Auditory Hallucinations in Schizophrenia: Collaborating with the Voices from Without

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Abstract
Differentiating between the pathological, and religious or spiritual connotations of schizophrenia sheds light on the possible mechanisms of coping, useful in developing clinical strategies in the treatment of schizophrenia. While many studies have focused on the nature and treatment of auditory hallucinations within modalities such as cognitive-behavioural therapy and/or psychiatric interventions, these modalities aim at eliminating the auditory hallucinations in patients with schizophrenia, perceiving them as a pathological symptom. Research has also been undertaken in understanding the cultural and religious components of schizophrenia, as well as how religion and spirituality have been incorporated in the coping mechanisms of this population.[1]

However, there appears to be very little research on how auditory hallucinations themselves may be incorporated into the recovery process, and into the development of new meaning and purpose as one grows beyond the catastrophe of mental illness.[2] Hence, this paper proposes that we consider the role of auditory hallucinations in the treatment and management of schizophrenia. A survey of historical literature suggests that in past centuries, individuals experiencing auditory hallucinations have been given much more credence than their counterparts in modern society. More recent studies indicate that auditory hallucinations in and of themselves are not debilitating. For instance, Romme[3] proposes instead that it is the fear of not being able to control or manage the auditory hallucinations can be disabling to the individual. In this paper I hope to demonstrate the need for further research into the ways in which auditory hallucinations may provide new pathways in the recovery from, and management of, schizophrenia.

Key Words: Auditory hallucinations, meaning, recovery, research, schizophrenia.

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1. Introduction

Schizophrenia is one of the most prevalent psychological illnesses in the United States. According to the National Institute of Mental Health, Schizophrenia afflicts approximately 2.4 million American adults.[4] The World Health Organization has reported that approximately 24 million people worldwide suffer from schizophrenia.[5] A definition of schizophrenia that would suffice for the purposes of this paper can be drawn from the

Diagnostic and Statistical Manual of Mental Disorders-IV-TR. Considered the most widely employed diagnostic tool in clinical psychology, the *DSM-IV-TR* describes schizophrenia as a mental disorder that lasts for at least six months and includes at least one month of active-phase syndromes (i.e. two or more of the following: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour.[6] In addition, schizophrenia has several subtypes that include Paranoid, Disorganised, Catatonic, Undifferentiated and Residual. One of the main features of schizophrenia is psychosis. Auditory hallucinations have been experienced in psychiatric and non-psychiatric populations, suggesting that they may be part of the human experience.[7] However, the primary focus of the paper will be on auditory hallucinations or voices in schizophrenia alone because individuals diagnosed with schizophrenia have often been overlooked by researches and mental health professionals - typically classified as "untreatable" and "hopeless" by mainstream psychology.[8] This idea is also reflected in the words of Karon: "the myths of the lack of meaning of schizophrenia symptoms…and the incurability of schizophrenic disorders are still with us."[9]

The onset of schizophrenia is typically between 17 and 35 years of age. However, schizophrenia is also age, culture and gender specific. For instance, the average age of onset in men is between 18 and 25 years, while women may be diagnosed with schizophrenia between the ages of 25 and 35.[10] In diagnosing schizophrenia, cultural and socioeconomic backgrounds are extremely important to take into consideration, especially in interpreting the meaning of certain 'symptoms' of schizophrenia. For instance, in some cultures such as Javanese,[11] Algerian[12] and Bangladeshi[13] symptoms of auditory hallucinations or catatonia are regarded as a common part of a religious experience that is culturally legitimised or normalised. This legitimisation is substantiated by the fact that cross-cultural researchers have consistently validated clinicians' impressions that schizophrenia differs according to culture, with a better course of recovery observed in non-Western societies.[14]

