University of Southampton
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Silencing the stigma of hearing voices: Implications for Educational Psychology understanding and practice

Ffion Davies. Essay, submitted March 2021

There is a great deal of stigma surrounding the experience of hearing voices despite findings that it is common, especially among children and young people. In children it is often transient, possibly part of normal development, and can be a positive experience. The Hearing Voices Movement urges a move away from a medical model and towards understanding hearing voices as part of a meaningful human experience. Possible explanations as to why people hear voices include coping with trauma, to serve a social function, or part of normal development. Evidence suggests different underlying mechanisms for positive vs negative experiences. More research is needed on how best to support young people in school and it is important that young people are included in research. Educational Psychologists are in a unique position to provide support on several levels, including individual, school and societal with an emphasis on normalising the experience and removing stigma.

Hearing voices (HV), often referred to as auditory verbal hallucinations, is described in the literature as an experience of hearing a voice that no one else can and which cannot be attributed to external stimuli (Alderson-Day & Fernyhough, 2016; Maijer et al., 2017; Pearson et al., 2001). This phenomenon is usually associated with schizophrenia and other psychotic disorders and is indeed a common symptom in both (American Psychiatric Association, 2013; CAMHS, 2017). However, research suggests that many people in non-clinical or 'healthy' populations experience HV, with prevalence rates of around 12% for children and young people (CYP) and 5.8% for adults (Maijer et al., 2018). Maijer et al. (2017) suggests that HV in childhood could be a normal part of development and is often a transient experience that does not always continue into adulthood.

Beavan et al. (2011) suggest that prevalence rates are often an underestimation due to the great deal of stigma surrounding the experience of HV, despite an increasing understanding of how common it is (Coffey & Hewitt, 2008). Perhaps this is partly due to its association with schizophrenia, which is also highly stigmatised (Valery & Prouteau, 2020). Media platforms publish sensationalised stories of people who hear voices (PHV) with dramatic and stigmatising titles such as, "*The terrifying ordeal of a brilliant student who started hearing voices and then fell into the abyss of insanity*" (Campbell, 2008). In the popular children's film, 'Harry Potter,' a main character says, *"even in the wizarding world, hearing voices isn't a good sign"* (Columbus, 2002), illustrating how this stigma is introduced from a young age and could be damaging to how children who hear voices view themselves and their experience.

As a result of this stigma, the Hearing Voices Movement emerged in the 1980s, which argues against a medical model of this experience and encourages the inclusion of experts-by-experience in research and discussion (Corstens et al., 2014). However, research is still generally dominated by pathologized paradigms and this is especially harmful for CYP, who are more likely to hear voices (Maijer et al., 2019) and who are less likely to be in a position to define their own experiences (ACAMH & Parry, 2021). This is not to deny the existence of HV in mental illness, however Beavan et al. (2011) suggests a move away from a medical model and towards understanding this experience as having meaning in people's lives. Beavan et al. (2011) also proposed understanding HV as a continuum ranging from positive and enriching experiences to clinical significance and distress.

In this essay I will use the term 'hearing voices'

(HV) or ‘people who hear voices’ (PHV) to refer to people who do not reach clinical significance or have a diagnosis of schizophrenia (unless stated otherwise). This is the language used by those who experience voices as well as charities and organisations who support CYP (National Hearing Voices Network, 2021; Voice Collective, n.d.). Using this person-first language and HV rather than ‘auditory hallucinations’ is important as it moves away from the idea of HV as exclusively part of clinical diagnoses.

From a social constructivist epistemology, the language we use and the stories we tell children will shape their understanding of themselves and their experiences. I will argue in this essay, therefore, that it is paramount that we allow CYP to create their own narratives of their experiences of HV as this is their reality and truth, regardless of whether the voices are audible to others or not. Adults should work with CYP to understand their perceptions since it has been found that CYP who understand the meaning or context of the voices report less distress (Parry & Varese, 2020).

