

# **Understanding the Experiences of Hearing Voices and Sounds Others do not Hear**

Anne Martha Kalhovde,<sup>1</sup> Ingunn Elstad,<sup>2</sup> and Anne-Grethe Talseth<sup>2</sup>

<sup>1</sup> Department of General Psychiatry, University Hospital of North Norway, Tromsø, Norway

<sup>2</sup>Department of Health and Care Sciences, Faculty of Health Sciences, University of Tromsø, Tromsø, Norway

## **Corresponding Author**

Anne Martha Kalhovde, University Hospital of North Norway, Department of General Psychiatry, Åsgårdveien, N-9291 Tromsø, Norway

Email: [Anne.Martha.Kalhovde@ihelse.net](mailto:Anne.Martha.Kalhovde@ihelse.net)

## **Abstract**

In this article, we aim to contribute to the understanding of how people with mental illness experience hearing voices and sounds that others do not hear in daily life. We conducted in-depth interviews with 14 people and analyzed the interviews using a hermeneutic phenomenological approach. The themes we arrived at included the following: hearing someone else or myself, am I losing my mind?, and daily life recurrently dominated by opposing voices. Our overall understanding of how the voices and sounds were experienced in daily life was that the intentions of others resounded intrusively in the participants and disrupted their lives. The tones and contents of these perplexing perceptions echoed and amplified past, present and future experiences and concerns. The results elucidate the value that exploring and attempting to understand people's daily life experiences of hearing voices and sounds might have for the voice hearer, their family and health care providers.

## **Keywords**

hermeneutics; interviews; lived experience; mental health and illness; mental health nursing; phenomenology

We do not completely understand how persons with mental illness experience hearing voices and sounds others do not hear in daily life. These perceptual experiences are commonly known as auditory (verbal) hallucinations and have been described in medical and psychological terms (Waters et al., 2012). The authors of diagnostic manuals (i.e., the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition-Text Revision [DSM IV-TR] of the American Psychiatric Association [APA], 2000), defined the experiences of voices and sounds as sense perceptions that have a “compelling sense of reality,” although they lack an “external stimulation of the relevant sensory organ” (p. 823).

The authors of DSM IV-TR (APA, 2000), furthermore, considered hearing voices a defining symptom of psychotic disorders and thus categorized these voice experiences as an often debilitating condition that severely impacts daily life by diminishing or disrupting contact with reality. When heard persistently (for at least 1 month; DSM IV, A-criterion, p. 312), the voice experiences are regarded as indicative of the most severe psychotic disorder, schizophrenia.<sup>1</sup> Of those diagnosed with schizophrenia, the majority hears voices, and a large minority<sup>2</sup> is significantly troubled by voices, despite long-term pharmaceutical treatment (Mueser & McGurk, 2004). Although less frequently examined, persons with other psychiatric diagnoses, (e.g., mood disorder, posttraumatic stress disorder, and borderline personality disorder) might also hear voices (Larøi et al., 2012).

In studies of the general population over the last two decades, researchers have nonetheless revealed that a significant minority (5-13%) have heard voices (Beavan, Read, & Cartwright, 2011). Closer investigations of voice hearers in the general population have revealed that most neither seek nor need professional help (Sommer et al., 2010). No significant differences have been found between those with and without mental illness in relation to whom,

how many, where and how loud the voices are. People with mental illness, however, perceive the voices as more disruptive to their daily lives; their voices are more negative, more frequent, last longer, and are more distressing and more difficult to control (Daalman et al., 2011). Hence, researchers have hypothesized that the hearing of voices is a dimensional experience that lies on a continuum from mental health to illness (Van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009) and are reexamining the diagnostic significance of hearing voices to specific disorders (Waters et al., 2012).