As a phenomenon in itself, schizophrenia has long been looked upon and understood in myriad ways: as a mental illness caused by the imbalance of body humours[15]; as a mental state of being caused due to the effects of black magic, sorcery and spirits; as a detrimental psychological illness which is the consequence of a traumatic childhood or sexual abuse; the result of an individual's environment; as a disturbance in the brain chemistry with neurotransmitters such a dopamine and serotonin. Understandings of the etiology of schizophrenia have evolved over time - over the centuries, schizophrenia has been understood from religious, cultural, socioeconomic, environmental, psychological, neurobiological, and metaphysical perspectives. Each school of thought has created a framework in which the causes, symptoms, and treatment of schizophrenia have been rooted;

however, several centuries later, there is still no generally agreed-upon understanding of schizophrenia as a mental illness in the 21st century.

The purpose of this paper is to provide a brief review of the current and traditional perspectives on auditory hallucinations in schizophrenia, with the goal of making a case for re-examining the role of auditory hallucinations in the recovery process of individuals with schizophrenia. In essence, this paper will ask the following questions: How can auditory hallucinations in patients with schizophrenia be incorporated in the recovery process? And is it possible that instead of viewing auditory hallucinations as a pathological symptom of schizophrenia, we "re-view" the experience of hallucinations as being meaningful in an individual's life?

2. Auditory Hallucinations in Schizophrenia

In layperson's terms, hallucinations are simply defined as perceptions that occur in the absence of an actual external stimulus. According to the *DSM-IV-TR*, hallucinations may occur in any sensory modality (auditory, visual, olfactory, gustatory or tactile), but auditory hallucinations are by far the most common in schizophrenia.

According to the *DSM-IV-TR*, an individual who hears voices distinct from his/her own thoughts, whether familiar or unfamiliar, is considered to be experiencing auditory hallucinations. However, voices that are heard during the course of falling asleep or while waking up are considered to be part of the normal human experience. A more detailed definition is given by Bentall, who explains auditory hallucinations as,

> ...any percept-like experience which (a) occurs in the absence of an appropriate stimulus, (b) has the full force or impact of the corresponding actual (real) perception, and (c) is not amenable to the direct or voluntary control of the experience.[16]

Several external factors such as sleep deprivation, the ingestion of psychedelics or psychoactive drugs such as marijuana or LSD, can account for the experience of hallucinations. Hallucinations have also been known to occur due to certain infectious diseases such as HIV or Lyme disease; due to the imbalance of various chemicals or neurotransmitters in the brain; or in patients suffering from delirium or dementia. Similarly, studies on brain temperature and the effects of hyperventilation on auditory and visual hallucinations have provided important clues to the causes of some hallucinations.[17]

The concept of auditory hallucinations has been grounded in a rather rich and deep history, spanning centuries of inquiry and exploration. In Western history and literature there are a number of examples of

hallucinatory experiences from the classical ages to the medieval ages and modern society. In the eighth century BC, we find reminisces of auditory hallucinations in Homer's *Iliad,* where the gods of Achilles spoke to him and guided him "in moments of strong emotion and indecision."[18] Similarly, in the fifth century BC, Socrates claimed to be in direct relation to a *daemon,* "a voice," "a divine presentiment," who warned him against certain actions and who exhibited accuracy and precision in the information that was presented to him.[19] The twentieth century AD can boast of the American poet Allen Ginsberg who had a psychotic episode where he heard the voice of William Blake. Ginsberg chose to treat it not as a sign of mental illness but as an aesthetic catalyst, as his poetic muse.[20] There have been various theories on the causes and nature of hallucinations, some viewing them as equivalent to insanity. Lelut, for instance, argued that hallucinations were inherently pathological, and an indisputable sign of madness.[21] Others have argued that hallucinations can be stimulating and inspirational. The German psychoanalyst Fromm-Reichmann spoke of psychosis and hallucinations as

> ...useful to the mentally healthy in really finding their minds, which are all too frequently lost, as it were, in the distortions, the dissociations...and all the painful hide-and-seeks which modern culture forces upon the mind of man.[22]

