Living With Voices

A NEW WAY TO DEAL WITH DISTURBING VOICES OFFERS HOPE FOR THOSE WITH OTHER FORMS OF PSYCHOSIS

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Hans used to be overwhelmed by the voices. He heard them for hours, yelling at him, cursing him, telling him he should be dragged off into the forest and tortured and left to die. The most difficult things to grasp about the voices people with psychotic illness hear are how loud and insistent they are, and how hard it is to function in a world where no one else can hear them. It's not like wearing an iPod. It's like being surrounded by a gang of bullies. You feel horrible, crazy, because the voices are real to no one else, yet also strangely special, and the voices wrap you like a cocoon. Hans found it impossible to concentrate on everyday things. He sat in his room and hid. But then the voices went away for good.

Modern American psychiatry treats auditory hallucinations as the leading symptom of serious psychotic disorder, of which the most severe is schizophrenia. When the German psychiatrist Emil Kraepelin first distinguished *dementia praecox,* as he called it, from manic-depressive disorder in 1893, back when Freud was drafting the *Interpretation of Dreams*, he argued that schizophrenia could be recognized by its persistent, deteriorating course. These days, schizophrenia is often imagined as the quintessential brain disease, an expression of underlying organic vulnerability perhaps exacerbated by environmental stress, but as real and as obdurate as kidney failure. The new post-psychoanalytic psychiatric science that emerged in this country in the 1980s argued that mental illnesses were physical illnesses. Many Americans and most psychiatrists took away from this science a sense that serious mental illnesses were brain dysfunctions and that the best hope for their treatment lay in the aggressive new drugs that patients often hated but that sometimes held symptoms at bay.

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The book that defined the era was called *The Broken Brain*, published in 1984 by Nancy Andreasen, later editor of the *American Journal of Psychiatry*, member of the National Academy, and recipient of the National Medal of Science. Her leading example was schizophrenia, recognized by its characteristic combination of hallucinations (usually auditory), delusions, and deterioration in work or social life.

The commonsense understanding that accompanied this wisdom was that nonpharmacological treatments for schizophrenia were useless. But recently a new grassroots movement has emerged. It argues that if patients learn to address their voices directly and appropriately, as if each voice had intention and agency, the voices will become

less hostile and eventually go away. From the perspective of modern psychiatry, this assertion is radical, even dangerous. But it is being taken seriously by an increasing number of patients and psychiatrists.

Hans is a Dutch man in his 20s, kind and large and careful in his speech and movement. He has the profile typical of someone with schizophrenia. He had been an excellent student in grade school, but things started to fall apart in his teens. He began to smoke a lot of marijuana and quit school at 17 to work in a factory. One evening, he heard a woman outside his apartment screaming for help. She was shrieking that five men were raping her and that they were going to kill her. Hans was afraid. He called the cops, anonymously, and they came to search, but they couldn't find the woman in the apartment complex. Hans saw them drive away. He could still hear her screaming, high, loud, spine-chilling screams. Hans began to think that if the men raping her knew he could hear them, they would come to kill him, too, so he ran to his car and drove. He drove for half an hour, hard, until he could no longer hear her screams. She's dead, he thought, and he didn't dare go back to his apartment. He slept in his car that night, then went to work the next day. He got a newspaper to find out what had happened, but no one had reported the murder. He concluded that the men who had done it wanted him, too. Then he decided that one of them was his closest friend. He took a knife and went to see his friend, intending to slit his throat. He sat there with his friend, drinking tea, waiting for the right time to kill him—but he didn't. He left his friend's apartment and went back to his car, where he lived for two months. He heard voices outside his head, talking about him, commenting on the way he dressed, the way he looked, what they thought he should do. Which was mostly to die.