Health care providers have commonly approached persons who hear voices with little engagement in these experiences. The main goal has been to reduce or eliminate the psychotic symptoms that lead the individual to behave or express him or herself abnormally. Thus, health care providers have mainly encouraged service users to adhere to prescribed medication and reinforced consensual reality (e.g., by diverting the patient's attention from the "false" perceptions to the present activities and shared experiences; Coffey & Hewitt, 2008; England, Tripp-Reimer, & Rubenstein, 2004). Researchers have developed new approaches (i.e., cognitive behavior therapy) to address the person's complaints and alleviating voice-related distress through dialog and engagement instead of focusing on diagnoses (Bentall, 2006). Health care providers have been encouraged to explore the forms, contents, and qualities of service users' voice experiences (Chadwick & Birchwood, 1995; England, 2007).

Romme and Escher (1989) introduced the perspective that hearing voices is a reaction to problems in life and need not be a symptom of a mental disorder. According to these authors, the voices should not necessarily be eliminated; instead, the voice hearer should receive support in making sense of the voice experiences if needed. Voice hearers and health care providers across the world have formed networks (e.g., the Hearing Voices Networks [HVN]) to promote this

view and to empower voice hearers in the process of understanding their voice experiences (Escher & Romme, 2012). The avoidance of addressing “unreal” voice experiences was central to the training of the first author (TFA) of the present article and a general approach during her ten years of psychiatric nursing practice (cf. England, 2007). This avoidance formed a barrier to establishing empowering relationships (Harrison, Newell, & Small, 2008; Kirsh & Tate, 2006) and motivated TFA to facilitate an HVN self-help group and workshops. She began to question whether the voices were (a) integral to psychotic disorders, or (b) normal variations of human reactions. Is it possible to integrate these perspectives when attempting to understand the voice experiences of people with mental illness?

In qualitative studies of voice hearers in psychiatric treatment, researchers have suggested that the characteristics and functions of the voices were related to ongoing activities (Fenekou & Georgaca, 2010) and that the voice content was of personal significance (Beavan, 2010). In a study of the experiences of voices in five people, Kalthovde (2005) revealed narratives of lonesome struggles despite extensive support from mental health care services. In another study (Coffey & Hewitt, 2008), voice hearers reported the need for community nurses to address the content and meaning of their voice experiences rather than to just review their medication. In our research project (2008-2013), we have aimed to explore the lived experience of hearing voices and sounds that others do not hear in people with mental illness. The research question we pose in the present article is the following: how do people with mental illness experience hearing voices and sounds in daily life?

## **Methods**

We conducted in-depth interviews with people with lived experience of hearing voices and sounds who had also been diagnosed with a psychotic disorder. We analyzed and interpreted the

transcripts with a hermeneutical phenomenological approach inspired by Gadamer's philosophy (2004). The design of this study has proven to be well suited to understanding lived experience (Geanellos, 1998a, 1998b). Gadamer (2004), however, emphasized that the circle of understanding is not a methodological circle, but describes the ontological structure of understanding. We determine this structure through our anticipatory movement of preunderstanding (Gadamer, 2004, pp. 293-294). Gadamer distinguished between conversations, in which one aims to know the other person and his horizon (i.e., a therapeutic conversation), and true conversations, in which one recognizes the other person's claim to truth (i.e., in-depth interviews about a subject matter; Gadamer 2004, p. 303). These perspectives have particular relevance for the study of the experiences of people who are categorized as being mentally ill.

Only when we expose ourselves to opposing views do we have any chance of reaching beyond the confines of our own assumptions (Gonzalez, 2006, p. 330). This exposure is a fundamental part of the hermeneutic experience and is essentially negative, a continual refutation of false generalizations. Gadamer argued that this negativity is productive because we acquire more comprehensive knowledge (Gadamer, 2004, pp. 347-348; Gonzalez, 2006, p. 330). Hence, the hermeneutic understanding of a text has the dialogical structure of questions and answers because the essence of questioning is to open up possibilities and to keep them open (Gadamer, 2004, p. 298).

