Dialogical engagement with voices: A single case study

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This paper raises the possibility that a dialogical, or discursive, model of human experience may be useful in helping someone who experiences verbal hallucinations. The model regards verbal hallucinations as a variety of inner speech with dialogical properties. The explication of these properties in the context of a personal narrative allowed the individual to engage in dialogue with the voices, through the medium of a new, supportive and positive voice. This process made it possible to introduce moral responses to distressing and potentially dangerous imperative verbal hallucinations, through the mediation of the new voice. Her dialogical engagement with this voice enabled her to deal effectively with troublesome voices, and was a powerful source of self-esteem. We briefly present the theoretical perspective underlying this approach, and compare and contrast the approach with cognitive–behavioural techniques.

In psychiatry, the experience of hearing voices is usually referred to as 'verbal hallucinations' (VHs), and regarded as symptomatic of psychosis. It may also occur after bereavement (Rees, 1971), in people who have experienced sexual abuse (Ensink, 1993) and in non-psychiatric individuals (Leudar, Thomas, McNally & Glinski, 1997; Posey & Losch, 1983; Tien, 1991). Recent work suggests that voices may respond to psychological interventions. Kingdon & Turkington (1991) have argued that cognitive therapy has a role in helping people suffering from schizophrenia, especially in conjunction with pharmacological and social interventions. Chadwick & Birchwood (1994) have demonstrated the value of cognitive therapy in altering voice hearers' relationships with their voices. Bentall, Haddock & Slade (1994) have argued that voices arise from a failure to attribute internal mental events to self. They have described the use of focusing (Haddock, Bentall & Slade, 1993) which helps the person to re-attribute the voices to self, rather than to external sources.

Our own recent research has clarified the pragmatic aspects of VHs, by investigating the relationship between voices and voice hearers (Leudar *et al.*, 1997). We found that

voices were more often personified through alignment with individuals significant to voice hearers, rather than supernatural agencies. Voices and voice hearers usually talked to each other, with voices initiating the talk as well as responding to the voice hearers' ongoing activities. Conversations were mundane, involving the regulation and evaluation of voice hearers' activities. Voices did not impel voice hearers to carry out actions, rather they influenced voice hearers' decisions on how to act. This influence was sometimes perceived by voice hearers as almost compulsive, yet it could be resisted. Our work also provided some support for focusing. The perseverative and negative qualities of voices were greater in those who ignored their voices, and lower in those who considered the voices' commands, and engaged with them dialogically. In our view the pragmatic, or dialogical, metaphor of VHs goes beyond focusing, which involves attention management and perception. The pragmatic approach involves engaging voices dialogically, although focusing (on voices) is an inevitable consequence. Our approach (Leudar *et al.*, 1997), regards voices as an unusual form of inner speech with *pragmatic* features. Ordinary inner speech is a means of regulating and evaluating activities (Diaz & Berk, 1992; Luria, 1961; Vygotsky, 1934; Wertsch, 1991), and a medium of problem solving. There is a long tradition in psychology according to which experience is dialogically organized (e.g. Bakhtin, 1981; Mead, 1934; Vygotsky, 1934), but research into VHs has neglected their pragmatic aspects. This view is consistent with recent work on schizophrenia, which emphasizes the relationship between the person and the person's experience of psychosis (Benjamin, 1989; Estroff, 1989; Strauss, 1989). In our approach, the relationship between the individual and psychosis is construed in dialogical terms, for example, how does the person relate to the voice? Cognitive models of psychosis are monological and place the emphasis on internal mental processes. They have, therefore, problems accounting for the reflexive relationship between an individual and his or her psychosis. These models are incapable of explicating the relationship between the individual and psychosis, which may be usefully construed in dialogical terms. This is possible in our model, which makes it possible to consider the nature of the relationship between voice hearer and voice(s). This is especially so since the dialogical approach is not just a theoretical stance, but stresses the person's own account of his or her experiences.