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These external commenting voices are so distinctive that if patients report only that one symptom, and if their life has gone awry, they meet criteria for the diagnosis of schizophrenia. The voices told Hans that truck drivers were in on the conspiracy, too, so he could no longer sleep in highway pullouts. He went home to his mother. Hans is a quiet man, so he didn't tell her about the voices or the knives he carried with him, and at first she didn't notice. Then he confessed to her that he had raped a good friend. His mother didn't believe it. She persuaded him to invite the girl to tea, and indeed the girl said he hadn't raped her. That relieved Hans, but not his mother.

So Hans found himself in an inpatient psychiatric hospital, where he stayed for more than a year. He was diagnosed with schizophrenia and given Clozaril, one of

the new "miracle" drugs for schizophrenia—miracle for a small handful of patients, a desperate stopgap for the rest. Nothing really changed for Hans on Clozaril, neither his voices nor his delusions, but he became calm. He became so calm that he slept all day. His panicked mother argued with the doctors, telling them this was no kind of life. They told her sleeping was normal "at this stage." Hans's skin itched. He gained 90 pounds, and now he could not think clearly or move comfortably, a Michelin man with tubby limbs. Over the course of the year, little changed.

Then Hans joined a group of people like him who met once a week. They talked about their voices, and they were encouraged to talk back to them. They were even encouraged to negotiate with their voices. One of Hans's voices thought he would be better off if he devoted his life to Buddhist prayer. Hans is not a Buddhist—like many Dutch, he grew up as a secular Protestant—and he did not want to follow the voice's command. The group persuaded him to cut a deal with his voices. He told his voices that he would read a book on Buddhism every day for one hour—but no more. He would say one Buddhist prayer every day—but no more. And if he did this, he told them, they had to leave him alone.

They did, more or less. He began to feel better. His psychiatrists began to lower his Clozaril from its high of 500 mg per day down eventually to a dose of 50 mg. He lost weight. He became more alert. He moved out of the hospital. The voices didn't disappear immediately, but they got nicer. When he was moving into an apartment by himself—and petrified by the prospect—he heard a voice say, "Buck up, we know you can do it." By the time I met him in 2009, he hadn't heard a voice in more than a year.

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That approach to what many people take to be the most disturbing symptoms of the most debilitating mental illness is the brainchild of the Dutch psychiatrist Marius Romme and his wife, Sandra Escher. Romme is a big, handsome man in his middle 70s, with a shock of white hair and a charming smile. More than 20 years ago he was working with a patient who had been struggling with her voices. She came in one day and told him that a book she had been reading had helped her because it made her feel that her voices had meaning. The writer was a man named Julian Jaynes.

The book, *The Origin of Consciousness in the Breakdown of the Bicameral Mind,* is one of those gangly, overwritten academic books that is undoubtedly wrong, but wrong in such an interesting way that readers, on finishing it, find that they think about the world quite differently. The book begins, "O, what a world of unseen visions and heard silences, this insubstantial country of the mind!" Jaynes was a psychology professor at Princeton, back in the days before psychologists had walled themselves off from literature, when he noticed that the gods in the Homeric epics took the place of the human mind. In the *Iliad* we do not see Achilles fretting over what to do, or even think-

ing much. Achilles is a man of action, and in general, he acts as the gods instruct him. When Agamemnon steals his mistress and Achilles seethes with anger, Athena shows up, grabs him by the hair, and holds him back. Jaynes argued that Athena popped up in this way because humans in archaic Greece attributed thought to the gods—that when the ancient kings lived in those strange beehive Mycenaean palaces, when social worlds were small and preliterate, people did not conceptualize themselves as having inner speech. Jaynes did not think that the role of the gods in the *Iliad* was a literary trope. He thought that people who did not refer to internal states used their brains differently and—the cognitive functions of speaking and obeying split across their unintegrated hemispheres—actually experienced some thoughts audibly. "Who then were these gods that pushed men about like robots and sang epics through their lips?" Jaynes asked. "They were voices whose speech and direction could be as distinctly heard by the *Iliadic* heroes as voices are heard by certain epileptic and schizophrenic patients, or just as Joan of Arc heard her voices."