### *Participants*

We recruited the participants through community-based (five) and out-patient (seven) mental health services in Norway from 2008 to 2010. Two participants initially volunteered after reading about the project in the media; one of these participants was not receiving treatment at the time and was therefore recruited after conferring with the ethics committee. Clinicians

conveyed oral and written information about the study to adult service users who (a) were hearing or had heard voices that they alone experienced for at least a year and (b) had been diagnosed with a psychotic disorder. Those interested in participating in the study contacted TFA directly. Three participants were acquainted with TFA prior to participation; however, their participation in the study had not been discussed before they volunteered.

Fourteen people (eight women, six men; age range: 19-57; median age: 39) who had been hearing voices and sounds for 2-39 years (age range of first voice experience: 8-32; median age 16) were included. All participants had previously heard voices daily. At the time of the study, seven participants heard voices daily, six participants occasionally heard voices, and one had begun to hear them daily. The participants reported having diagnoses in the schizophrenia spectrum (nine) or combinations of other different diagnoses, such as personality disorder, posttraumatic stress disorder (PTSD), and depressive psychosis (three). One participant was initially diagnosed with schizophrenia and was being reassessed for PTSD at the time of the study. One participant was unable to disclose a diagnosis.

All of the participants had used neuroleptic medication; nine participants were taking this type of medicine at the time of the interviews. Eleven participants had been subjected to involuntary hospital admissions. Seven participants resided alone; four resided in supported accommodations; and three resided with family. One participant was married, one widowed and five had formerly lived with a partner. Six participants had children, most of whom were grown, and none of the participants' children were living with the participants. The majority of participants were unemployed and received disability pensions (11); three worked part-time; and three attended school full- or part-time.

### *Ethical Considerations*

The research project was approved by the Regional Committee for Medical and Health Research Ethics in Northern Norway. Because the study explored sensitive and personal matters, care was taken to inform the participants of possible reactions the interviews might trigger (e.g., emotions and increased voice hearing); TFA, who conducted the interviews, offered to assist the participants in contacting the recruiting clinician if they desired. None of the participants withdrew from the project or requested assistance. All identifying characteristics were carefully modified to avoid the identification of the participants while preserving the information we believed to be related to the goals of the study.

### *Interviews*

TFA and the participants established the location, number, and timing of the interviews according to the participants' preferences at the end of each interview, although the maximum number of meetings was limited to three. TFA conducted follow-up interviews to enhance trust, openness, and understanding (Fleming, Giadys, & Robb, 2003). The majority of participants (nine) participated in two interviews; three participated in one; and two participated in three. In total, TFA interviewed each participant for approximately one and a half to two and a half hours. TFA conducted 11 follow-ups within a month and three follow-ups within six months. Two interviews took place at the workplace of TFA, and the rest (12) took place in the interviewees' homes, where all interviewees had arranged to be alone during the interview. One participant requested that the follow-up be conducted by telephone.

The authors used everyday language in both the consent forms and interviews. TFA avoided medical terms unless the interviewee introduced them with the aim of promoting the participants' openness about and emphasizing our interest in his or her daily life experiences (cf. Binding & Tapp, 2008). Initially, TFA asked the participants to relate what it was like for them



to live with voices or sounds others did not hear. Follow-up questions involved clarifying particulars, encouraging the participants to elaborate on matters that seemed relevant, and reflective statements that ensured mutual understanding. When required to engage more actively in the interviews, TFA used questions from an interview guide as prompts. Thus, we aimed for each interview to contribute to the formation of a hermeneutic learning process. TFA's focus in all of the interviews was to learn from the participants, not to confirm presuppositions or emerging theories. (cf. Binding & Tapp, 2008 on genuine dialogue; Gadamer, 2004 on true conversation). The interviews were digitally recorded and transcribed verbatim, with one exception. In this case, the interviewee did not approve of having the first interview recorded, and TFA made notes during and immediately after the interview.