The most current and dominant perspective of schizophrenia is the psychiatric or "medical model," which views mental illness as a problem concerned with brain chemistry - the solution is likewise a chemical one.[23] Proponents of the medical model claim that mental illness is as a disease, a dysfunction of the brain.[24] In this context, hallucinations have been understood strictly as the unfortunate 'symptoms' of a disease. Karl Jaspers, the German psychiatrist, claimed in 1963 that it was not possible to discern meaningful content in psychosis. In his words, "[m]uch has been explained as meaningful which in fact was nothing of the kind."[25] This view continues to be upheld in today's society, for the majority of patients who experience auditory hallucinations are under the direction of psychiatric care, where the preferred treatment is medication.

To elaborate, the National Alliance of Mental Illness (NAMI) was founded in the United States in 1979. The mission statement of the NAMI proposes to see the "eradication of mental illness,"[26] thereby expressing and promoting the view that mental illness is something society should aim to eliminate. This idea is in direct opposition to the views of Laing[27] and Jung,[28] who claim people suffering from mental illness can offer insights into the human processes that are fundamental to living in a world shared with others. NAMI holds that schizophrenia is a "treatable medical condition,"[29] an illness caused by the biochemical disturbances of the brain.

Time and again, auditory hallucinations have acquired a rather negative connotation; an experience not understood by most mental health professionals, even after decades of research and investigation. Seldom are auditory hallucinations looked at positively, as a possible psychological aid in the healing and recovery process of the individual. Psychiatry, the predominant model of treatment, generally recognises minimal or no value in auditory hallucinations, rendering them a bane or a futile aspect of the human condition. Romme succinctly illuminates this idea when he says that:

> … psychiatrists and others who insist that such voices do not exist are missing the point. It is wrong to deny them…these voices represent real influences, and they have something to say; sometimes the message maybe unwelcome and uncomfortable; sometimes wise and instructive.[30]

According to Bentall, the treatment of schizophrenia has been primarily psychiatric medications, particularly because of the belief that psychosis is a biological or a medical disease.[31] He argues that psychiatric services tend to rely exclusively on neuroleptic medication, and make little or no effort to respond to patients' psychological needs.[32] This idea is echoed by Whitaker in his book *Mad in America*.[33] Based on his research regarding recovery rates in schizophrenia, Whitaker points out that despite the rampant use of psychiatric drugs by patients, recovery rates for schizophrenia are almost negligible.

The historical stability and power of the psychiatric model is also reflected in Letizia Gramaglia's chapter of this volume where she eloquently describes the role and impact of 'Colonial Psychiatry in British Guiana.' In her analysis, Gramaglia addresses the manner in which immigrants were treated as patients in the mental asylum where, according to Foucault, such treatments were a disguise "for more effective controlling strategies aimed at producing the internalisation of acceptable moral and behavioural standards." It would not be a stretch of the imagination to draw parallels between the practices of Colonial Psychiatry and modern-day psychiatry. It appears that both past and present practices have the general aim to control an individual's symptoms and to bring them in line with the norms and standards of society. Perhaps the only difference between the two is that with the former, the intent and motivation for such treatment was more obvious.

3. Auditory Hallucinations in the Recovery Process of Schizophrenia

About a century ago, Carl Jung spoke on the significance of auditory hallucinations in individuals with schizophrenia, stating that:

> ... there is no symptom which could be described as psychologically groundless and meaningless. Even the most absurd things are nothing more than symbols for thoughts which are not only understandable in human terms but dwell in every human breast.[34]

The above quote suggests that there may indeed be meaning and symbolism in the auditory hallucinations of patients with schizophrenia. Furthermore, an inquiry into the content of hallucinations may be of significance. Auditory hallucinations continue to be viewed as a symptom to be eliminated, thereby providing minimal context for exploring the efficacy of assimilating such experiences within a treatment framework. As Smith explicates, the notion of seeking meaning in auditory hallucinations is not generally part of therapeutic practice:

> What matters most to the contemporary clinician is the experience's form - what grammatical tense and "person" it speaks in...whether it speaks continuously and intermittently. This information is the key to making a correct diagnosis, and therefore to prescribing the most effective treatment. Discussions of meaning are commonly thought to distract from this work.[35]

In her chapter, 'From Indiscriminate Love to Imagined Ugliness,' Christine Montross reveals how an individual's symptoms may also be considered part and parcel of the individual herself. As Montross's analysis suggests, it is not the individual that is of primary importance, but rather his or her diagnosis - how quickly a diagnosis can be made and how symptoms are classified or understood in the *DSM-IV*. The patient then becomes a diagnostic label and not the person. Thus, it is the symptom alone that becomes the focus of treatment. In general, clinical symptoms are considered unfavourable and the focus of treatment is the elimination of symptoms. This is especially seen in the case of auditory hallucinations in schizophrenia. Bentall and Slade have commented that hallucinatory experiences are assumed to be strictly pathological in nature.[36]

However, over the last few decades a significant number of researchers have challenged the dominant paradigm of mental illness by altering and re-constructing their perceptions of the same. This paradigm shift can be noted in the emergence of the relatively new concept of "recovery," described by Anthony as

> ... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a

> way of living a satisfying, hopeful, and contributing life even with limitations caused by illness.[37]

The more individualised notion of recovery challenges the existing idea that mental illness is debilitating and of very little significance to individuals with schizophrenia. In reference to individuals with auditory hallucinations in schizophrenia, recovery may imply that such individuals have learned to cultivate a more favourable attitude towards their auditory hallucinations, thereby possibly viewing them as an aid to psychological healing instead of something to be completely extinguished from the human experience.

Similar to the multiple ways in which we may interpret the concept of recovery, Christian Perring sheds light on the different interpretations of "disability." In his paper titled, 'Madness and Brain Disorders: Stigma and Language,' Perring points out that "while people classified as disabled do have an impairment, they are not intrinsically disabled but instead are disabled by society." This suggests that we need to expand our perspectives regarding individuals who are identified as disabled, instilling hope and providing an environment of support and community, instead of stigmatising such individuals as hopeless or insignificant.

Hence, a more expansive recovery model may be of great relevance to individuals with auditory hallucinations. However the process of recovery has not been well researched, perhaps because scientific studies of schizophrenia seldom focus on the subjective experience of the individuals.[38] One of the hindrances for such a study is the common belief that such individuals may be incapable of providing any insight into their illness. As Davidson's works exemplify, "there is a common perception within psychiatry that many people diagnosed with schizophrenia have little to no insight into, or are in denial of their condition."[39] Thus, there is a crucial need for exploring the subjective experience of auditory hallucinations, including the value of incorporating auditory hallucinations into the recovery process of individuals diagnosed with schizophrenia.

With the introduction of the recovery process, there appears to be a gradual departure from the predominant manner of viewing auditory hallucinations. However, there still exist varying attitudes towards auditory hallucinations, both from patients and mental health professionals. To elaborate, some patients have found immense value in attending to their auditory hallucinations; many stated that the voices were pleasant and they did not want them to disappear as a consequence of treatment.[40] Dating as far back as the 1970s, Al-Issa has documented that:

> Schizophrenic patients may want to get rid of unpleasant hallucinations but might resent attempts to eliminate those

> that are positively self-reinforcing…Thus, any attempt to eliminate hallucinations, particularly those with pleasant content, maybe anxiety arousing to the patient.[41]

However, since hallucinations have most often been perceived negatively, the assumption has been that they interfere with daily activities and interactions.[42] In most cases, schizophrenic speech and behaviour have been discouraged and actively suppressed - often actively ignored.[43]