This topic is relevant to Educational Psychologists (EPs) and schools, since teachers are often the first person CYP disclose mental health concerns to and key stakeholders have reported that children rely on their teachers for information about mental health (O’Reilly et al., 2018). However, teachers have reported not feeling confident about their skills in managing mental health difficulties (O’Reilly et al., 2018). EPs might work with schools to educate teachers and staff about HV, in turn helping them to feel more confident in supporting CYP who hear voices without reinforcing stigma or invalidating their experience. Emphasising the need to eliminate voices may not be appropriate, as some CYP have reported finding them to be comforting and supportive (Parry & Varese, 2020). Consequently, it is important for teachers to understand CYP’s individual interpretations: both distressing and positive experiences of HV exist (Løberg et al., 2019), although both groups receive the same fearful stigma.

In this essay I will discuss an alternative approach to the medical model, with emphasis on the need to destigmatise the experience of HV. Using a social constructivist epistemology, I will explore possible explanations and functions of HV, the differences in distressing and non-distressing experiences, and the different levels of intervention or support and implications for EP practice.

An alternative approach to the medical model

It could be argued that the medical model is a narrow and ‘one-size-fits-all’ view of HV. Evidence shows huge variation in the experiences of PHV. For example, Woods et al. (2015) conducted a large-scale study which surveyed PHV between the ages of 16 and 84 with a diverse range of medical histories, including people with no clinical diagnoses. The characteristics of voices reported varied significantly. Of the 153 participants, most reported hearing more than one voice, 37% described having two-way conversations with the voices, 30% reported positive and helpful voices and 35% described the voices as abusive. Most voices were described as having distinct anthropomorphic characteristics such as age, gender, accent, loudness, and predictable emotional responses indicating unique personalities. Indeed, 22% of participants identified their voices as existing individuals (e.g. celebrities or people known to them), whereas 16% reported the voices as supernatural entities. The experience of HV can vary from intrusive thought-like voices to audible expressions as if from an external speaker (Woods et al., 2015). This study illustrates the diversity within this experience and suggests that a ‘one-size-fits-all’ approach to support from the medical model is not appropriate.

It may be more helpful to appreciate the variety in experience in order to help make meaning of individuals’ voices; this is ultimately more empowering and less stigmatising than a pathologized approach. Research suggests that a barrier to disclosure of HV is the fear of stigma from friends, family, wider society and even from professionals; this is reinforced by professionals who do not deem it appropriate to talk about the voices (Coffey & Hewitt, 2008; Hazell et al., 2018). Discouraging children from talking about their experiences could reinforce the stigma which stops them from seeking support (Hazell et al., 2018).

An alternative approach, called the Maastricht approach, encourages PHV to accept and make sense of their voices as a way to manage their experience. This involves talking about the voices (Beavan, 2011). Woods et al. (2015) found that 45% of their participants were able to exert some control over their voices by engaging with them or exploring their meaning. For young people, this feeling of control over their voices is more important for their wellbeing than the nature of the voices themselves (Parry & Varese, 2020).

Because HV is viewed so negatively in society and often regarded with fear and stigma, it could be distracting from a more important underlying cause. Professionals working with children who are distressed by their voices should resist the temptation to only focus on the voices, and instead approach with cautious curiosity about what this experience might be communicating (Maijer et al., 2019).

Why do young people hear voices?

Trauma

It is widely accepted in the literature that trauma in childhood is associated with the development and persistence of HV and research suggests a bidirectional dose-response relationship (Maijer et al., 2019). It might be that a function of the voices is a coping strategy when faced with seemingly uncontrollable situations (Iudici et al., 2019) or trauma, as voices often discontinue when the trauma has ended (Beavan, 2011). Participants in the study by Woods et al. (2015) described experiencing their first voice in childhood and linked this to a traumatic event. Indeed, in a qualitative study of 68 young people who hear voices, Parry and Varese (2020) found that the majority of their participants reported first hearing voices between the ages of eight and 11. As the transition into adolescence can itself be a confusing and turbulent time (Woolfolk, 2016), voices might develop during this time as a coping mechanism. The link between trauma and HV is well documented in both clinical and non-clinical populations, yet this is not the only pathway to this phenomenon as not everyone who experiences trauma goes on to hear voices and not all PHV have experienced trauma (Luhrmann et al., 2019).

