSTC circuit. Several divisions of this circuit can be distinguished: e.g., a cognitive part, a motor part and an emotional/motivational part. By blocking dopaminergic transmission in the striatum antipsychotic drugs are believed to decrease the formal thought disorders in mania and psychomotor agitation in mania and schizophrenia.

The input to the brain is analyzed by posterior parts of the cerebral cortex and conveyed to the hippocampal complex for recognition. The hippocampus functions as the controller of the memorization process. The dopaminergic activity in the parahippocampal region of the mesial temporal cortex regulates the easiness with which this process is accomplished. During a psychosis this process can be considered to be overactive. Therefore, non existing sensory information is recognized (hallucinations). By inhibiting dopaminergic transmission antipsychotic drugs decrease the activity level of the parahippocampal region. This results in an anti-hallucinatory effect.

The emotional response, e.g., the fear or aggression reaction, is controlled by parts of the hypothalamus. This response type is considered an intuitive response that determines the reaction of the organism to potential threatening situations. This saves the organism from damage when there is no time to carefully plan a suitable reaction. The response is initiated by activation of the amygdala within the temporal lobe. The activity level of the amygdala is regulated by dopaminergic fibres. Over activity of the amygdala is believed to result in a basic feeling of insecurity. Paranoid delusions are considered to be the cognitive constructs that explain the existence of these feelings. Antipsychotic drugs down-regulate the sensitivity of this system by blocking dopaminergic transmission in the amygdala.

## Using medication wisely



*J. Watkins (AU)*

**John Watkins** has practiced as a mental health counsellor and educator for more than twenty-five years. He has a particular interest in researching and promoting holistic approaches to understanding and treating mental illness and regularly conducts training courses and workshops based on holistic principles. His previous books include *Living With Schizophrenia* and *Hearing Voices: A Common Human Experience*.

### **Abstract:**

Conventional psychiatric treatment is now firmly centred on use of potent psychotropic medications. Neuroleptics (commonly known as “anti-psychotic” drugs) provide some

people with relief from the torment of symptoms such as anxiety-provoking thoughts (e.g. “persecutory delusions”) and hostile voices, while mood-stabilising drugs can help limit the disruption of extreme mood swings. The prophylactic effects of both classes of drugs are now widely relied on to reduce the likelihood of further psychotic episodes: so-called “relapse prevention”. Though such treatment is undoubtedly beneficial in some instances, widespread misuse has resulted in the role of these drugs becoming one of the most hotly debated topics in contemporary mental health care. There is no doubt such medications are sometimes prescribed inappropriately, administered in excessive doses, or continued longer than necessary. There are many legitimate reasons for concern about the way these drugs are used. However, if they are employed with wisdom and skill – and never simply as way of “managing” people – they can sometimes be a valuable aid in the work of healing and recovery.

## Coming off medication; a harm reduction approach



*W. Hall (USA)*

*Wilton* was diagnosed with schizophrenia and spent a year in San Francisco’s public mental health system. After discovering his own pathway to recovery, Will became co-founder of the support community Freedom Center in Massachusetts. Today Will is internationally recognized for his advocacy and educational work. He is a co-coordinator of The Icarus Project, host of the FM radio show Madness Radio ([www.madnessradio.net](http://www.madnessradio.net)), and has been a consultant with Mental Disability Rights International. He recently started a new group in Oregon, Portland Hearing Voices ([www.portlandhearingvoices.net](http://www.portlandhearingvoices.net)). More information at [www.willhall.org](http://www.willhall.org).

### **Abstract:**

Coming off medication; a harm reduction approach What is the most effective approach to reducing and coming off psychiatric medications? The Icarus Project and Freedom Center are US peer-run support communities that recently published the 40-page Harm Reduction Guide to Coming Off Psychiatric Drugs. The Guide gathers the best information we’ve come across and the most valuable lessons we’ve learned in 8 years of helping each other explore coming off. A ‘harm reduction’ approach doesn’t mean being pro- or anti- medication. It means supporting people to make their own decisions balancing the risks and benefits involved. Adverse effects and other dangers of psychiatric medications are examined alongside circumstances where medications have great usefulness.

## **A Case Study: successfully working with a woman hearing voices in a residential drug/alcohol rehab**



*Brendan Georgeson, UK*

### **Biography:**

**Brendan** has been the treatment coordinator of Walsingham House for over four years. He built the dual diagnosis service there in partnership with Cliff Hoyle and the other staff. His background is in addiction counselling for which he has a BSc from Bath University and in addition has received many hours training in mental health and dual diagnosis working. Brendan was a member of Bristol Dual Diagnosis Strategy Group 2009 and of the Dual Diagnosis Strategy Group for South Gloucestershire PCT (2008/9). He is the inventor of the Matrix Model of Dual Diagnosis Service Delivery, peer reviewed and published in *Journal of Psychiatric and Mental Health Nursing*, 2009, 16, 305–310,

contributor to the evidenced based Good Practice Guidelines for Treatment of Dual Diagnosis 2007 published by Turning Point September 2007 and in September 2006 co-authored 'Dual Diagnosis', the cover story for *Drink and Drug News*. Brendan is a visiting Lecturer in dual diagnosis to AoA (Action on Addiction) Foundation Degree in Addiction Counselling in partnership with Bath University.

Brendan's involvement regarding hearing voices has been with service users trying to work with their voices and recover from addiction. Brendan is an ex-service user of addiction and mental health services.

### **Abstract:**

Walsingham House is a residential abstinence based drug rehabilitation centre in Bristol in the South west of England.

In 2005 Cliff Hoyle and Brendan Georgeson developed service protocols to ensure that those with a mental disorder had equitable access to the substance misuse service under the banner of a dual diagnosis service.

Walsingham House has been offering a dual diagnosis service for over 3 years and has received national acclaim and recognition in good practice guidance published by Turning Point.

Walsingham House has a philosophy of de-pathologising mental illness and allowing the service user to express their experience of the world and for peers within the project to have empathy. This is achieved by open discussion, awareness groups and self-disclosure.

A large part of our work with voice hearers help them accept and understand their experiences, help them to deal with their voices, learn methods to cope, regain control and focus on recovering from pathologies/psychiatry and to encourage the voice hearer to meet with others with similar experiences.

The ways in which we try to achieve this involves working with the individual to help them regard their voices as real and meaningful and speaking to them in a metaphorical way about their lives, emotions and environment. With our clients being dual diagnosed that often means reframing their experience of voices telling them to drink or use drugs as a part of their illness of addiction/dependence. This metaphor technique gives the opportunity to develop resilience and to empower the individual to take a stand against the voices and not believe they have to obey or react to them. We have found that by encouraging them to describe their experience in a group setting they reduce the feelings of anxiety about being uniquely shameful and that others even non-voice hearers also experience voices telling them to drink or use drugs except they experience them as powerful thoughts rather than powerful external voices.

Relaxation techniques can help our residents develop an initial distance or need to automatically react to the voices by becoming centred in the midst of conditions. This initial stability then provides the foundation for interpreting and challenging voices.

# 18 September Afternoon programm

## Master classes

### Transformation of emotions linked to the different voices



*R. May (UK)*

*Dr Rufus May* ([www.rufusmay.com](http://www.rufusmay.com)) is a clinical psychologist working in adult mental health for Bradford District Care Trust. He has an interest in psychological approaches to hearing voices, unusual beliefs and disassociative states of mind. He has worked extensively with hearing voices groups and individuals. He has an interest in using the voice dialogue approach and mindfulness and offers training in these approaches. He is also interested in developing public understanding of mental health issues. His work was featured in the Channel 4 documentary 'The Doctor Who Hears Voices'. He is an organiser of Evolving Minds, a public meeting about different approaches to mental health. He is also one of the contributors to [www.comingoff.com](http://www.comingoff.com) a website that offers information about ways to approach psychiatric

medication reduction. As well as writing about this approach to mental health, he has also written about his own psychotic experiences when he was and his recovery process.