The events described below have features in common with focusing, but differ from this, and other cognitive interventions, in a number of important respects. We regard human experience as being organized dialogically. We work within the person's explanatory framework. Although reduction in voice frequency may be an outcome, the main objective is the reduction of distress due to voices, by helping the person to integrate the experience. It is important, however, to point to some limitations. The account is anecdotal and no attempt was made to obtain measures of frequency and severity of hallucinations. This was because the study was not originally designed as an intervention study. Its purpose was not to prove or disprove hypotheses, but to bring to life features of the dialogical model that have been quantified in our earlier study. We do not claim that if this procedure is followed the outcome will be the same.

The patient

Peg is a 59-year-old single retired woman with a long history of schizophrenia, re-referred to psychiatric services by her general practitioner in 1993. She was seen initially by P.T.

in the company of her companion, Sheila. At the initial assessment (1994) Peg's diagnosis was schizophrenia (residual), with 'second person auditory hallucinations' (International Classification of Diseases-9). There are problems with the diagnosis, because of evidence of dissociative phenomena. On one occasion she described what appeared to be a fugue state whilst hearing voices, as well as unexplained perceptual disturbances in which she felt reduced in size in comparison with objects around her (an electroencephalogram was normal). Peg reported that her voices were profoundly disturbing and difficult to resist (see below). They were ego-alien and located in external phenomenal space. The point of this paper, however, is to suggest a new way of helping people who hear voices, not a new way of treating schizophrenia.

Peg gave the following account of her life. She was adopted aged 12 months, after her biological mother had abandoned her. Her adoptive parents were in their 40s and middle-class. She described herself as a 'difficult child', disobedient and naughty. She completed normal schooling, attended teacher training college, and then taught at a school for physically handicapped children. She did well and was eventually promoted to head-mistress of a residential school for maladjusted children. She was gifted in this work, having a particular empathy with the children. In the mid-1970s she experienced considerable stress in her life. In addition to pressures at work, she had to deal with the impending loss of her elderly adoptive mother, who was terminally ill. Peg's first admission was in 1977, after she had tried to suffocate her mother and give her an overdose of tablets. She said her actions were in response to imperative auditory hallucinations. She did not feel personally responsible for them. This feature may be of general interest: impulsive, dangerous conduct in response to voices, and the problem of who is responsible for the conduct, the voice hearer, the voices, or both. We know little about Peg's voices at this time as their characteristics were not investigated in detail. Their presence as hallucinations was of diagnostic significance only. After this admission, she returned to work but was readmitted 2 years later. She had broken into the local Catholic Church and stolen the Host from the Tabernacle, in response to imperative auditory hallucinations. Her flupenthixol decanoate (Depixol[1]) was increased and this appeared to resolve the problem. On discharge, Peg took early retirement and moved to Wales with Sheila, where they have lived since. Depixol damped the voices down, but Peg continued to hear voices most days. For this reason she relied heavily on Sheila, going nowhere without her.

Peg's narrative

Peg produced a detailed account of her history, starting from her earliest memories to the present, including all events that she considered significant. She selected the following points as being of particular significance. Her elderly parents were extremely strict, and found it difficult to deal with emotional intimacy. They never allowed her to forget that they had saved her by adoption, but she was puzzled as to what it was they had saved her from. As a result, she felt in debt to them, a debt she could never repay. She felt compelled to 'behave' and be the perfect daughter so as to feel worthy of their love. She always had to

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[1] Flupenthixol decanoate (Depixol) is a long-acting injectable antipsychotic drug widely used in the management of chronic psychoses.

keep herself 'in check'—that is, to monitor her behaviour and edit out impulses that she considered unacceptable to her parents. Despite this, she never felt that she could be a good enough daughter for them. In early adulthood she traced her biological mother, and discovered that she had to give up caring for Peg whilst having to look after her own mother who was dying of cancer. Peg believed that the part of her self that she held in check somehow reflected her biological mother.