Romme wasn't interested in whether Jaynes's theory was right. (Most psychologists think that his brain science is quite wrong—they find it hard to take seriously the assertion that consciousness is a cultural construction—but the idea that awareness is the result of the way a language represents the mind is still startlingly compelling, and there are some scientists who defend a version of Jaynes's model.) What Romme noticed was that attributing meaning to voices had made a difference to someone who was hearing them. By the psychiatric standards of the time, this was shocking. In the new biological psychiatry, which had begun to dominate the profession in Europe and America in the 1970s, voices were symptoms of psychotic illness in the same way that a sore throat was a symptom of flu. Sore throats didn't "mean": they were signs of a problem that had to be treated and resolved. So, too, voices. When a patient heard an audible voice, it was the sign of an illness that had to be treated with medication. Thus would the symptom be removed. These days, talking much with a patient about voices is often seen as encouraging that person's belief in the false reality the voices represent. In biomedical psychiatry, mental health professionals ask whether the patient hears voices, not what the voices say. The goal is to get rid of the voices, like getting rid of a fever, and the mind-numbing, sleep-inducing antipsychotics are prescribed toward that end. Often, the medications do not work, with dosages increased in the hope that they will. Back in the '70s, when we thought that antipsychotics would change forever the way patients lived with schizophrenia, doses were so high and side effects so visible that the way drugged patients moved under their influence was called the Thorazine shuffle.

In the mid-1980s, Romme advertised for voice-hearers on national television in the Netherlands. The local network ran a segment on Romme and his patient who had read Jaynes and asked voice hearers to send postcards. Seven hundred cards arrived.

More than half were from people who seemed to experience audible voices, and many of them had never seen a psychiatric professional. They coped with their voices just fine. By now, Sandra Escher, a warm, funny woman who was working as a journalist (she eventually got a doctorate in psychology) was involved. Romme and Escher decided to hold a conference for everyone who had sent in cards. All sorts of people turned up, including people who had struggled with voices and hadn't been able to do anything about them despite the efforts of psychiatrists and medication.

The people who were comfortable with hearing voices told the same story; their experience had a trajectory. Some voices had started out mean and difficult, and the hearers had first responded with startled fear, but once they had chosen to interact with them, the voices settled down and became more manageable, sometimes even useful. "They show me the things I do wrong," one voice-hearer said, "and teach me how to do them otherwise. But they leave the choice to me if I really want to change it or rather leave it as it was." That was the kernel Romme and Escher took away from the event: if people could accept their voices and create a relationship with them, they could get their voices to change.

Romme and Escher now began to talk to more voice-hearers about what they had learned, and people diagnosed with schizophrenia in the United Kingdom and the Netherlands began to organize events. In a series of workshops, Romme and Escher taught that people who heard voices should take them seriously and pay attention to what they said. In 1993 they published *Accepting Voices,* with techniques, case studies, and commentary by mental health professionals and patient activists (the activists sometimes call themselves survivors of psychiatric care). More detailed manuals and books followed. The workshops grew into conferences. Soon Romme and Escher were the unofficial leaders of a movement.

These days, the Hearing Voices Network is an international organization with members in many countries, including the United States, and 180 groups in Great Britain alone. It has a newsletter, a web page (intervoiceonline.org), and a society that meets annually. More than 300 people, including 121 voice-hearers, showed up at its first international conference in Maastricht in 2009, which I attended because I have always been interested in voices and visions.

Its method, to treat voices like people, is almost the inverse of the biomedical understanding of psychotic voices and a completely different perspective on how to handle them. The organization insists that hearing voices is a normal human experience, which indeed it is, although what is common (and thus "normal") is hearing a voice as you slip into sleep, perhaps calling your name, perhaps your mother's voice. About half of a standard subject pool (read: university undergraduates) will say that they have had some experience like that at least once. Many more will say so if the experimenter gives them examples. The Hearing Voices method takes this fact and

turns it into an attitude. The problem is not the voices but the relationship to the voices, and the goal is to help voice-hearers live with them as if they were sharing a cramped apartment with crabby roommates. The voice-hearer is asked to talk directly to the voices and negotiate with them: asking what they want, offering to meet them partway if they will leave the hearer alone for a time. The hearer is told to treat the voices with respect, just the way you would treat a roommate you cannot kick out, whose behavior you really want to change.