Abstract: This workshop is based on the assumption that voices are messengers about emotions that the voice hearer needs to give voice to. The workshop aims to consider how voice hearers can work with the underlying emotions and integrate them. A voice that tells someone to kill themselves may be expressing anger the person has not been able to express about their life. If the person can learn to express and process their feelings needs, angry voices will calm down. Sometimes voices that urge suicide represent angry feelings the person harbours towards themselves. So here there is a need to forgive themselves or develop compassion for themselves. Voices that are cruel and bullying are likely to represent past relationships that have been of a similar nature. Here the task is to build a sense of self that is resilient. Role play and positive self talk can help. Developing ways to express emotions and needs is also very important. Ways to do this will be discussed. Voices that are manipulative are likely to represent past or present relationships where the person has felt manipulated. Learning ways to be more assertive about one's true feelings and needs will be important. Challenging voices are often messengers about past tragedies and or injustices. Where there has been injustice finding ways to give voice to this is important. Difficult voices may elicit strong feelings of fear and resentment, these also need to be transformed. The person may benefit from developing a strong but calm attitude towards their voices. Ways of developing a compassionate attitude to difficult voices will be discussed.

## Recognizing ones own emotions expressed by voices



*J. Woolthuis (NL)*

### **Biography:**

**Jeannette Woolthuis** is psychosocial therapist who works mostly with children and young adults. Their problems can involve the hearing of voices or psychotic experiences.

To assist her in this work she has completed training courses in a number of therapies including art therapy, hypnotherapy as well as body-oriented psychotherapy. Further more, she gives training to different healthcareers, as well as coaching/courses with parents to enable them to assist their children in a more positive manner. Beside therapy she gives training and workshops for therapist and pedagogic courses for parents.

### **Abstract:**

What is the relationship between emotions/feelings and the hearing of voices. Can this interaction be

used to achieve a positive result. Wich method or treatment can best be used to enable clients and healthcareers to give support during the proces of recovery.

## The experienced trauma treatment according to J. Herman's book 'Trauma and recovery'



*J. Dillon (UK)*

**Jacqui** is the Chair of the National Hearing Voices Network, England, a user led charity which works to promote acceptance and understanding of the experiences of hearing voices, seeing visions, tactile sensations and other sensory experiences. She is an international speaker and trainer specialising in hearing voices, 'psychosis' and trauma. Jacqui is a member of the campaign co-ordinating committee for CASL – the Campaign to Abolish the Schizophrenia Label. She is a published writer.

### **Abstract:**

The experienced trauma treatment according to Judith Herman's book 'Trauma and Recovery'. Judith Herman's landmark work, 'Trauma and Recovery' presents a compelling analysis of the

consequences of trauma and the process of healing from trauma. Using Herman's stages of recovery as a theoretical framework to underpin and guide recovery, experiential approaches will be presented from the perspective of a survivor of trauma, promoting confidence and optimism in the possibilities of healing and recovery for all survivors of trauma and their allies.

## Preventive changes with children hearing voices



Dr. S. Escher (NL)

**Sandra Escher** was first trained at the School of Journalism in Utrecht, before she began to work at the University of Maastricht, department of Social Psychiatry. She became also a senior staff member at the Community mental Health Centre in Maastricht in 1987. Since that time she works together with Marius Romme on the hearing voices project. With Romme she wrote two books which have been translated into several languages. With him she developed the Maastricht Interview for Voice hearers. Sandra organised eight annual well attended congresses and helped voice hearers to write their presentations. In 1999 she became an honorary research fellow at the University of Central England in Birmingham. Sandra began a 3-year follow-up on 80 children hearing voices. On this research she got her

M.Phil and PhD in Birmingham and she got a PhD at the University of Maastricht. At present she is co-director of Intervoice.

### Abstract:

In children as in adults, auditory hallucinations, or hearing voices, is generally seen as a sign of psychopathology. In psychiatry, hearing voices is interpreted as a symptom of an illness, perhaps a life-long one, which has no relationship to the individual's life history. However, contemporary research challenges these assumptions.

Recent epidemiological studies have found that at least 8% of children sometimes experience hallucinatory phenomena, although only a small number have been given a psychiatric diagnosis. For the majority of the children these experiences appear to be non-pathological. This fact, along with the frequent relationship between voices and the child's life history, is often ignored.

A group of 80 children of mean age 12.9 years ( $SD=3.1$ ), both patients and non-patients, were interviewed at baseline and three times at yearly intervals thereafter. The cumulative rate of voice discontinuation over the three-year period was 60%. In 85% of children there were trauma or problematic circumstances at the onset of voice hearing, suggesting a relationship between the onset of the voice hearing and life events.

This study suggests that persistence of the voices is more related to voice appraisals in terms of intrusiveness and "omnipotence" (Chadwick, 1994) than to the severity of associated psychopathology, problem behaviour, level of functioning or patient status. The implication is that the experience of voice-hearing in children should be the target of early interventions which normalise the experience in order to reduce anxiety, offer support to the parents, and explore the problems at the root of voice-hearing. In this chapter we argue for this approach and discuss the form that early intervention might take.

# Presentations around the theme: Therapy models

## Illustration and amplification of the HIT-programme

Effectiveness of Hallucination focus Integrative Therapy

Dr. J. Jenner (NL)

### **Abstract:**

Voice hearing exists in both healthy people and patients. Its causes are many. Voices are far from pathognomonic for schizophrenia.

Voices may disturb voice hearer as well as his/her relatives and beloved persons.

Hallucination focused Integrative Therapy (HIT) has been developed for people who suffer from voice hearing, for those who have lost command of their thoughts and control of their senses.

Many voice hearers feel offended and rejected by therapists who name these voices unrealistic and hence don't properly listen to voice hearers, but try to convince them that their reality testing is being disturbed. Pivotal in HIT is the two-realities-principle. HIT accepts the reality of voices together with the reality that most relatives and therapists don't hear voices. This two-realities-principle is our starting point of a joint venture of helping voice hearers to regain control of their senses and to empower them to master their feelings and thoughts. Focus of HIT is a training of voice hearer and key figures in optimal coping with the voices. This requires a thorough investigation of the voices, their characteristics and possible meaning. But also the assessment of somatic disorders and medications that can cause hallucinations.

Effects of HIT are good. Over 80% of voice hearers and relatives are satisfied with HIT.

Seventy percent improves with HIT in terms of less burden, more control, better quality of life and improved social functioning, less depression and anxiety and less disorganisation in thinking. In a randomised controlled trial, improvements of HIT were significantly better than of a control treatment. These improvements remained over time after treatment was stopped. I will illustrate the in's en out's of HIT.

## Understanding voices in a relational framework



*M. Haywood (UK)*

**Mark Haywood**, Clinical Psychology at the University of Surrey, UK, Mark Hayward works as a Clinical Psychologist. His academic remit includes lecturing on the Doctoral Programme. Within the NHS he works as Director of Research within Sussex Partnership NHS Foundation Trust. Specialist interests and publications span three areas: the experience of hearing voices; the involvement of service users and carers within training and research; and training in psychological understandings of psychosis and psychotic experiences. Work with people who hear voices has spanned several years and has recently focussed on the exploration of voices within a relational framework – acknowledging the voice as an interpersonal ‘other’ and researching differing aspects of the relationships that people develop

with the voices they hear. These relationships are currently the subject of therapeutic scrutiny as a new form of individual therapy (‘Relating Therapy’) seeks to assertively engage the voice and transform distressing relationships into those that are experienced as more balanced and less intrusive. In collaboration with Professor Paul Chadwick (University of Southampton), a contrasting form of group therapy is being developed that draws upon relational and mindfulness frameworks to enable the hearer to disengage from distressing voices.