Social function

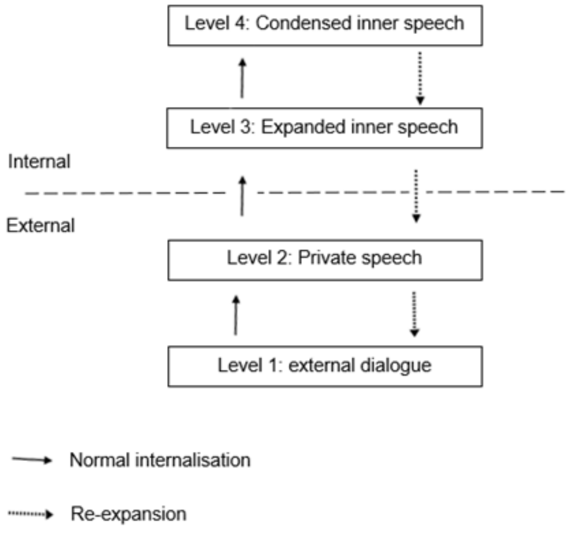
In the study by Parry and Varese (2020), participants also reported their voices as serving a social function, perhaps to compensate for loneliness or lack of friendships. This does not imply causality, however, as it is unclear whether the voices developed to compensate for lack of friendships or whether the children did not seek friendships as their voices filled this social need by providing company, emotional connection and reassurance (Parry & Varese, 2020). This is similar to descriptions of imaginary friends (IFs) and research has suggested a possible link between IFs and HV (Fernyhough et al., 2019). Up to two thirds of children engage in IFs, which often serve a social function. Fernyhough et al. (2019) explored the association between IFs and proneness to HV using the Launay-Slade Hallucination Scale – Revised, Auditory Subscale (LSHS-A). The study, which consisted of 1,472 UK participants, found that adults who had an IF in childhood were more susceptible to HV in adulthood, and those whose IF persisted into adulthood were even more susceptible (Fernyhough et al., 2019). Interestingly, a child having an IF is not perceived with the same fear and stigma as a young person who hears voices.

Part of normal development

Evidence suggests that HV in childhood may be part of normal development, much like IF (Maijer et al., 2017). The prevalence of HV is likely to be an underestimation due to stigma. Additionally, however, studies may also miss out on PHV who have positive experiences (and have no desire to supress their voices). These people might not be part of the support groups or mental health services which researchers typically recruit from (e.g., Kapur et al., 2014; Parry & Varese, 2020; Woods et al., 2015). This may be particularly pertinent for young people, as children may not perceive HV as problematic or realise that not everyone experiences voices (Parry & Varese, 2020). In children under the age of seven it is difficult to discern whether they are hearing voices, interacting with an IF or dreaming, and HV can be a transient experience (Maijer et al., 2017), therefore we may be underestimating the prevalence of HV as part of normal development. One explanation of how HV is related to development comes from the idea that HV is a misattribution of inner speech (Allen et al., 2007). The re-expansion model explores the mechanism of this misattribution (Fernyhough, 2004), however to understand this we must first understand how inner speech develops.

Inner speech was first defined by Vygotsky as an internal dialogue (Woolfolk, 2016). Vygotsky claimed that every mental function develops in two stages, first on the inter-psychological plane where a child learns a skill or function through scaffolding, usually with a caregiver; second, on the intra-psychological plane, an internalised version of this skill or function. For inner speech this means a child progresses through different levels. First, they hear their caregiver's dialogue, often in the form of Infant-Direct-Speech (IDS) (Saint-Georges et al., 2013), which involves a caregiver asking questions and modelling a 'give-and-take' form of conversation (i.e., external dialogue). In the next stage, the child will repeat the same kind of questions to themselves out loud (i.e., private speech). Gradually this will become a whisper and eventually this will become internalised, although a child may still verbalise these thoughts during cognitively demanding tasks. The first stage of internalisation is expanded inner speech, where children will have the give-and-take form of conversation internally, and eventually this will develop into the final stage of condensed inner speech. The re-expansion model (illustrated in Figure 1) explains the phenomenon of HV as when a person is under stress or high cognitive challenge they move back through these levels and inner speech is experienced as an expanded dialogue with the reciprocal nature of conversation, which is mistakenly perceived as an external voice (Fernyhough, 2004).