Hans first encountered this approach after he had already been identified as having chronic schizophrenia. He had been institutionalized for a year when his parents and the hospital staff decided that he could not live alone. He moved into a 24-hour care facility with 12 patients and 12 staff members, the kind of place, he said bitterly, that is now too expensive to run and has been shut. The staff members began to teach him how to live. They would take the bus with him and show him how to buy a ticket, and then make him take the bus by himself for one stop, and then two, then three. At this point he was taking that horse-felling dose of medication—500 mg of Clozaril—and with that dose, it would be hard to think, let alone function. And still he had two voices outside his head that he heard with his ears.

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At that point a staff member came to talk to him about a Hearing Voices group. He joined, and he was astonished to find that people talked back to their voices. Until then, he had done all he could to escape them. Confronting them, dealing with them, seemed utterly novel. So he tried it. He began saying yes to them when they spoke, and then he began saying no. The group taught that one had to talk with respect even to the harshest voices—the ones that screamed and cursed and wanted you dead. It is not easy, Hans said slowly, to talk nicely to your most aggressive voices. But the group said that if you showed respect, they would calm down. And they did.

The paradoxical assumption here is that if the voice-hearer treats the voices as if they are real, as if they are like the independent, external people in the world they are perceptually experienced as being, the voices will become less real. Psychoanalysts once used this therapy style, working with paranoid psychotic patients. The analyst would align his chair with the patient's, so they would sit side by side looking out at the world, and then the analyst would speak as if he were so much more paranoid than the patient—"can't trust anyone around here, they'd as soon stick a knife in you as answer a question"—that the patient would start chortling at the doctor's foolishness, and thus at his own. At least that was the idea. As the psychoanalytic treatment of psychosis sank beneath the onrushing scientific wave, the approach was seen as risky and then irrelevant or worse.

The Hearing Voices method not only puts people in groups to encourage them to talk about and then engage their voices, it also asks other people to treat the voices as real. Staff members conduct "voice dialogues," often working one on one with a client. The staff member asks to speak with the voice. The client will listen for what the voice says and then report it back, in a strangely ventriloquized process. Some staff members invite the voices to attend the group meeting. At the Maastricht conference, someone stood up to report that she had 21 members of her Hearing Voices group: three professionals, four voice-hearers, and 14 voices. It got a little complicated following who was present, she said, so they had to work out elaborate rules of order. Some people learn to hold their own group conferences for their voices, insisting that they all come forward at the same time and talk about their concerns.

Hans had developed a new voice by the time he arrived at the group, and one of the psychiatrists wanted to talk directly to it. The old voices were somewhat calmer by then. They no longer threatened to drag him off into the forest and bind, torture, and kill him. They mostly just told him that he was lazy and fat. But this new voice seemed like it might get nasty. The group had told him that he needed to talk to it. They said that he should say, "We have to live with each other and we have to make the best of it, and we can do it only if we respect each other." He did that, and this new voice became nice. It gave him good advice. When Hans went to see the psychiatrist who wanted to talk to his voices, only the new, good voice would come out to talk. Hans could see that the old, mean voices were afraid of the psychiatrist. This stunned him. They were strong, mean voices, but they were afraid. Hans said that when he realized this, he went home very happy. Now he knew that his voices were not as strong as they pretended to be. He told me that in the same interview, the psychiatrist had explained that the old voices represented Hans's alcoholic, depressed father. This surprised him, because the voices didn't sound like his father. But he knew that the psychiatrist was right. And now the voices began to lose their power. Hans would go to the group and talk about the feelings he had when he heard the voices, and the voices became weaker and weaker. They came for only an hour, and then only half an hour, and then finally they simply stopped.