### **Abstract:**

The experience of hearing voices has been construed as that of relating to an interpersonal other. Attempts to understand the relationships that people may develop with their voices have drawn upon three interpersonal theories: Benjamin’s (1989) Structural Analysis of Social Behaviour; Gilbert’s Social Rank Theory (Birchwood et al (2004): and Birtchnell’s Relating Theory (Hayward, 2003; Vaughan & Fowler, 2004). Findings suggest that relationships with voices may influence the emotional response of the hearer. Similarities with patterns of social relating have also been found. Many related questions are currently being explored.

What does the use of a relational framework mean to people who hear voices? Are we merely socialising people to an interpersonal understanding, or do relationships with voices make intuitive sense (Chin, Hayward & Drinnan, 2009)?

What of the experiences of people who hear voices and do not require support from mental health services? Do such individuals relate differently to their voices (Sorrell, Hayward & Meddings, 2009)?

What about the amenability to change of relationships with voices? Can change be facilitated through a therapeutic process (Hayward & May, 2007; Hayward et al, in press)?

This presentation will address these questions with reference to qualitative and quantitative

findings from recent studies. The value of a relational framework to enhancing understandings and facilitating recovery will be explored by sharing lessons learnt from a case series of individual therapy and an ongoing trial of group therapy.

## Experience focused psychotherapy



*Dr. Dirk Corstens (NL)*

**Dirk** is a Social psychiatrist and psychotherapist working at the RIAGG (mental health service) Maastricht. Since 1992 he has been a collaborator of Romme and Escher participating in research, treatment and education on voice hearing. Leads a treatment facility for voice hearers in Maastricht. Currently preparing a PhD on courses for voice hearers and professionals and the voice dialogue method for voice hearing. Speaker at several international conferences and workshops about hearing voices.

### **Abstract:**

#### **Making sense: a systematic method to exploring the function of the voices**

The so-called 'construct' is a means to restore the relationship between life history and voices.

Often this relationship is lost because emotions that gave rise to the voices are difficult to bear. Voices represent situations that were too threatening to the person. To voice hearers their voices seem to speak in a strange code of which the original meaning became unclear. Making the construct helps to break this code. Several items from the Maastricht Hearing Voices Interview are used to elucidate the persons from the past and problems that the voices are representing. The way how to work with the construct is explained, several examples will be presented and how it can help to establish a more productive relationship with the voices.

## Hearing voices and self-care



*Marlene Janssen, Perth, Western Australia*

**Marlene** is a voice hearer and is coordinator of the Hearing Voices Network Australia.

### **Abstract:**

Hearing Voices and Self Care, Key Words: A meaningful life: self care, sustainability

How often does it happen to you that you see someone loitering along the shop-front footpaths, muttering to themselves under their breath, wearing dirty clothes and sporting an unkempt appearance? How often do we take a wide berth around such people?

Because of the “restraints” on talking about Hearing Voices and other like experiences, consumers tend to hide these experiences from mental health professionals. As a result, they are neglecting to care for themselves in a holistic

way and maintain good health. The ideas surrounding Voices are still in the dark, and most see them as negative and bad, making consumers “mad”, because they are experiencing something out of the ordinary. Traditional psychiatry would rather consumers take medications to suppress Voices, rather than working with them.

The lack of self-care impacts on how mental health workers interpret consumer attitudes and the common perception is that those who look unkempt and don’t take care of themselves do not want to work on their recovery. What consumers need is encouragement, support and education in how to look after themselves.

This paper will discuss the importance of self-care when hearing voices or other like experiences, and how mental health workers can support consumers in taking care of their basic human needs.

**Learning Objective One:** What will people in the audience gain or learn from attending this presentation?

The aim is that consumers will learn the importance of looking after themselves even if they hear voices, and that mental health workers will understand why consumers tend to neglect themselves and not take proper care of themselves and their own health. A number of tips will be provided that the audience can take home with them and try, so that their self-care enhances.

**Learning Objective Two:** How is this topic/issue relevant to mental health services and mental health issues?

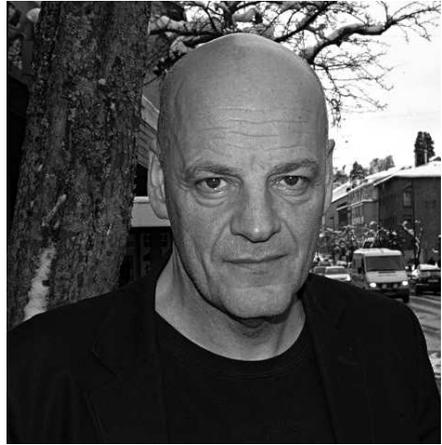
Oftentimes consumers are misunderstood if they appear to be self-neglected, and mental health workers interpret unkempt appearances and bad nutritional intake as a sign of refusal to work on their recovery and to help themselves get back on their feet and their life on track again. This myth needs to be dispelled, as many consumers are giving it their full 100%, but

need assistance to meet up to the expected of them standards to gain mental health workers' approval. Workers within mental health services need to understand fully the concept of hearing voices and the difficulty associated with this in relation to self-care.

## Focus on the therapeutic relationship and trauma treatment



*R. Nilsen (N)*



*G. Fredriksen (N)*

**Geir Margido Fredriksen** (psychologist) and **Ronnie Nilsen** (voice hearer), Norway. Ronny Nilsen: Ex psychiatric patient and voice hearer. To day he doesn't have any contact with the mental health system. He doesn't use antipsychotic medication or other medication any more. Geir Margido Fredriksen: Sosial worker and psychodrama therapist. He has a Master degree in voicehearing and have written a book "Mestringsbok for stemmehørere". He works in the mental health system with voicehearers, in group and individual.

### **Abstract:**

Ronny and Geir will lecture, play guitars and sing. In the lecture will Ronny first talk about his experience of hearing voices and his experience with the mental health care. How we together worked with his voices and how he gradual took control over his voices and life. We want to focus on the important topics in the therapeutic process, what the effects was, with focus on our relation and trauma treatment. We will also say something about how music became important for us and in his recovery.



# Presentations around the theme: Complementary therapy

## What can transpersonal psychology offer?



*A. Welling (NL)*

*Anneloes Welling-Maassen* (1954) is voice-dialogue trainer, trained at the Institute of Transformational Psychology.

### **Biography:**

After her study medicine at the University of Groningen she has been working as a generalist and as a doctor in the outpatient psychiatry. Particularly fascinated by communication and the ability of people to get the best out of themselves and each other, she took additional training in family therapy, bodywork and t'ai chi. Working with transformational psychology brings, to her, all these disciplines together; she gives workshops and trainings in transformational psychology.

She is working as a teacher at Fontys University of Applied Sciences, school of nursing. Beside workshops in transformational psychology, she gives workshops about the ways of using language, based on transformational grammar and on working with affirmations.

### **Transformational psychology:**

Transference and counter transference in professional relations

In working with voice hearers there often is transference and counter transference of emotions like anxiety and powerlessness.

As health workers we ask ourselves in this relations questions like.

“Why is working with this specific type of client so difficult to me?”

“What exactly is going on between me and this group of health workers?”

The model of consciousness as used in transformational psychology, offers a possible view on the processes behind these questions. It can be clarifying to us by its simplicity and by the fact that it touches our own daily experience, thereby showing a way of getting along with it.

Important aspect of the model is experiencing different sub personalities in ourselves: various parts of our personality. Some of these parts we know, some we don't. Basically the sub personalities are energy patterns which we have developed throughout our lives, and as such are of physical, emotional, mental and spiritual nature.

Our sub personalities interfere with those of whom we are in contact. Sometimes the interference creates “bonding patterns”. The answer on questions as posed above is often found in understanding the bonding patterns in which we are involved. These bonding patterns are also known as “transference / counter transference”.