The generally negative outlook towards auditory hallucinations determines to a great extent, the level and kind of treatment that is made available for patients with this experience. Treatment of auditory hallucinations has been primarily approached through methods of operant conditioning, systematic desensitisation, thought stopping, counter-stimulation, aversion therapy, earplug therapy, as well as self-monitoring.[44] Each of these treatment methods are aimed at eliminating the auditory hallucinations of patients. But what if we were to change our perspective and shift our focus from eliminating auditory hallucinations to assimilating them into a more flexible recovery model? In other words, what if the goal of treatment was to develop a collaborative and healing relationship with auditory hallucinations rather than simply trying to eradicate them?

This approach to assimilating auditory hallucinations was adopted by the Dutch psychiatrist Marius Romme and Sandra Escher in the 1990s. Using a non-pathological view of auditory hallucinations, Romme and Escher emphasised the importance of controlling or managing hallucinations. In one study, they compared patients diagnosed with a mental illness with non-patients who experienced auditory hallucinations. They found that there were few differences between the two groups.[45] Both patients and non-patients experienced a combination of positive and negative voices, but the non-patients often felt they had some control over their voices. This suggests that it is not the hallucinations *per se* that determine whether people seek help from psychiatric services, but how well they are able to cope with these experiences.[46]

Wilhelm Mayer-Gross, a German psychiatrist working in the 1970s, also looked upon psychosis as an opportunity for growth. He believed that the way in which the psychotic episode was assimilated by the individual determined prognosis. The most favourable outcome was through "a kind of "integration" of the experience into the ongoing life of the individual…"[47] Laing perhaps foreshadowed Mayer-Gross's observation when he declared in 1960 that madness need not be all breakdown, but also breakthrough.[48]

In summary, there appears to be two schools of thought that are key players in providing a model for understanding auditory hallucinations in schizophrenia. The medical model, or psychiatric perspective, deems it important to eliminate auditory hallucinations through the administering of

neuroleptic medications. Therefore, it could be suggested that according to this view, the suppression or elimination of auditory hallucinations is an indication of successful treatment, and necessary for an individual to resume a normal life. The second model suggests that auditory hallucinations are a significant part of the individual's experience, and therefore should not be eliminated. The proponents of this paradigm, including Romme and Escher, Jung and Laing, propose that auditory hallucinations may have a purpose in the individual's life, and may have meaning or relevance to an individual's sense of identity. Romme and Escher, on speaking of the importance of accepting auditory hallucinations, states that "hearing voices has been considered solely as a symptom of illness, and the psychiatric intervention has paid no attention to the possible meaning of voices to the patient's life history."[49]

Romme and Escher also conclude that an individual who experiences auditory hallucinations should not necessarily be diagnosed with schizophrenia or any other mental illness. Other researchers are of the view that all diagnostic categories, as originally instituted by Emile Kraepelin and are now a significant part of psychology, should be completely done away with. For instance, Bentall argues that because the course of psychosis is very unpredictable and because the outcome is enormously variable between individuals, the very idea of diagnoses provides a "fool's-gold standard against which to evaluate the predictions achieved by psychiatric diagnoses."[50]

Such a radical perspective, although quite appealing in providing a broader framework for understanding mental illness as only a fraction of the broad spectrum of human experiences, neglects the utility of such classifications with regard to prognosis and course of treatment. However, as a researcher, I am in some agreement with Bentall's stand on the value of diagnostic categories, in that they are not necessarily the only instrument for understanding the psychological conditions that are presented in individuals with a clinical diagnosis. In fact, as mentioned previously, most diagnoses are based on the "form" rather than the "content" of the individual's experience. However, hallucinations make up only a part of the clinical diagnosis for schizophrenia. To be diagnosed with schizophrenia, one must experience one or more other symptoms as well, such as delusions, disorganised speech or catatonic behaviour. Therefore, I do not propose that schizophrenia is non-existent, but do propose that we consider more closely the role and content of hallucinations when they are present.