Figure 1. *Stages of internalisation and re-expansion model adapted (with permission) from Fernyhough, 2004.*



There is limited research on this model, however it has been found that children hear more voices in times of stress (Pearson et al., 2001) and it explains how HV may be related to trauma and why voices disappear when trauma is resolved (Maijer et al., 2019). This theory may be useful for CYP or adults who support them as it offers a clear and normalising model. However, it does not fully explain the social aspect so often reported by PHV. Perhaps, as people automatically pick up on social cues and recognise features of agents, the personalities of voices are constructed by the hearer after the event as a way to make sense of the experience - meaning the social nature of HV is secondary to the hallucinatory experience (Alderson-Day & Fernyhough, 2016). This model and how it may explain the social function of voices would be an interesting area for future research.

In the study by Woods et al. (2015), a majority of participants reported negative feelings such as fear, depression, and stress, however 31% reported positive feelings. Again, this is likely an underestimation due to recruitment via clinical networks and mental health forums, which may not be accessed by PHV with mostly positive experiences.

If the voices are indeed a coping mechanism or serve social functions, why are some CYP distressed by them? There may be a fundamental difference between the two subgroups of PHV who are distressed and not distressed as the voices seem to serve different functions and therefore may develop in different ways.

The difference between distressing and non-distressing experiences

People who hear voices have vastly different experiences, ranging from helpful and positive to extremely distressing. This may suggest different forms and functions of distressing and non-distressing voices. One study that looked at the different psychosocial factors and experiences of CYP who hear voices was conducted by Løberg et al. in 2019 as part of the Bergen Child Study in Norway. This was a longitudinal piece of research looking at youth mental health in which all adolescents attending high school in the city of Bergen answered a web-based questionnaire that included two questions relating to the experience of HV (Løberg et al., 2019). Of the 9,873 participants, 13.9% reported HV, which is similar to other estimates of prevalence (Maijer et al., 2018). However, only 5.6% reported being distressed by these voices and, when compared on several psychosocial variables, there appeared to be a distinction between distressing and non-distressing experiences. Distressing voices were predicted by trauma and bullying, less family support, anxiety, negative self-worth and self-efficacy, and distractibility. Non-distressing voices were predicted by trauma, social dysfunction, affective symptoms, perceived negative self-worth, distractibility, older age, and male gender. The strongest predictor of non-distressing voices was social dysfunction. Returning to the re-expansion model, this might provide the looked-for link to social function, with this arising out of (and compensating for) specifically socially stressful situations.

Furthermore, the study reported a seemingly contradictory relationship between the presence of non-distressing voices and better grades. This suggests the possibility that the voices might be a coping mechanism for CYP who are 'over-achievers' and perhaps have an unhealthy work-social life balance. We can speculate that their voices might be acting as a coping mechanism for stress and compensation for a lack of social interaction. Currently, this is conjecture as participants in this study were only grouped into three categories: no experience of HV, experience of HV and distressing experience of HV. Consequently, this did not allow for information to be collected about CYP who have *positive* experiences of HV as the 'experience of HV' category cannot be separated into the neutral, positive or mixed feelings categories used in other research (Parry & Varese, 2020). Therefore, we can only conclude differences in distressing vs. non-distressing and speculate about distressing vs. positive experiences. There is a need for more qualitative research in this area, specifically involving CYP who HV as experts-by-experience.