Next to the experience of the energy patterns is the awareness.

Consciousness in transformational psychology is defined as awareness and experience of energy patterns.

Experiencing opposite sub personalities in ourselves liberates energy, creates cheerfulness and relativity. Growing awareness of our energy patterns and the role they play in our lives and in our work, creates wisdom; it allows self-consciousness and authenticity to grow.

The goal of the presentation is giving insight into the model of consciousness of transformational psychology and its relation with communication.

## Developing awareness in relations to one's voices



*S. Luckwell (AU)*

**Sigari Luckwell** is a senior clinical psychologist from, Australia, Sigari works currently part-time as a Senior Clinical Psychologist with the Western Australian Mental Health Service. She also has a part-time private practice and teaches meditation courses in the community. Originally trained in Clinical Psychology BA Hons at the University of WA, (1969-1972) and M. Clin Psych. (1976-1977), Sigari's background has included years of work in prisons (1972-1976), mental hospitals (1977-1981), student counselling (1976) working with both adults and children in all fields. In 1982 she qualified as an Analytical Psychologist (Jungian) and also undertook training and subsequent work in Art-Therapy, Dance-Therapy, Rebirthing and Meditation. In 1996 she qualified as a Cranio-Sacral Practitioner.

### **Abstract:**

Coming from Beyond. Are voice-hearers nuts? Are they receiving information or guidance? Are they like the alcoholic who temporarily hears messages when going through the process of withdrawal. And then, what about those many, ordinary instances in half sleep when some of us hear something said?

Are voice-hearers nuts? Are they receiving information or guidance? Are they like the alcoholic who temporarily hears messages when going through the process of withdrawal. And then, what about those many, ordinary instances in half sleep when some of us hear something said? We have moved along from the days when hearing voices was considered the prerogative of the psychotic mad man. I mean, what do we make of St. Paul on the road to Damascus? Did he have a psychotic episode, or was he inspired by the word of God? What makes the difference? What makes the difference is the groundedness of the voice-hearer. Many people have or profess a psychic capacity (is their third eye more open in the sixth chakra?) but if you look at their present-moment awareness, they are not necessarily grounded in their bodies. Do some psychics tend to be overweight because they are out of their bodies much of the

time? It takes an openness of the entire being to have our feet rooted on the ground and our arms outstretched to heaven; it takes awareness: an awareness that encompasses the physical body, the emotional, astral, mental and spiritual. Western pioneers like Freud and Jung mapped out the unconscious at the beginning of the twentieth century. From the east we more have maps of the superconscious that reveal more meditative states. Let's look at these together so that voice-hearing as pathology or guidance or just 'one of those things' becomes clearer. Even so-called pathology is largely conceptual and can be explored for the feeling tone and physical dynamics that ask for expression from within. The other question to ask is, 'Has the ego gotten hold of the voice for its own ends?' Or, is the voice-hearer so egoless, that the phenomenon is no big deal because it is a natural facility of being at one with existence. All voice-hearing is of the mind whether of the unconscious or of the superconscious: the next step is beyond the mind into meditation.

## Spirituality, trauma and psychosis



*Prof T. Luhrmann (USA)*

**Professor Tanya Luhrmann**, Depts Anthropology and Psychology, Stanford University, California, USA, an anthropologist with long ethnographic experience with psychiatry, psychosis and religion.

### **Abstract:**

Back in the era when psychoanalysis dominated American psychiatry and symptoms were vehicles of meaning, not by products of the broken brain, many people—anthropologists and others—assuming that modern society's schizophrenia was non-modern society's shamanism. Then the culture of psychiatry changed. The new biomedical psychiatry created strict boundaries between the "truly" sick and those who can function with culturally appropriate behavior.

By the criteria of modern biomedical psychiatry,

the shaman can usually not be diagnosed as schizophrenic. Modern American psychiatry, while perhaps admitting that there is a cultural range to hallucinatory experiences, would nonetheless insist upon the psychological difference between the dissociative voices heard as the result of trauma (experienced 'inside' the head), the voices of psychosis (experienced 'outside' the head) and the inspirational, sought after voices and visions of spiritual experience. At the same time, our increasing research sophistication has led to the realization that the boundaries between spirituality, trauma and psychosis might not be as clear as the biomedical paradigm suggests, and yet clear enough to distinguish distinct subtypes.

This paper uses rich ethnographic fieldwork in contemporary experiential evangelical Christianity and empirical work among Christians to discuss the range of unusual sensory experiences—in particular, auditory sensory experiences—and their associations.

In particular, it argues that a proclivity for absorption may be associated with some voice-hearing experiences and not others. Roughly one third of the ethnographic sample and one half of the empirical sample report at least one form of unusual sensory experience. For the most part, these phenomena are patterned in different ways than those phenomena described as “psychotic.” Nevertheless, these are complex distinctions and there is a small category of persons who hears or sees often, but exhibits no signs of psychosis (Claridge identifies such persons as “schizotype,” although the name implies more pathology than he intends.). Some psychiatrists interpret all such unusual symptoms as evidence of vulnerability towards psychosis. This evidence of different patterns of experiences suggests that the phenomenon may be more complicated. In fact, the ethnographic evidence suggests that unusual sensory experiences may have a relationship to training or practice. .

## **Clairaudience in the Spiritualist Church: When hearing spirits is a culturally sanctioned experience**



*Dave Harper*

*Jo Temple & Dave Harper*  
University of East London

### **Biographies:**

Jo Temple is a final year clinical psychology trainee at the University of East London. She has a deep interest in the relationship between religion, spirituality, peak experience and ‘psychosis’. Her doctoral research looked at experiences of hearing spirit voices in the Spiritualist Church. As part of her current training post she has worked clinically in a range of health settings across London.

Dave Harper is a Reader in Clinical Psychology at the University of East London where he has been since 2000. Prior to that he worked in NHS mental health services in the North West of the

UK for over ten years. His research interests are in critical psychology and social constructionist approaches in mental health, particularly in relation to psychosis. He is member both of the editorial collective of *Asylum: The Magazine for Democratic Psychiatry* and of the Advisory Group of the London Hearing Voices Project.

### **Abstract:**

Many voice hearers involved with psychiatric services say that their experiences are not accorded any value or meaning. By way of contrast, members of the spiritualist church who hear voices may be seen as being clairaudient (the ability to hear and communicate with spirits). Clairaudient mediums are highly valued, and the ability to hear spirits is seen as ‘a gift’. This study sought to explore the aspects of mediumship that were found to be helpful in

managing these experiences. Seven Spiritualist mediums who heard spirit voices, either externally or internally, were interviewed (by the first author -- a non-Spiritualist researcher) about their experiences and how they arrived at this interpretation. A qualitative analysis identified that the mediums heard spirits in a range of ways, but all shared the belief that the content of what they heard was meaningful, and was generally intended to be helpful or comforting to themselves or to others. In order to find ways to manage negative or overwhelming experiences, each medium had spent time with more experienced mediums in 'development circles'. This enabled them to learn techniques for invoking protection from malevolent spirits, and strategies for negotiating with spirits - allowing them to feel more in control of their experiences. Each medium said they valued their role as it meant they were able to both help others and experience personal growth; by learning from their spirit guides and by perceiving themselves and the world differently. Implications for voice hearing outside of the context of the Spiritualist church will be discussed.

## What does transpersonal psychology have to say?



*R. Suri (USA)*

**Rochelle Suri**, San Francisco. PhD student in psychology, she holds a M.A degree in Integral Counseling Psychology from the California Institute of Integral Studies, where she also currently pursues a Ph.D in East West Psychology. She has lived in San Francisco for 7 years, before which she resided in India and the United Arab Emirates. Being exposed to several cultures and ethnicities, Rochelle has enormous experience working with diverse populations and minorities. She is currently pursuing her Marriage and Family Therapist license in the state of California. Rochelle is dedicated towards integrating western psychology and eastern spirituality within the realms of her psychotherapy practice. She has worked with the geriatric population for over 4 years. Currently, Rochelle is involved in her

ongoing research on auditory hallucinations in schizophrenia, a paper she has also presented at the First Global Conference on Madness in Oxford, England.