Dialogical properties of Peg's voices

Peg's voices were investigated in 1995 over a period of 2 weeks when she was admitted to a community support unit to provide her extra support. After she had completed her narrative, we obtained a detailed description of her voices using the interview of Leudar & Thomas (1995), details of which are reported in Leudar *et al*. (1997). The purpose of this was to identify each voice and describe its interactions with Peg. We used the interview categories to orient Peg at the voices, to provide a language to talk and think about voices, and to help structure the information she reported. The categories involved are not simply technical, but widely used in reporting verbal interactions. Peg talked about her voices without having them rendered 'meaningful' by interpretation. She first heard voices after the Aberfan disaster of 1966, in which over 100 children were killed when a slag-heap engulfed their school. She recalled '... seeing the suffering in their eyes, hearing their (the victims') screams and being powerless to help ...' This was a chorus voice[2] (cf. Leudar *et al*., 1997) heard on one occasion only. Since 1977, she had experienced two recurrent voices with stable, well-defined identities. The following descriptions of these voices emerged.

Voice 1: 'The guardian angel' (GA). This voice first spoke to Peg when her mother was dying. She felt powerless to help, but the voice suggested she should suffocate her and give her an overdose. The voice had no gender features, but sounded adult. It sounded like no one she knew, but she then said that it reminded her of her father because, like him, it had an opinion about everything. For example, it directed her and told her what to do. It occurred when she was under stress, such as in the company of old people who 'invaded' her space. She once thought of it as her friend, but now she doubted this. It told her to do 'wicked' things which she found almost impossible to resist. For example, she heard the voice some months before admission to the support unit, whilst visiting a friend in hospital. Peg felt helpless to relieve her suffering, and the voice told her to smother the old lady who was very ill. She would have reacted to the voice automatically by embarking on the action suggested, were it not for Sheila's presence. Fortunately, such actions would not necessarily come to fruition, as happens when we ordinarily act on 'bad intentions'. (Carrying out intentions is a situated activity, see Leudar & Costall, 1996). Other than tell the voice to go away, she would not question its instructions. More recently she had tried to cope by avoiding situations which precipitated the voice. Aside from issuing directives and providing relevant information to carrying them out, this voice was pragmatically restricted. Peg's problem was the voice's instructions.

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[2]Chorus voices are voices whose content is not discernible (speech without language).

Voice 2: 'My little devil'. This voice had no gender or accent, but sounded younger than the GA. She named it my 'little devil' (LD) because she could see it sitting on her shoulder— 'it is a total experience'. It came on when she had 'destructive' thoughts, such as those which heralded the appearance of the GA. She regarded this voice as helpful, because it told her to take the Host, which she believed would help her to resist the GA's suggestions. She never questioned the LD, and acted 'automatically' in response. This voice was also pragmatically restricted. It neither gave her permission nor forbade her from doing things, but it gave her information to resource the actions it suggested. For example, it would say 'the key (to the Tabernacle) is there—there is no one there'— information indicating that she could take the Host without being discovered.

Both voices addressed Peg directly as 'you'. They always spoke individually and were never present together. They never spoke to each other, nor did they address other people through Peg. The GA commented on things that P.T. had said. For example it told her to ignore his comments about the incident in which she had almost smothered her elderly friend in hospital (P.T. had said that in his view she was responsible for her actions, despite the voice's instructions). Peg was confused about the conflict between P.T.'s views and those of the GA. She could distinguish between her voices and her inner dialogues. Talking to herself was quite different from being addressed by the voices—'I am doing the talking—that is me. The voices are outside me, the voices are directional', meaning they told her what to do and their intentions were not her intentions. She had frequent internal dialogues with herself which did not involve the voices, so hearing voices was not a substitute for inner speech. Her reactions to both voices were impulsive rather than mediated. When, later, she considered the voices' instructions she was horrified. The difficulty was that this response was too late to modify her response to the voices. Interestingly, she relied on other people (Sheila, P.T.) to stop her acting as the voices commanded. Peg was in a difficult situation. A part of her mental life was alienated, or 'colonized', so she recruited others to help regulate her activities. Her personal autonomy was compromised in two ways. The problem of how voice hearers respond to their voices' injunctions to commit dangerous acts is complex, and in need of much more detailed consideration. With a dialogical approach, however, there is no particular reason why voices should be compulsive. P.T.'s strategy was to help Peg to introduce moral considerations to mediate the voices' commands and her actions. This placed the onus on Peg to consider potential actions as her own. Psychiatrists often function to take away responsibility from patients, but here the purpose was to work with Peg (and Sheila), as allies, to help Peg assume more responsibility.