Gender differences in distressing vs non-distressing voices

In a literature review of people in the general population who HV, Beavan et al. (2011), stated that hearing voices is generally more common in women than men. Løberg et al. (2019) found that adolescent boys were more likely to experience non-distressing voices compared to girls. Interestingly, other research has also shown that women more often report negative voices rather than positive and that these negative voices are often connected to controlling, critical or abusive people in their lives (McCarthy-Jones et al., 2015). Adolescent females are more likely to seek support for their voices which could be interpreted as females experiencing more distressing voices (Parry et al., 2020). However, men are less likely to seek help for mental health difficulties in general due to problematic norms of masculinity (Gough & Novikova, 2020), therefore the number of men experiencing distressing voices may be an underestimation.

One possible explanation for this gender difference in distressing vs. non-distressing voice hearing is the link between negative self-worth and distressing voices. Løberg et al. (2019) found that negative self-worth is a significant predictor of distressing voices. Women and girls have generally lower self-worth than men and boys (Zeigler-Hill & Myers, 2012) due to the negative messages they receive from society (Fredrickson & Roberts, 1997). There is also evidence that distressing voices reflect social inequalities. For example, in a qualitative study by Haarmans et al. (2016), the voices of women diagnosed with schizophrenia used racialised or gendered conditions of worth to undermine them. These participants reported that their voices criticised them using gender-specific expectations such as appearance and sexual purity. The voices of ethnic-minority women also used racist slurs and stereotypes to undermine them. This study suggests that PHV may internalise societal inequalities and expectations which are then reflected in their voices. Although this study was conducted with adults with a clinical diagnosis, the study by Parry & Varese (2020) found similar results with CYP where voices often reflected social or personal oppressions. McCarthy-Jones et al. (2015) described this link between voice hearing and gender oppression as "*society's historical silencing of women's voices was compounded by the social stigma and isolation attached to voices*" (McCarthy-Jones et al., 2015, pp. 8). Van der Gaag et al. (2003) suggested that beliefs about voices are not based on the content of the voices but are constructed by the hearer in an attempt to make sense of them. Therefore, perhaps an explanation for the gender difference between distressing vs. non-distressing voices is that girls are subjected to negative messages from society about their self-worth and these messages are mirrored in the voices they hear, which renders them distressing. Currently, this is conjecture based on several separate findings. Exploring this idea further in future research may shed light on the apparent gender differences, and ultimately inform intervention and support.

Issues in research

There is limited research in the area of HV particularly involving CYP. This may be due to an emphasis on research with individuals with schizophrenia diagnoses or stigma around the experience of HV. Young people may not tell their parents about their voices due to the numerous barriers to disclosure of HV, including stigma, confusion and denial (Hazell et al., 2018). This makes it difficult to recruit young people for studies as parental consent is often required for participation in research. However, as previously mentioned, more qualitative research involving CYP is needed as many studies rely only on retrospective reports from adults (Luhrmann et al., 2019). One study that has been successful in this is by Parry and Varese (2020). This study used a qualitative design to elicit young people's views about the forms and functions of their voices.

The participants of this study were between the ages of 13 and 18 and parental consent was not required to participate. Some of the CYP in this study identified their voices as specific people in their lives who were often connected to a difficult experience: if this had been a parent or guardian then to gain consent might have proven difficult. This study therefore only required consent from the young people themselves. This was an inclusive and important study, since young and marginalised people have very few opportunities to influence the way others understand the phenomenon of HV and the narratives are so often from other people or professionals (ACAMH & Parry, 2021). The issue of disclosure in much of the research discussed raises the question of who we are hearing from. This study takes a step in the right direction of making research more inclusive and empowering for the people it effects most.