### **Abstract:**

Hearing voices or auditory hallucinations have been considered and investigated from various schools or branches of psychology. Psychoanalysis, cognitive-behavioral psychology, neuropsychology, humanistic psychology and psychiatry (among other branches), have shed light on the nature and causes of hearing voices. These disciplines have sought to discover means of managing or coping with the voices, providing sufficient literature on the same (see Bentall, 2003; Fadiman & Kewman, 1979; Romme; 1993).

However, there appears to be a dearth of research and literature on transpersonal perspectives on hearing voices. Transpersonal Psychology, considered the fourth force of psychology, provides a unique view of hearing voices, respecting the voice hearers and their experience. Simultaneously, transpersonal psychology is concerned with finding ways to integrate the experience of voice hearing into the individual's day-to-day life. Nonetheless, as a branch of psychology, transpersonal psychology has been overlooked by psychologists who are primarily interested in the behavioral, developmental and cognitive facets of the human experience. Hence, this paper aims to illuminate the contributions of transpersonal psychology to the experience of hearing voices. Elaborating on the tenets of transpersonal psychology, as well as focusing on the etiology, nature and approaches to hearing voices from a transpersonal lens, this paper will highlight a radical perspective on voice hearing. Transpersonal and spiritual implications of voice hearing will be discussed, as well as the pioneering work of Grof (2000), Jung (1960), Lukoff (1985) and Nelson (1994). Transpersonal approaches within psychotherapy will also be elucidated through brief case examples.

## Presentations around the theme: Special issues

### Prevalence of hearing voices in the normal population

*B. Kårkvik (N), A. Kalhoven (N), F. Leroi (N), K. Hugdahl (N), E. Vedul-Kjelsås (N)*

**Bodil Kråkvik** works as a leader of a research department at Nidaros DPS, St.Olavs Hospital in Trondheim (Norway). She is a reg. mental health nurse and is engaged as a leader of a randomised, controlled trial of cognitive therapy for persons suffering from delusions and auditory hallucinations.



*A. Kalhoven (N)*

**Anne Martha Kalhovde** is a reg. mental health nurse and PhD student at the University hospital in Northern-Norway, Tromsø. She has been engaged in interview studies on experiences with voices, establishing selfhelp groups for voicehearers in the region and a norwegian hearing voices website [www.romforstemmer.no](http://www.romforstemmer.no).



*F. Leroi (N)*

**Frank Leroi** works as a lecturer and researcher in the Cognitive Psychopathology Unit, University of Liège (Belgium). His research interests include examining cognitive and emotional mechanisms involved in hearing voices in nonclinical participants.

**Abstract:**

Background: Traditionally, hearing voices has been related to mental disorders and abnormal behaviour. Several studies in the US, and Europe have shown that people in the general population hear voices. These studies give reason to believe that the majority of individuals in the general population who hear voices are not in need of mental health care. Decreasing prejudice and taboos related to hearing voices seems to be important for both those in need of mental health care and those who manage without. There has been little focus on this in Norway.

Aim: We aim to give prevalence figures from the general population in Norway in the first community-based prevalence study in Scandinavia. Furthermore, we want to increase the knowledge about hearing voices among health workers, and to decrease prejudice in the population.

Method: A total of 8000 women and men aged 18-90 years, randomly recruited in a two-step design with postal questionnaires and subsequent interviews. The Launay-Slade Hallucinations Scale (LSHS, Launay and Slade, 1981; modified version Larøi et al., 2004) were used.

Results: Preliminary results will be available in September.

## Comparing benign and pathological voices

***Mike Jackson***

Consultant Clinical Psychologist

North West Wales NHS Trust/

University of Bangor

Mike.Jackson@nww-tr.wales.nhs.uk

**Abstract:**

We wanted to compare the experiences of voice hearers who do and do not have a mental health diagnosis. We recruited 20 patient voice-hearers and 20 'benign' voice hearers and interviewed each one about their life histories and experiences of and beliefs about their voices. Preliminary results suggest that the patients had more negative beliefs about their voices and that these were influenced by more negative experiences in their pasts such as trauma and attachment difficulties. We then offered everyone an fMRI brain scan to see what was happening in their brains while they heard voices. Not everyone wanted to have a brain scan and not everyone who wanted one was able to go through with the procedure but we did have viable scans from 3 patients and 7 non-patients. Preliminary data suggests that similar areas of the brain, namely language and hearing areas, were activated during voice-hearing in both sets of participants.

# ASSESSING AUDITORY VOCAL HALLUCINATIONS: THE PSYCHOMETRIC EVALUATION OF THE AUDITORY VOCAL HALLUCINATION RATING SCALE (AVHRS)



*A. Bartels (NL)*

**Agna A. Bartels-Velthuis**, Gerard van de Willige, Jack A. Jenner, Durk Wiersma  
University Medical Center Groningen, University Center for Psychiatry, Groningen, the Netherlands  
a.a.bartels@med.umcg.nl

## **Abstract:**

**Background:** Assessing characteristics of auditory vocal hallucinations (AVH) is a key issue both for clinical practice and research purposes.

Therefore, a structured interview was developed, the Auditory Vocal Hallucination Rating Scale (AVHRS). Its psychometric properties were examined in terms of inter-rater agreement, internal consistency and face validity. Also, a first step in investigating concurrent validity was made.

**Method:** All patients (n=62) of the Voices

Outpatient Department of the University Medical Center Groningen in a defined period, were interviewed with the AVHRS about voice hearing in the past month. Inter-rater agreement was established on 23 successive interviews. Analyses of internal consistency included all 62 interviews. Concurrent validity was analysed by comparing the AVHRS severity index with SCL-90 indices. Internal consistency rates were also established in a general population sample of 347 voice-hearing children aged 7 and 8 years. Inter-rater agreement was also established in the follow-up study of the children's sample. Patients were systematically questioned to assess face validity.

**Results:** Agreement analyses showed weighted kappa's of 0.84 and 0.88. Internal consistency (Cronbach's alpha) was 0.84 (adult sample), respectively 0.77 (children's sample). Pearson's correlation coefficients with the SCL-90 were  $r=.66$ ,  $p<0.01$  (psychoticism dimension) and  $r=.62$ ,  $p<0.01$  (SCL-90 total). According to the patients face validity was very good.

**Conclusion:** Analyses thus far showed that the AVHRS is a comprehensive instrument with good psychometric properties, for a thorough assessment of characteristics of auditory vocal hallucinations. It seems useful in both clinical and research settings.

## Voices and the concept of the ‘double-brain



*L. Blackman.Ph.D. (UK)*

**L. Blackman.Ph.D. (UK)** Senior Lecturer in Communications, Goldsmiths, University of London, London,

### **Abstract:**

What has been left out or silenced in psychiatry’s engagement with this issue? I will focus on Julian Jayne’s book, *The Bicameral Mind*, and explore how this concept has re-emerged in contemporary psychiatric discourse, albeit, silencing the important aspects of Jayne’s work which allow an engagement with voices as potential sources of inspiration/creativity and trauma/abuse. This is part of my current book which is exploring how the hearing of voices can be both containing and yet also disturbing and how these embodied experiences can be approached more relationally

through techniques which work through more non-cognitive registers.