### *Text Analysis*

We were inspired by the four cyclic steps outlined by Fleming et al. (2003) in our analysis of the interview texts. These steps are in harmony with the hermeneutical circling in Gadamer's hermeneutics (2004), as previously described. First, TFA wrote down an overall understanding of each text unit in relation to the research question (cf. Fleming et al., 2003). Transcripts of the interviews and follow-ups, as well as notes taken subsequently concerning each participant, formed a text unit. We began to analyze each text unit once the recording was transcribed. TFA listened to and reflected on the recordings, and all the authors read and reread the texts. This initial understanding formed the basis for further questioning and in-depth interpretations of the texts. The second and third authors are nurses experienced in the fields of qualitative inquiry, philosophy, and the education of nurses and mental health care providers.

Second, TFA marked all units of meaning (paragraphs, phrases or parts of phrases), and the authors reflected on them together to reveal variations and nuances of how the participant in

question experienced the voices and sounds in daily life (cf. Fleming et al., 2003). TFA presented written interpretations that facilitated the ongoing dialog with the second and third authors and the formation of themes and subthemes (cf. Binding & Tapp, 2008). Sometimes when we met, we developed themes together using the blackboard. Throughout the analysis, we continually challenged each other's presuppositions and interpretations.

Third, the themes and subthemes were compared with the written overall understanding of each text unit and adjusted (Fleming et al., 2003). Then we developed, and TFA put into writing, our comprehensive understanding encompassing the commonalities and nuances of all the participants. We read the themes and subthemes related to all participants consecutively, compiled and compared them with each other and the comprehensive summary, and we revised the summary. Although the themes were unifying and abstract entities, we kept them close to the participants' own words (DeSantis & Ugarriza, 2000).

Finally, we included passages that illuminated our understanding of the phenomena in question (cf. Fleming et al., 2003). Furthermore, we reflected on the results in light of the relevant literature. We concluded the analysis when we had reached a shared understanding, that is, when our and the participants' perspectives were integrated, and our understanding of the whole of the text corresponded with our understanding of its parts. TFA used the computer software NVivo 8 (QSR International, 2008, Victoria, Australia) in the initial phases of the analysis and to organize the notes made throughout the study.

## **Results**

We present the results regarding how the participants experienced and described hearing voices, and sometimes sounds, in daily life through the following themes and subthemes.

### *Hearing Someone Else or Myself*

The participants were puzzled by the sometimes intrusive voices, sounds or loud thoughts that they alone heard. The participants described the voice experiences along a range that included being “almost completely convinced” that the voices derived from someone else, perceiving the voices “as if” they derived from someone else, and perceiving the voices as originating in themselves. The voice experiences were personal, and the features of the voices and sounds varied greatly among those who said they had schizophrenia, as well as among those with other diagnoses. The following subthemes illuminate these aspects: (a) hearing the voices of someone in particular, (b) hearing sounds made by someone, and (c) something originating in me.

*Hearing the voices of someone in particular.* Most of the participants heard a distinct number of individuals deliberately addressing them. These were ambiguous experiences. The voices resembled common voices and sounds, but were intimately bound to the voice hearer; “it’s sort of illogical,” said one participant. These voices could not be verified through other senses or by other people. When the voices were heard in the presence of others, the participants scrutinized their expressions and reactions.

The participants sometimes asked if others had heard anything, especially when the voices were new or intense. Thus, the participants realized that the voices were something that they alone heard. One participant said, “No one else can see him, so I’m just forced to believe that it’s something I’m imagining.” Another said, “I was solemnly convinced that there was someone following me, ‘cause I did hear someone walking behind me, but when I turned around I didn’t see them.” This female participant recurrently heard the voices of two unfamiliar men and a vaguely familiar woman talking behind her back. Those who perceived the voices as emerging from within their body were almost certain that they alone heard the voices. One participant was certain that the most troubling voice she heard not only resembled, but actually

came from a relative. She spoke of the relative and the voice interchangeably and described how deep an imprint both had made throughout her life. The following is a sample quote: “he’s always bullied me. . . . He tries to govern the whole planet. . . . He thinks I’m dense.” She was, however, aware that this voice was a controversial issue and carefully selected with whom she shared this information. Some participants were immediately certain whom the voices resembled, whereas this was not obvious for other participants. After many years, one participant realized that one of the angry male voices she recurrently heard bore a close resemblance to a relative. She had witnessed this relative exhibit rage over a minor problem and apprehended that his unreasonable anger matched that of the angry voice.