A further challenge in this area of research is recognising the cultural differences in understanding HV. In the study by Fernyhough et al. (2019), one of the scales used to measure voice hearing was the LSHS-A which includes the statement *"In the past I have heard the voice of God speaking to me"* (Bentall & Slade, 1985, p. 528). This question seems only relevant to people with typically western Judeo-Christian religious beliefs. It is important to note that there are vast cultural differences in how voices are perceived and even discrepancies within cultures (Cook, 2018). For example, in Western Christian societies, HV is commonly stigmatised and associated with mental illness, however when framed in a religious context, HV in Christianity can be viewed as a revered gift (Cook, 2018). This supports the idea that the narrative individuals tell themselves (or hear from others) is most likely to influence how people cope with and give meaning to their experience (Beavan et al., 2011). It is therefore important that research considers the influence of culture and religious beliefs when investigating the experience of HV

The various levels of intervention and implications for EPs

There is limited research about how CYP who hear voices feel about support given by schools, however we can learn from experiences of CYP and parents who have engaged in mental health services and how this may apply to education. In a study by Kapur et al. (2014) 32 young people who hear voices and 27 parents completed a questionnaire about their experience of engaging in CAMHS. Parents and young people expressed a desire for support to be more normalising and destigmatising with less emphasis on mental illness, pathologized approaches and medication. Participants also reported that social support and support groups were helpful. Schools and EPs can take useful guidance from these findings as social support and normalising the experience are realistic goals for working with CYP in education. The knowledge that CYP are not seeking a medical model approach may also give school staff confidence in discussing mental health difficulties and providing social support (O'Reilly et al., 2018). To maximise positive change, EPs should look at how to support CYP on multiple levels which impact them such as the individual, school and societal level (Bronfenbrenner, 1989). Supporting schools and reducing stigma on a societal level will enable EPs to reach more children in indirect ways.

Individual level

On an individual level EPs may encounter CYP who hear voices as part of both statutory and traded work and may be in a unique position to work closely with the child, school and family to understand why they may be HV using a holistic approach. EPs' problem-solving skills and understanding of child development will enable them to understand whether a child is HV due to trauma, to serve a social function, as part of normal development or for a reason not yet identified in the literature. This is important as starting from the child's perception of their voices is paramount in providing support, normalising the experience and enabling the child to create their own narrative free from other people's preconceptions.

School level

There are mixed findings around whether CYP feel a need for more information about their own voices. For example, in the study by Kapur et al. (2014), the majority of participants said it was difficult to access information about HV to aid understanding, however nearly two thirds of the young people said they had some idea of why they heard voices. Perhaps it is not the people experiencing the voices who need the pscyho-education, but instead the people and systems these CYP interact with, such as schools and teachers. As there is limited training around HV in the general population of CYP and an emphasis on HV as part of a clinical diagnosis (Corstens et al., 2014), EPs could create and deliver training about HV from an evidence-informed and child-centred approach. This may build teachers' confidence in having open discussions about HV, which is important as CYP often look to their teachers for information about mental health (O'Reilly et al., 2018). Furthermore, due to the association of HV and trauma (Maijer et al., 2019), EPs can help schools to be trauma-informed which will help all children, not only those who hear voices.

Wider systems and society

There is a clear need to de-stigmatise the experience of HV and although this may seem like a wider societal issue, EPs are often advocating for the voice of CYP: this is an opportunity for EPs to educate people about the experience of HV. This might take place through multi-agency work that EPs are often involved in, ensuring that the child's perception of their voices is heard and used to inform support when and if it is needed. EPs can also encourage a holistic approach to support in multi-agency meetings, since this has been found to maximise engagement in mental health services (Maijer et al., 2019). Research focussing on the lived experiences of CYP who hear voices from a non-medical model perspective may also help to reduce stigma and normalise the experience. EPs are well-positioned to lead research on what support CYP who hear voices would benefit from in school. EPs are skilled in working with young-people and advocating for their views and can therefore facilitate research with young experts-by-experience to guide and inform future intervention.

Conclusion

In conclusion, it is important for school staff, and society as a whole, to move away from a medical model of HV and towards understanding the phenomenon as a meaningful experience in people's lives. It is important to support CYP in exploring their voices to make meaning and to empower them to define their own narratives. Supporting schools to support CYP and to reduce stigma on a societal level through research will enable EPs to create positive change for all CYP who hear voices.

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