## The need for assessing positive hallucinations



*S. Rutten (NL)*

**Sonja Rutten**, Janke Beuckens, Nynke Boonstra, Sjoerd Sytema, Jack A. Jenner  
University Medical Center Groningen, University Center for Psychiatry, Groningen, the Netherlands  
s.rutten@psy.umcg.nl

**Introduction:** Voice hearers who seek treatment often suffer from negative auditory vocal hallucinations. However, some of them also report positive or useful voices, that they wish to preserve. When this wish is neglected by their therapist, this may lead to rejection of therapy or low compliance. This study describes prevalence, characteristics, course of and attributions to these voices in psychotic and non-psychotic patients.

**Method:** For this study, the Positive and Useful Voices Inquiry (PUVI), a self-report inventory,

was developed. Auditory hallucinations of 131 patients of a Voices Clinic and 65 members of the Dutch Resonance Foundation were assessed with the PUVI.

Results: First voices are most often reported as negative. The lifetime prevalence of positive voices ranged from 50 to 75%, useful voices were reported by 40 to 60% of respondents, with higher prevalences among the members of the Resonance Foundation. Positive voices occur more among non-psychotic patients. No significant association was found between voice characteristics and diagnosis. Attributions of protective power to positive voices has the strongest association with positive experience. Useful voices that are advising are experienced as most useful. Over 30% of respondents want to keep their positive and/or useful hallucinations. This wish is significantly associated with perceived control over the voices.

Conclusion: The prevalence of positive and useful voices is considerable and a substantial part of voice hearers want to preserve these voices. Therefore, assessment of these voices is important for both clinical practice and research purposes.

### **A poll to sensibilitize the public.**



*Theresja Krumenacher (SW)*

#### **Abstract:**

The campaign aiming at sensibilisation the public to intra-, extra - sensorial perceptions, especially of voices, is a start of REEV (Voice Hearers Network). So as to begin to inform two population it seemed that a poll was an adjusted method. We do not have the ambition to pretend that our results are exhaustive, nor représentative. They are merely tools to compare and reflect on the basis of what we collected and which deserve to be recorded.



## Discussion group around the theme:

### Alternatives for schizophrenia

#### The History of the Schizophrenia Label



*Bill George (NL)*

**Bill George**, MA Cantab., PGCE, has been diagnosed with schizophrenia. He published his story about his route to recovery way back in 1987 in *Social Work Today*. In that article he describes his traumas related to sexuality both as a child and as an adult. He is a member of the Anoksis Think Tank. Anoksis is the Dutch Association for people with chronic psychosis or schizophrenia, the Association which has started a competition to find a better label for schizophrenia. Anoksis means ‘open mind’.

#### **Abstract:**

**The History of the Schizophrenia Label.** At the end of the 19th century the German professor Emil Kraepelin used the term *dementia praecox* to distinguish premature senility from manic

depression. Although the idea was around in the 19th century, the Swiss psychiatrist Eugen Bleuler did not introduce the term schizophrenia—to mean split mind—until 1908. In the 1980’s Marius Romme here in Maastricht showed that delusions and hallucinations occur sometimes to people who are not mentally ill. Romme and his successor here, Jim van Os, also argued that the malady schizophrenia does not exist as a distinct entity. At the beginning of the 21st century the movement to abolish the schizophrenia label really got under way. But it encountered certain paradoxes. How can you abolish schizophrenia if it does not exist? And if indeed it is instead Post-Traumatic Psychosis or Trauma-Induced Psychosis, then would it not exist but under another name?

In 2002 Japan replaced ‘split mind’ by Togo Shitcho Sho to mean integration disorder, followed by Hong Kong. Korea is about to follow suit. In February of this year Jim van Os published an Editorial in the *British Journal of Psychiatry* arguing for the name *Salience Dysregulation Syndrome*. My challenge was that the term *Salience Dysregulation* was obscurantist and demeaning. My own psychiatrist, Dr Henk Colijn, asked me, “What does salience actually mean?” I thought to myself, “I had hoped you would tell me!”

Now..... since February I have come across the term *salient* regularly. It comes from the French *saillant*, meaning standing out conspicuously. In psychopathology it refers to internal or external stimuli that have come to have greatly increased relevance, significance or ‘reality feel’.

The question is, “How can there be two realities, one for the patient and one for the doctor?” In my view the way forward in order to change the image of my illness is to emphasize the positive through the recovery movement, or as Wilma Boevink calls it, the discovery movement. In the meantime we in Anoiksis, the Dutch Association for people with chronic psychosis or schizophrenia, have started a competition to find a better name for the sickness. The winner will be announced at a gala on 3 October in the Trianon in Utrecht here in the Netherlands.

## Campaign for the abolition of the schizophrenia label



*P. Hammersley (UK) Spectrum Centre,  
University of Lancaster UK*

### **Abstract:**

In 2005 after a Hearing Voices Network conference in Manchester UK, a group of individuals consisting of Peter Bullimore, Jacqui Dillon, Paul Hammersley and the late Terry McLaughlin decided to form a Campaign to have the diagnosis / label of schizophrenia removed from psychiatry.

The campaign was motivated by two main reasons, firstly the very poor science that underlies the diagnosis of schizophrenia, secondly the appalling stigma associated with this label and the unfair association it has with hopelessness and dangerousness. The campaign was joined by Marius Romme and Sandra Escher along with other academics and individuals from within the users movement, the campaign was formally launched at The Science Media Centre in London in 2005, and the first CASL conference which was a sell

out was held at Thornton Hall in Merseyside in October 2006. CASL now has supporters all over the world and is actively campaigning to have the diagnosis of schizophrenia removed or at least significantly modified in the new diagnostic manuals which are to be published in 2011. This presentation will comprise of the reasons behind the forming of CASL, the progress to date and advice on how you can help

## Salience disregulation syndrome



*Prof. Dr. J. van Os (NL)*

### **Abstract:**

Discussion around the theme of the morning speech. Japan was the first country to abandon the confusing and mystifying 19th century term of “mind-splitting disease” (schizophrenia), replacing it with a scientifically more valid concept. Revisions of DSM and ICD are forthcoming. Should the rest of the world follow Japan’s example and similarly develop a new system of representation of psychosis?

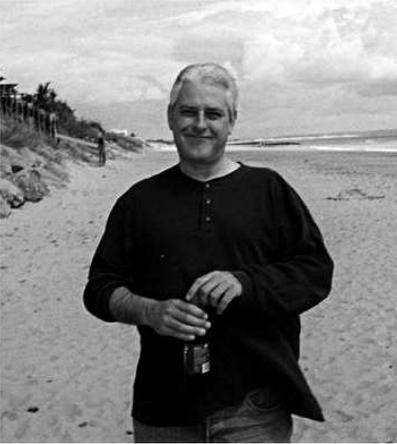
The discussion about re-classifying and renaming schizophrenia and other psychotic disorders is clouded by conceptual confusion. First, it is often misunderstood as a misguided attempt to change societal stigma by changing the name. This is not the case, however, as renaming schizophrenia may be more correctly conceived as an attempt to change iatrogenic stigma occasioned by the use of misleading, mystifying and,

ultimately, stigma-inducing terminology. Second, it is misunderstood as a purely semantic discussion, whereas in actual fact it touches on the very core of psychiatry: which concepts should be used to represent and communicate about psychiatric nosology?

In other words: the discussion is about an entirely new concept of classifying psychotic disorders. Third, it is seen as a discussion about a single diagnostic category: schizophrenia, that has a population prevalence of 0.5% . In actual fact, however, it is about the total morbidity force of psychosis and its current myriad of diagnostic categories in DSM and ICD with an estimated prevalence of 3.5%. Fourth, it has been suggested that the debate is political. This is not the case however, as solid scientific evidence pointing to the absence of nosological validity of diagnostic categories that nevertheless invariably are subject to paradoxical psychiatric reification, lies at the heart of the argument. Fifth, there is much confusion about the scientific distinction between what constitutes a syndrome (a group of symptom dimensions that cluster in different combinations in different people and for which one or more underlying diseases may or may not be found) and a disease (a nosologically valid entity with specific causes, symptoms, treatment and course). Is it argued that both scientific and societal developments point to a syndromal system of classification combining categorical and dimensional representations of psychosis in DSM and ICD.