The participants perceived most of the voices as having distinct and unchanging tones. The messages were personal and could vary according to the participant’s current circumstances. Nearly all participants heard angry, hostile, or critical voices with mostly discouraging, hurtful, frightening, or annoying messages. One said, “they laugh at me and mock me.” This participant’s voices also conveyed to her that she did not deserve to enjoy herself or meet her own needs or desires. Some participants, however, occasionally heard reassuring and helpful voices. These voices were not intrusive, and some participants could even evoke them voluntarily. One had recently become aware of and able to evoke the reassuring comments of a deceased relative when worry threatened to ruin her day. She said, “just hearing her voice reminds me of the good times.” Another participant had silent dialogs with angels who clarified the religious and existential questions he often pondered.

*Hearing sounds made by someone.* Some participants heard sounds unheard by others that were directed toward them. These sounds included the following: the indiscernible buzz of a crowd, incomprehensible whispering, crying, and harsh laughter. Other sounds, such as

a phone ringing, church bells or music implied that some, albeit anonymous, person was making them. One experienced both tinnitus and the buzz of a crowd. Although both were persistent sounds that he alone heard, he did not attribute the tinnitus to someone else's intentions, and it did not affect his life. "The voices can be very far away, and they can come closer . . . whereas tinnitus is very constant," he said.

*Something originating in me.* At the time of the interviews, most participants were certain that the voices, albeit alien and uncontrollable, derived from themselves. One spoke of the persons she so vividly experienced talking behind her back as "something I know is myself." The voices were essentially experienced as echoing and amplifying their feelings, thoughts, and recollections. To some participants, the voices were traces of others or encounters with others. For example, one participant said the following:

Sometimes I manage to place that voice. It resembles someone I know, but it's not like I feel that the person is talking to me now. It's more like . . . a trace in me of that person either for good or bad. . . . I have a friend of mine that has some anxiety, and when I feel that I get anxious over a certain issue then his voice comes in. . . . I'm the one feeling the anxiety though, but it's his voice that's talking.

When the voices started sounding from within her head, another participant was convinced that the persons who had been assaulting her had implanted a microchip there. Later, she reflected that the voices moved into her head because the assaulters and voices had taken over her entire life:

They [the voices] got to bothering me so much that they took over life, or my quality of life and values and all there was. Then I thought that I, yeah, something or other must have been implanted at least.

Some participants said the voices welled up from “depression and hidden feelings.” The voices also echoed questions and dilemmas regarding (e.g., whether the participants were good or bad, loved or unlovable, sane or insane, and whether life was worth living). Several participants spoke of voices filling a void created by the turmoil of family conflict and illness. These voices were perceived as both positive and negative. One participant heard voices criticizing him for wasting his money because he should actually spend less. Some participants comprehended the voice hearing as unrelated to their lives and a mere symptom of illness caused by a brain malfunction. One said he knew that they were “nonsense” and mere symptoms of schizophrenia; nonetheless, he answered the phone that only he heard ring.