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If this sounds like the style of therapy found in the old dissociative disorders groups, back before the scandals of repressed memory blew the protocols apart, that is because it is. In the treatment of multiple personality disorder (now chastely renamed dissociative identity disorder), therapists were encouraged to talk directly with the personality "parts." These parts, called alters, were invited to group therapy meetings.

The therapists treated the alters with respect and as if they were real.

"Voices arise when the person is confronted with overwhelming emotional trauma he cannot handle," Marius Romme explained as he strode across the stage at the Maastricht conference. "We know this." It is generally agreed that the concept of dissociation was coined by Pierre Janet, as the 19th century turned into the 20th, to describe a disruption in the normally integrated processes of identity, memory, and consciousness. Freud gave dissociation its distinctive relationship with trauma, and even though he soon repudiated it, his early vision of trauma has come to dominate much of our thinking about intense psychological distress. Dissociative disorders are thought to be caused by memories of unbearable fear, now called trauma, and particularly by sexual experience in childhood. Powerless and terrified, a young girl protects herself from horror (so goes the clinical argument) by escaping into a trancelike state as her father rapes her. When she returns to her normal state, she can no longer remember the experience, but the memory remains active in her psyche, disrupting her sleep, distorting her motivations and behavior, intruding into her normal life like an eruption from a possessing spirit. If raped again, clinicians argue, the girl may reenter that protective absorbed state, or re-create it in a new form, and the state becomes like an alternate self, intermittently taking control of the person's mind and body. Indeed, when the repressed memory movement was at its height in the early 1980s, such a patient commonly reported in therapy that she had a hundred or more "parts" associated with particular memories, each wreaking havoc with the "host" personality's attempt to live a normal life. People with dissociative disorders often say that they hear voices, although usually those voices are perceived not as externally heard auditions but as strong, alien thoughts. These internal voices are understood as the marks of the alters, these strange, split-off pieces of the psyche.

The new way of thinking suggests that people do not hear voices because they are crazy, but that their apparent craziness results from the brain-numbing chaos of hearing voices.

Schizophrenia has never been a satisfying diagnostic category. The conditions that meet the diagnostic criteria are just too various, with such different illness trajectories and outcomes, that many serious researchers recognize that the category is flabby at best. They agree that something is seriously amiss with people who can be diagnosed with schizophrenia (to meet the diagnostic criteria, a person's life must have dramatically deteriorated), but they also agree that what is wrong with one person might not be what is wrong with another. Meanwhile, some kind of childhood nastiness—violence, or living with violence—is increasingly identified in the lives of people who can be diagnosed with schizophrenia, and the poor outcome of those who

meet the criteria is increasingly shown to be the result of cognitive dysfunction, not hallucinations. Some researchers at Maastricht—Richard Bentall, Jim van Os, John Read, and others—argued that it made more scientific sense to separate out the different symptoms (like hearing voices and cognitive dysfunction) associated with the general condition called schizophrenia, and to consider them as having independent pathways and different consequences. And when you focus on the hallucinationary experiences of someone in extremis, schizophrenia and dissociative disorder do not look so different. People are in thrall to personlike beings who have no real external presence. As someone explained to me, "When you scratch the surface, a lot of the stuff that's supposed to be schizophrenia looks a lot like dissociation."

If it is true that distressing auditory hallucinations are the dissociative consequences of trauma, the implications are enormous. Dissociative disorder has a positive prognosis, one of the most positive in the realm of psychiatric disease, whereas schizophrenia is often thought to have the worst. Dissociative disorder is understood to be a reaction to events in the world; schizophrenia is usually imagined as a largely inherited vulnerability. Dissociation is best treated with therapy and interaction; schizophrenia is assumed to require medication, often heavy. The new way of thinking opens the possibility that people do not hear voices because they are crazy, but that their apparent craziness may be the result of the brain-numbing chaos that can result from hearing voices. It suggests that we can help by teaching people to cope with their voices, rather than viewing the voices as evidence of organic damnation.