It is proposed to introduce, analogous to the functional-descriptive term “Metabolic Syndrome”, the diagnosis of “Salience Syndrome” to replace all current diagnostic categories of psychotic disorders. Within Salience syndrome, three subcategories may be identified, based on scientific evidence of relatively valid and specific contrasts, named Salience syndrome with affective expression, Salience syndrome with developmental expression and Salience syndrome not otherwise specified. It is argued that the concept of “salience” not only has scientific validity, but also has the potential to make the public recognise psychosis as relating to an aspect of human mentation and experience that is universal, thus potentially reducing stigma and exclusion.

## The Irish solution



*B. Hartnett (IR)*

is a voice hearer and founder of HVN Ireland, Ireland, A Peer Advocate with The Irish Advocacy Network (IAN). He has also started an organisation called Hearing Voices Ireland (HVI). He facilitates the Friends group for Schizophrenia Ireland (SI) {soon to be known as Shine}. This is a self help group for people with mental health difficulties not just Schizophrenia. I am also helping Shane Maher who set up Campaign Against Suicide (CAS) to open up a drop in centre in Limerick for people who are suicidal. I am also a member of The National Service User Executive (NSUE). NSUE is like a union for service users. They also support carers and have produced an information booklet for carers called 'The Journey Together' in conjunction with the HSE, IAN and Shine.

### **Abstract:**

I was diagnosed with schizophrenia in 1996. I was diagnosed with schizophrenia because I told the psychiatrist I was 'hearing voices'. I had been having a lot of 'unusual' experiences for a number of years in particular feeling that I was connected to a force far greater than me as an individual. This included 'hearing voices' but it was much more than this.

Because I had lived with this extra layer of experience for so long it had become my way of life. I found it hard to relate the enormity of what I lived with to other people and learned to cope with dealing with consensual reality and my reality at the same time. Being diagnosed with schizophrenia and being told that I would have to take psychiatric medication if I was to get better added an extra element to my life. The idea that what I was experiencing was a mental illness never made any sense to me as I knew that I was not mentally ill, I just had a different experience of reality to most people around me.

The medication did not bring me back to consensual reality but simply numbed my perception and affected my physical, mental and spiritual wellbeing adversely. Thirteen years later my life journey has brought me to the conclusion that my wellbeing is paramount to myself and others and that it is a balance of being strong in the three areas of mind, body and soul simultaneously.

As regards my perception of my double layer of reality I believe that I experience the physical and spiritual at the same time and that when I 'hear voices' that are not of the physical world they are of the spiritual world. I believe that there is a balance between the two and for some people like me they live with an awareness of both at the same time.

To diagnose people like myself with a concept of a mental illness such as schizophrenia is a denial of their reality and does not help them to live with this reality. The idea that people like myself are mentally ill with a life long illness such as schizophrenia causes confusion about the validity of individual perception of reality and leads to division between families, friends and communities.

People like me who have been diagnosed as mentally ill often become very isolated. I started Hearing Voices Ireland (HVI) in 2006 and I believe its main function is to help improve and support social networking amongst people who have become isolated in this way.

## The Japanese solution



*W. Sato (JP)*

### **Biography:**

Wakio Sato, Japan

The representative of the Hearing Voices Network Japan since 1996. The president of the Japanese Association of Clinical Psychology since 2005. The representative of an NPO named “Linden” for community mental health founded in 1999 in a countryside, Konko-cho, Okayama prefecture, where I live.

Born in 1938. Majored educational psychology at Tokyo University and graduated in 1961. Worked at several facilities for juvenile delinquents as a psychologist officer for 9 years. Changed careers to a psychiatric hospital and worked for 21 years. After that, studied and worked abroad at the Richmond Fellowship in Britain placed at a halfway house for community mental health for

two and a half years. During this period, got an opportunity to attend the first meeting of Hearing Voices held in London in 1991, which was really a great encounter with Hearing Voices, meeting Marius, Sandra, Paul and others. After returning, translated the article “Hearing Voices” by Marius and Sandra, to be put on the Japanese Journal of Clinical Psychology. Since then, have been working to promote Hearing Voices in our country, organizing the network and meetings, and issuing its newsletters. Also working to organize symposia and workshops in the conventions of our Clinical Psychology Association. Wrote articles and essays about Hearing Voices on its journals. In 2000, helped organizing lecture meetings by Marius, Sandra and Ron inviting them to the convention of our Association. In 2002, attended the 12th World Congress of Psychiatry held in Yokohama, Japan, and helped organizing a couple of symposia re. Hearing Voices attended by Romme, M., Thomas, P., other colleagues of Japanese and myself. Having been attending the INTERVOICE meeting many times.

# Hearing voices groups

## How people experience hearing voices groups

Findings of a qualitative research study into hearing voices undertaken with assistance of HVN England



*Judy Kriby*

### **Biography:**

I have a clinical background as a Registered General Nurse, and academic qualifications in applied social sciences. My interest in the phenomenon of hearing voices dates back to the early days of my student nurse training in the 1980s; during this time I had contact with (non-distressed) voice-hearers in spiritualist groups and (distressed) voice-hearers in the mental health care system.

I was intrigued by why the phenomenon is experienced so differently; distressing for some voice-hearers but not for others. Following the completion of a BA in Applied Social Sciences in 1999 I successfully applied for a PhD studentship exploring 'schizophrenia' and gender. Given that there is an association between 'hearing voices' and the highly debated diagnostic category of

'schizophrenia', the studentship offered me an opportunity to revisit my long-standing interest in the phenomenon. During my literature searches I found the ground-breaking work of Professor Marius Romme and Sandra Escher and began to shape my study around the idea of hearing voices as an interactional phenomenon in terms of how it is experienced. During the early days of the study I received much appreciated support from the Manchester branch of the Hearing Voices Network; I was honoured to serve for twelve months as a Trustee. I am currently a Senior Lecturer at Edge Hill University, Ormskirk, UK.

### **Abstract:**

This paper gives an overview of findings from a recently completed qualitative PhD study exploring the phenomenon of hearing voices from the perspective of those who experience it. The purpose of the study was to explore the impact of social (situational) processes/factors on shaping experiences of the phenomenon, and in particular those linked to gender. Over the course of the study other situational processes/factors such as those linked to 'race' and experiences of abuse also emerged as significant in terms of how the phenomenon is experienced.

The theoretical framework drew upon feminist theory and the work of American Pragmatist Philosopher G.H. Mead who developed a situated, embodied, reflexive ontology to understand the self/society relationship. Sixty-two self selected voice-hearers were recruited to participate in the study through an advertisement placed in mainstream media publications and the

Hearing Voices Network. Participating voice-hearers included mental health care services users, ex-service users and voice-hearers who had never sought out mental health care intervention. The findings from this study suggest that social situational processes/factors underlie both the commonality (as voice-hearers) and differences between voice-hearers.

Gender was significant only in the experiences of voice-hearers for whom gender was socially 'problematic' in some way. More broadly, voice-hearers who experienced relatively unproblematic social circumstances experienced relatively unproblematic voice-hearing. Generally, distressing or problematic social circumstances resulted in distressing or problematic experiences of voice-hearing. The therapeutic message from the findings suggest that in terms of interventions for distressed voice-hearers, comparing their experiences with non distressed voice-hearers is akin to comparing apples and pears. The social circumstances of voice-hearers are of fundamental importance in terms of how the phenomenon is experienced.