Engagement

The purpose here was to enable Peg to comment on the voices' instructions. The difficulty was that the voices usually appeared in specific contexts, so she was asked to rehearse in memory situations in which the GA and LD appeared. Any intervention with her voices was achieved through Peg's 'I', which follows from our theoretical approach which regards voices as regulating the person's actions. Unlike psychotherapeutic interventions in dissociative states, where the therapist may interact directly with subpersonalities, there were no interactions between P.T. and voices. The intention was that Peg should write out in longhand (as part of her journal) a typical sequence of statements made by

each voice, and for her to insert her considered reply to the voices, which she could rehearse, like learning the lines of a play. This proved unnecessary. After the first session in which she explored her voices she felt very stressed, and she awoke in the early hours hearing a new voice telling her that the GA would not destroy her. She wrote in her journal that: 'I have called it (the new voice) my holy angel, but I think it is the voice of Peg'. The holy angel (HA) told her that she would be all right and that the other voices would not destroy her. This new voice was '. . . like Peg speaking . . .', and although she called it her holy angel, it was Peg's voice. We are not using a metaphor. Peg heard a new voice, sounding like her own, but she was not speaking to herself. This voice shared pragmatic qualities in common with Sheila and P.T., because like them, it reassured and supported her, and enhanced her self-esteem.

Subsequently, she provided a detailed journal of her interactions with this new voice, which indicated that complex dialogues took place between the HA and Peg. It reassured her spontaneously with positive and encouraging comments, and did so in response to her requests. One set of dialogues concerned Peg's request for reassurance about her biological mother, especially that she had loved Peg. It also told her that she should not 'punish' that part of herself that represented her biological mother. This part of her needed love and acceptance, and it was important that Peg was able to do this for herself. Traditionally the appearance of a new voice might be viewed as a negative sign indicating yet further fragmentation of self. It is clear, however, that HA worked constructively on Peg's behalf. The voice mediated between Peg and the other voices, saying that what they told her to do was wrong. The HA, though autonomous from Peg's 'I' (that is, Peg referring to herself as 'I'), was aligned with her and faced the other voices with her. It reassured her directly in response to her questions about itself and the other voices.

Follow-up

During follow-up Peg maintained a detailed written diary. This showed that her confidence increased and she started driving for the first time in 2 years. Four weeks after discharge she requested a reduction in her Depixol. She heard neither the GA nor the LD after the intervention, although she heard the HA about once a week. The appearance of this new voice was associated with a subjective decrease in the frequency of the other voices. Eight weeks later, she found herself in difficult situations in which the other voices usually appeared. They visited Sheila's ageing mother who was physically ill. During the visit the GA spoke to Peg, suggesting that she could ease the old lady's suffering, but the HA appeared immediately telling the other voice to leave Peg alone, which it did. Peg found this immensely reassuring. She was certain that had the new voice not intervened she could have acted on the GA's suggestion. On Christmas Day she accepted the role of sacristan at church, which meant having access to the Host. She did this without difficulty and without the appearance of the LD.

Then, in March 1996, 15 children and a teacher were shot dead in the Dunblane massacre. At some point that day she heard the children's voices crying out in her head. She was also distressed by vivid visual images of the carnage in the gymnasium. 'It was like Aberfan again'. These chorus voices took over despite her attempts at distraction by knitting and watching the television. In discussion with P.T., she talked through her response with the HA (she had heard no voices for 3 weeks before Dunblane). The

children's cries were very distressing but the HA comforted her, saying that although the tragedy was terrible, the children were out of this world, so there was no more pain or suffering for them. The injured children had holy angels to care for them, because doctors and nurses would relieve their suffering. Gradually, the cries abated and she fell asleep. She awoke feeling 'sad and desolate' but free of voices until that evening when they reappeared as she tried to sleep. The HA appeared again and reassured her, so that she was able to sleep. Over the next week the cries recurred in response to reminders of the tragedy, such as the funerals, but each time the HA reassured her, so that her distress did not get out of hand. Since then (and until July 1998) Peg has remained free of voices.