Does it matter if, in the process, people who suffer so terribly come to believe things about themselves that might not be true? Proponents of the Hearing Voices movement believe that the emotional pain carried by a voice must be acknowledged and understood before its ferocity can abate. A manifesto on Intervoice, the movement website, is clear: "Hearing voices is related to problems in the life history; to recover from the distress the person has to learn to cope with their voice and the original problems that lay at their roots." Given the way our society conceives of trauma, finding root problems often involves a determined search for childhood sexual abuse. One afternoon at the Maastricht conference, when the voice-hearers met together with clinicians to discuss recovery, the search for sexual trauma hung heavy in the air. Over the course of the afternoon, the book that had been one of the mastheads of the repressed memory movement—Judith Herman's *Trauma and Recovery*—was praised, and phrases out of it floated through the discussion. For instance, "You cannot begin to heal until the trauma has been spoken."

The politics are different. The dissociative disorders crowd was focused fundamentally on what they took to be patriarchy—even though, as the writer Joan Acocella

pointed out in *Creating Hysteria*, this backfired into creating a sick role that effectively removed competence and capacity from the women involved. The Hearing Voices Network, by contrast, has it in for biological psychiatry, which they regard as not only mistaken but also downright harmful for patients. When *The Oprah Winfrey Show* aired a program about a little girl who heard voices, encouraging empathic concern for a family powerless in the face of a terrible, incurable disease, the Hearing Voices people wrote an open letter explaining that this was precisely the kind of thinking that made things worse: "If parents cannot accept that hearing voices is fairly normal, but believe only that it is the symptom of an illness and are afraid of them, then the child naturally picks up this feeling. Imagine for a moment if you were the child and were afraid of the voices, and when you looked for support from your parents you found that they were even more afraid of the voices than you."

The treatment of schizophrenia has always been a Faustian bargain, an attempt to wrest a solution to agony by a sacrifice that left someone to blame. When psychoanalysis dominated American psychiatry, back before the biomedical revolution, psychiatrists believed that the condition was the result of the patient's own emotional conflict, caused by a "schizophrenogenic" mother whose own ambivalence paralyzed her child and drove him or her into the clinical impasse of the illness.

When psychiatry shifted to a biomedical model of mental illness and the *Diagnostic and Statistical Manual of Mental Disorders III* was published in 1980, the diagnostic category for schizophrenia narrowed sharply. The diagnosis "schizophrenia" was reserved for the really sick. Mothers were no longer to blame. Yet as the mother was freed from fault she was also stripped of the capacity to do anything about the train wreck that had been her beloved child. And so, to a large extent, were her child's psychiatrists, whatever they might offer in the way of medication. The patients who had been removed from the category by the new diagnostic disease categories were precisely the ones thought not to be so ill. Schizophrenia now became a devastating brain disease caused largely by bad genetic luck, with the inevitable degenerating course Emil Kraepelin had outlined for it when he first distinguished it from bipolar disorder primarily because patients did not improve. These days, many psychiatrists will respond to the news that a person with schizophrenia can get better with the comment that if a person gets better, he or she didn't have schizophrenia in the first place.

The Faustian bargain made by the hearing voices approach is that the risk of recalling false trauma is less dangerous than ignoring the potential healing power of its method. Evidence exists that trauma—sexual abuse, emotional abuse, and physical assault—makes a difference. Recent research has found an association between trauma and schizophrenia so powerful that there are European psychiatrists who will argue that trauma lies behind every psychosis. Yet mistakes will happen. With the new method will come the search for childhood sexual abuse to explain life's pain, and inevitably,

some of those recollections will be false. People might even search for evidence of hearing voices to give force and stature to the criticism raging in their souls. On the train back to Brussels from Maastricht, I sat next to a woman who had come over from England for the conference. She struggled to make a living as a seamstress and had never been to college. She went to the conference because a friend of hers was going, and because her brother had been diagnosed with schizophrenia and had spent many years behind locked doors. She told me that it was wonderful to realize that her own problems were caused by voices. She used "voice" to refer to the caustically self-critical commentary often running through her head, not to anything she heard with her ears. And she was relieved to understand at last what her mother had refused to share with her: that she had been molested when she was very young. She couldn't remember the abuse herself, but it explained the way her mother had treated her.