## **Setting up and facilitating hearing voices groups in London**

R. Waddingham (UK)

Abstract:

Not received

## 17 benefits of a hearing voices group



*F. Brummans (NL)*

*Flore* was sexually abused from her 6th till her 14th, when she tried to tell about it she only was punished or it was denied. Even in the psychiatric hospital where she was advised to burn the story she had written about the abuse. After 34 years getting haldol at last in high doses injected every week made a zombie out of her, she found a self-help group. Here she could freely tell her story and about her voices. Flore will tell about the 17 advantages of the self help group she recovered with. She also found there someone who supported her to stop with the medication and she got her feelings back. Flore will tell about the advantages of self-help with other people who hear voices and have been abused. She now is 8 years free of medication and functions very well as an active organizer. Some we will tell about here

1. The opportunity to talk about voices and other experiences in a frank and open manner. "I did not dare to tell my counsellor, I was scared to be admitted. In the self help group I had the courage to do that, others had that courage too there and that is when I thought: 'I'm not the only one'. When I started talking about it, it helped me and also, that I dared to admit it."
2. My experiences were accepted as reality. "I had many tasks that I executed, I felt ashamed about that I did not dare to come out in the open with these. I hurt other people. Now that it has been accepted by me and others, I am far more in control of it."
3. The fact there are many more voice hearers and I am not the only one  
That was great for me and important to express myself and dare to tell about them
4. That I did not have to keep my experiences a secret any longer or that I had to defend myself. "I still keep it a secret and I only talk about it in the self help group. That has a positive impact. Outside the group I don't talk about it, I dare not. You cannot transfer it to other situations. People in the self help group experience freedom.
5. That I can work with my voices and that I don't just have to suppress or obey them. "That helps me."
6. That I was given positive encouragement for the small steps I made. "That applies to me too."
7. That I progressed in my dealings with the voices. "I've got them under control and that is encouraging."
8. That I learned to recognize when to expect the voices. "Yes, when you think about it, it does help as you are able to do something else, where in the past you just let it happen."
9. That I became increasingly convinced that the voices had to do with me personally. "They related to me as well as having a relationship with my personal history. "
10. That I learned not to obey the voices blindly, but to realize that I had my own opinion. "That was a very big step, and it only came late, in the self help group."

11. That I learned about the relationship between my voices and what had happened to me.  
I knew already that the voice was the voices of the abuser, but I learned that the anger he expressed was my anger.
12. That I learned to listen more carefully to these voices and to talk to them.  
“In the past I only obeyed, but I never talked to them. I’ve become stronger within myself. I gained insight into what I was doing.”
13. By talking to the voices I started to discuss topics with them which until then I had mainly kept a secret to myself. “Not applicable to me.”
14. That I can cope with certain activities better again like e.g. shopping, playing sports,  
“I did not live for 34 years. Because of the self help group, I have become more active again.
15. That I became a member of a club again, which made me less lonely. “The self help groups really work” (Time-out).
16. That I could cope better with my daily activities again. That helped in managing my voices better. undeniably: yes.
17. That I’ve started a course again. “I’ve given and followed many courses which helped me a lot.”

## Support group activities in Italy



*P. Pini (I)*



*D. Miccinesi (I)*

Pino

Pini, Mental Health Europe and Donatella Miccinesi, Italian Association for Mental Health (AISMe)

### **Abstract:**

We will present an update of our work in Prato and Florence during the last fifteen years with people who hear voices. We will describe the development of our mental health association AISMe and the relationships with other associations wanting to share our experience with voice hearers. Some relationships with the mental health services, with the GPs, with the social workers, will be also described. Finally we will speak about our international local mental health system project which continues to be the main frame of our work and the guarantee of a positive developments within our local context

## Recovery promoted by Hearing Voices groups in Denmark



*J. Sparvag (DK)*



*A. Schakow (DK)*



*T. Eyles (DK)*

***Trevor Eyles, Johnny Sparvang and Anders Schakow*** are from Denmark

Trevor Eyles is developmental consultant employed in Social Psychiatry in Aarhus to work solely with voice-hearers, to implement services, and to teach a growing group of professionals in the greater Aarhus area.

**Abstract:**

Two voice hearers (Johnny Sparvang and Anders Schakow) have all learned to cope with their voices in different ways whilst working closely with mental health services. They will give a candid view of their respective recovery processes, including discussing the obstacles thrown up along the way.

## The Italian group from the region of Genua



*Marcello*



*Christina*



*Angelo*



*Alessandra*

Biographical information about Marcello Macario; Franco Angeli and Christina Contini and Alessandra.

Marcello Macario, started as a Psychiatrist to work with voice hearers, and became a very stimulating person for the Italian national network together with Franco Angeli, who in 2006 translated Ron Coleman's book, and composed a book about hearing voices in a new style, with a chapter accepting and making sense of voices. Together with the voice hearer Cristina Contini from Capri, they make a stimulating trio organizing and leading hearing voices groups in their areas.



**At the Mecc in Maastricht there will be an exhibition of Susans work**

## **SUSAN J ADAMS**

### **they leak through me**

*a visual exploration  
of the hearing of voices*

ISBN 978-0-9545595-1-9



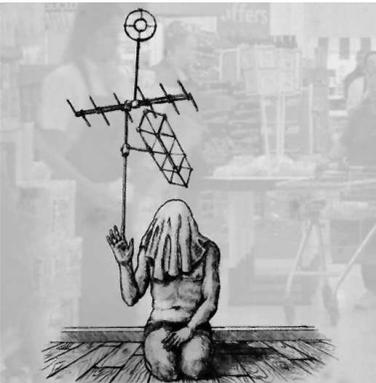
The hearing of voices has spiritual and cultural implications historically, not just through accounts of the lives of the saints and hermits but reaching far beyond into prehistory. Largely because of the stigma and taboo associated with unusual mind experiences and mental health issues today we seldom have a chance to consider the visionary and creative potential in the phenomenon of voice-hearing. My intention with the launch of this booklet is to promote interest and discussion about hearing voices as something much more than a “pathological” experience.

As a visual artist attempting to understand what it is like to live with voices, I have been privileged to listen to people talk about their experiences. Also drawing on published accounts of voice-hearers and seminal texts I have made a series of 14 drypoints reflecting what I have heard and read. The images come together with extracts from my interviews with voice-hearers in a publication that resembles the form of a CD booklet, suggested by the idea of images given to accompany an auditory experience.

Susan J Adams

[www.susan-j-adams.co.uk](http://www.susan-j-adams.co.uk)

The project was a collaboration between Susan J Adams and Safile with the financial assistance of the Arts Council of Wales. The publication is generously supported by a Chance to Create Award funded by the Rural Development Plan for Wales 2007 - 2013 which is financed by the European Union and the Welsh Assembly Government.



# Secretary of Intervoice

Responsible for the website



*Paul Baker*

**Paul Baker** is a community development and group worker, specialising in working with young people and people with mental health problems. Paul has worked in the health care and education sectors for the last 30 years. He helped develop innovative mental health care services in the community including services run by the people who use them, self-advocacy services, supported housing services, social firms and enterprises as well as the development of forums for people to enable them to have a direct input in the development and running of services. For fifteen years Paul was the chairperson of a large housing association for homeless people in Manchester.

Paul was one of the founding members of the Hearing Voices Network in England and is currently the coordinator of INTERVOICE, the influential coordinating body for the international hearing voices movement. He also specialises in assisting organisations in harnessing and developing on-line communities to complement

and support their work. More recently Paul has worked with the Mental Health Foundation, Working to Recovery, Radish Online Ltd and the Scottish Hearing Voices Network. He has a special interest in working with groups of people to find ways of help themselves overcome difficulties and problems. He also has a strong commitment of forging international partnerships in the development of progressive and effective mental health services. Paul has published books and written chapters and articles for many publications on mental health issues. He provides consultancy services, lectures and trains on empowerment and recovery issues and the relationships these have to developing effective mental health services.