Discussion

Peg's voices are similar to those described previously (Leudar *et al.*, 1997; Nayani & David, 1996). She had five voices. Two were chorus voices (Aberfan and Dunblane), and the others had stable identities. These three voices had supernatural identities, yet they were not attributed supernatural powers, and close examination revealed that the voice identities involved alignments with ordinary individuals significant to Peg. Chadwick & Birchwood (1994) imply that the voices of people with a diagnosis of schizophrenia are likely to have a supernatural identity, and our own work confirms this. All of Peg's voices had supernatural names (angels or devils) but we could discern pragmatic elements of people known to Peg (the GA resembled her father, the LD resembled Peg, the HA resembled Peg, Sheila and P.T.). Why disguise these characters? We speculate that this relates to differences in the process of socialization in childhood. The representation of the internalized other depends on the nature of her parental relationships, which, in her case, were authoritarian. Romme & Escher (1991) have noted that voices have metaphoric properties, and that clarification of this may allow the meaning of the voices to become more apparent. In addition, religious faith and spirituality formed an important feature of Peg's explanatory framework, and this may have influenced voice personification. It must be stressed, however, that this is speculative, although we argue that a dialogical approach has hermeneutic potential capable of generating meaningful individual accounts of voice-hearing experiences.

The dialogical arrangement of voices is not unusual. The voices LD and GA were focused on Peg and regulating her activities. They addressed her, not each other nor anyone else. The HA intervened on Peg's behalf when the GA appeared, but there was no dialogue between the two. This resembles patient A.M. in our earlier paper. Peg's dialogical relationship with her voices was that of a small child in relation to strict, authoritarian parents. Her relationship with the HA was quite different. This was a dialogically rich interaction, in which she sought and was granted reassurance. The origin of this voice is puzzling. It started several hours after the interview with P.T., and after she was asked to write a 'script' of her own responses to the other voices. This opened up the possibility of engagement with voices, which she did through the mediation of the HA. This new voice shared pragmatic features with Peg's own voice, as well as Sheila and P.T., suggesting that Peg internalized aspects of these figures, making their reactions to the voices her own. The increase in the number of voices does not imply a deterioration in her clinical state, or increased ego fragmentation. The new voice had an integrative function and was associated with a gradual improvement in her self-esteem and social function,

observed by her close friend of many years. The pragmatic features of the new voice were not unusual. In our earlier study, we frequently encountered similar voices in non-clinical voice hearers. We argue that this is consistent with the dialogical organization of human experience, and the mediational use of language as inner speech. Vygotsky (1978) proposed that in the socialization of the child, language plays a central role as a self-regulating device in interpersonal action (cf. Leiman, 1994; Ryle, 1994). Peg, of course, is not a child.

There are similarities and differences between cognitive techniques and this approach. Unlike the dialogical approach, cognitive therapy disputes and challenges the person's explanatory framework to make the voices more benign. On the other hand, cognitive therapy, like the dialogical approach, draws out the structure and meaning that lies at the heart of the subjective experience of psychosis. Focusing also brings out the significance of personal meaning in voices, especially the importance of understanding the functions that voices have for the person. Another similarity between the three approaches is the role ascribed to the wider social world and its influence on voice content. The voices of case 3, in Chadwick & Birchwood's (1994) study, became worse after the dramatic economic changes of 1992. Likewise, Peg's voices intensified following the Dunblane massacre. All three techniques draw attention to the meaning of voices. There is evidence that attempts to help people cope with intrusive thoughts by ignoring them may, paradoxically, make the thoughts more intrusive (Lavy & van den Hout, 1990; Wegner, Schneider, Carter & White, 1987). The outcome of our study suggests that, contrary to perceived wisdom, attending to the content and meaning of hallucinatory voices may be beneficial.

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