In this regard, I am closely aligned with the ideas and concepts of Romme and Escher, who have shown through their research and case studies that there is meaning in auditory hallucinations. However, the literature to date is lacking in qualitative research relevant to incorporating auditory

hallucinations into the treatment or recovery process, specifically in the case of schizophrenia.

The two research questions I propose (can auditory hallucinations be meaningful for individuals with schizophrenia? And how can they be incorporated in the recovery process?), have two implications. First, the simple act of acknowledging that auditory hallucinations may have some meaning in the individual's life signifies that they may also have a function, and that the meaning and function of hallucinations may be determined and worked with within the therapeutic relationship of the therapist and the client/patient. Second, in acknowledging the auditory hallucinations or voices, individuals may be able to probe deeper and gather insight into the meaning of their auditory hallucinations, thereby integrating the experience of hallucinations into their recovery process.

It is crucial to re-state that recovery (for the purpose of this paper), does not necessarily equate to cure, but is rather evidenced by the individual developing a new understanding of his/her life circumstances, and living a more satisfying and hopeful life. This idea is best illustrated through the case example of Catherine Penney who was diagnosed with schizophrenia at the age of 17. On his experiences regarding Catherine's auditory hallucinations, her psychiatrist states, "her voices were not just hallucinations - meaningless symptoms; they spoke the rage she dared not acknowledge."[51]

4. Conclusion

Over a century ago, Emile Kraepelin informed the scientific world about the existence of "dementia praecox," now referred to as schizophrenia. According to Jenkins and Barrett, schizophrenia is *the* defining problem for psychiatry.[54] Researchers in the fields of psychology, philosophy, anthropology, existentialism and sociology (to name a few) have explored the phenomena of auditory hallucinations. Yet, they have been unable to subscribe to a universal conceptualisation and understanding.

Auditory hallucinations in schizophrenia have been explained in myriad ways including changes in brain chemistry, environmental factors, genetic factors, cross-cultural frameworks, religious considerations, impulsions and introjections of the human psyche and spiritual agents. I propose that these frameworks provide a conceptual and sometimes practical comprehension and appreciation of the form of auditory hallucinations in schizophrenia. Simultaneously, they are devoid of an absolute or ultimate explanation of the same, leaving one to conclude that perhaps there is no single interpretation or claim to comprehending auditory hallucinations in schizophrenia.

With time, it is becoming evident that perhaps even a slight modification in our attitude towards auditory hallucinations and the possible significance they may hold in the recovery process is what is most needed.

This is not to say that such an attitude is a panacea for schizophrenia. Yet, instead of viewing auditory hallucinations solely as a symptom, it may be of certain benefit to the patient to "re-view" auditory hallucinations in a more progressive light.

It is not unusual to think of auditory hallucinations as unreal, futile aspects of the human experience, an enigma relegated to the world of the unknown. However, it seems that the time has arrived to acknowledge the possible utility of auditory hallucinations and not to think of them as an illusion, but as Jung warns us,

> … [to] experience the reality of this illusion…The products of the dissociation tendencies are actual psychic personalities of relative reality. They are real when they are not recognised as such…[52]

Post-Kraepelin times, for most part, have taken a rather unfavourable stance towards auditory hallucinations, with most methods of treatment rescinding them. In many instances, these theories and methods appear to be outdated, leaving ample room for the introduction and research of more innovative ideas and perspectives. Research has sought to understand auditory hallucinations from a rather scientific and material basis, viewing the suppression of auditory hallucinations as a successful indication of treatment in schizophrenia. In shifting our attitude, it may be hoped that an acknowledgement of the role of auditory hallucinations may pave the path to a less pathological perspective. Furthermore, from the current research and literature, it seems that a progressive and tolerant attitude towards auditory hallucinations in schizophrenia may be beneficial in deepening our appreciation and perception of this widely studied phenomenon.

Notes

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