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European psychiatrists have no history with the ravages of the repressed memory movement, when thousands of American women discovered memories of childhood sexual abuse at the hands of their fathers and pressed charges on the basis of those memories, so that many fathers were falsely arrested and even imprisoned. European psychiatrists do not know about the strange collusion between some therapists and some patients, when patients seemed to deliver one alter after another, satisfying the eager expectations of their determined therapists. By the early 1980s, many of those memories included accounts of horrific satanic rituals in which women were forced to eat their own babies before masked and murderous men. Patients struggling with whatever had brought them into therapy now also had to deal with the anguished grief of remembering that they had cannibalized their own children. A thorough FBI investigation found no evidence to support these assertions, and not one police report had been submitted at the time that the babies supposedly had died.

Imagination is a powerful tool that cuts both ways. It may be able to capture and reorient the soul-shattering experience of hearing distressing voices, yet we must be careful that the memories it leaves behind do not do damage of their own. These thoughts jostled in my mind at the Maastricht conference.

At the conference, I met Adam, who was once diagnosed with schizophrenia but is now employed, effective, and—to all appearances—recovered. He fell ill early in his 20s, when he had a summer job with a beekeeper. One day he discovered rats nesting in one of the boxes. A mother rat, suckling her young. He didn't know what to do, so

he killed them: smashed them over the head with a shovel. He hated doing that, but then he found another nest, and he killed those rats, too. Then he found a third, and at this, he told me, he lost it. He left the job, ran off. And soon he heard them, the rats, scratching behind his ears. Many people with psychosis describe these weird scratching sounds, up back behind the ears, signals or messages or rodents scratching in the walls. Once, someone told me of being terrified by the sounds of a whole field of rats running toward her, behind her back.

Adam thought the rats he heard were getting back at him. His fear grew, but the rats never materialized, and he began to think up explanations for why they had not yet appeared. He concluded that a conspiracy was afoot, that the rats had infiltrated the government and were setting traps for him. Soon he was hospitalized and diagnosed with schizophrenia. His psychiatrist said the deadly thing that doctors say: "I believe you when you say that you believe that you are hearing rats." Adam hated that comment. It was clear to him that the doctor did not believe him.

Somehow Adam made his way to a Hearing Voices psychiatrist who said, "You don't hear rats. You hear a sound, and you are interpreting the sound as rats." To Adam, that made all the difference. He found it utterly liberating to be told that what he heard and what he believed were related but not the same. The psychiatrist taught him to treat the sounds respectfully, to respond to them, to interact with them, and to find their meaning—to identify the kernel of trauma that might have given rise to his terror of the rats. Adam listened and found that what he heard was not rats but a swishing sound through grass. A memory came back to him of old days, when he looked at two water rats swimming in the water at the foot of the meadow when his babysitter's hands played around his body.

There is no simple answer to the question of whether it matters if the babysitter fondled him or not.

Although the Hearing Voices movement is one of the most innovative approaches in decades to the problem of hearing distressing voices, clinical research is still in the early stages, with, to my knowledge, no completed randomized, controlled trials. The emphasis on childhood sexual abuse will certainly put off American psychiatrists with vivid memories of the repressed memory movement in this country. But the search for hidden memory is not intrinsic to the movement's central insight, which is that the way we understand our mental experience has the potential to alter it fundamentally. The Hearing Voices proponents believe that if you do not envision schizophrenia as a life sentence, you increase the chance that patients will be able to discover their own resilience. That is a profound insight, and it offers hope to those who face the horrors of psychosis. ●