### *Am I Losing my Mind?*

When the participants realized that they alone heard the convincingly real voices, most began to fear that something was wrong with their head and that the voices were symptoms of schizophrenia. Additionally, they feared that others would see them as mad and no longer take them seriously. These fears dwelled like a shadow threatening to engulf them. When one participant determined that only she heard the chiming of church bells, she said, “it frightens me a little, because then I understand that I’m not well.” When intensely troubled by the voices, another said, “I thought I was about to go completely insane.” “Feeling bad” or having a “bad period” were the terms used by the participants about being overcome by crises or trauma, being depressed, anxious or “in psychosis.” When they felt bad, most participants experienced the

voices as continually nagging and terrorizing, to the extent that they were willing to take desperate measures to achieve a short pause. One participant realized that she was hearing the voices that others did not hear; nonetheless, she submitted to the demands of these voices because she was so desperate for a break:

I did take, eh, eat cd's, and I broke in bits and ate, 'cause then I thought maybe I'd die that way. . . . When someone's constantly talking to you . . . there's a whole lot you'd consider doing to get rid of it. . . . I can hear when it's the voices, but when you're feeling bad they rule over everything.

Several participants also heard voices demanding that they hurt themselves. One heard, "you have to hurt yourself. . . . Do it now. . . . You're so ugly it doesn't matter if you get uglier." Nearly all participants had contemplated or attempted to end their lives during such periods. Most participants conveyed that they were not without reason or in psychosis, although they heard voices. While still employed and long before she had started receiving psychiatric treatment, one participant observed, "when those patients were restless and ill and talking about voices, I'd think; gosh, I have those experiences too!" While undergoing involuntary treatment, another participant eventually chose how and with whom to talk about the voices; this participant stated, "first I told her that I had only heard it once, but that was not entirely true."

Having pulled through crises, depression, and psychoses, most participants found that these were not infinite states, but came in episodes. The participants realized that these states were things that they went 'into' and thus could come 'out of'. Their minds had not yet been infinitely "lost." One participant said, "if I'm in psychosis then I'm in the utmost, utmost way. . .

. I've crossed the line in a way, that I don't have the ability to reason anymore" "It hurts like the devil the first times you're psychotic, those are the worst," another participant said.

### *Daily Life Recurrently Dominated by Opposing Voices*

Most participants found their daily lives dominated by the voices either because the voices were constantly present or because they were so troublesome when they were present. The shifts and the themes the voices addressed were related to circumstances in the participants' daily lives.

When the participants felt well and life was good; the voices usually faded, disappeared or, sometimes, only positive voices remained. The relief that this cessation brought to many was filled with uncertainty because the participants feared that the voices would return or increase.

When the participants were weary or physically ill or when life became more demanding, the voices often reemerged or intensified. One participant recounted an occasion when she heard the voices. Although she was well and able to work, she realized, in hindsight, that she had been working too much:

So I was in the office...and there was no one else there, and I sat there working, and then I heard someone behind me that said I was doing so bad and there was no use in trying too hard, 'cause I wouldn't get it right anyway. . . . Then I got scared because I was, I am so scared of becoming ill again. It's my worst fear.

In the following, we present two subthemes that encompass important facets of the present theme: (a) hearing voices in the background made daily life harder, and (b) hearing convincing voices disrupted daily life.

*Hearing voices in the background made daily life harder.* Many participants recurrently heard voices in the background that generally made their daily lives harder. One said,



“the voices do direct me and occupy me every day, but not as strong, intensely or like the whole time. . . . Some days are worse than others.” Another said, “I can rest as much as I like; I am never fit, ‘cause there’s always something going on in my head.” The participants struggled to concentrate on matters of their choosing or matters of importance. One wrestled with his homework because he sometimes heard the voices in addition to being disturbed by a rapid flow of thoughts: “I struggle more to concentrate. Not only because of that [voice hearing], but it does contribute.” Most participants experienced the voices as “more in the background” when they were using neuroleptics. One participant said that the voices mostly became “loud thoughts.” Another participant usually heard “low buzzing, [that] seems almost unreal or unconvincing.” Using this type of medication, however, did not prevent the voices from becoming more intense in periods and even resulted in unwanted effects (e.g., involuntary movements, slow thinking, and less engagement in life) that also made daily life harder.

*Hearing convincing voices disrupted daily life.* For most, daily life was often entirely disrupted when the voices were at the foreground of their attention. The voices could be convincing and commanding and influence the participants’ daily life activities. One participant often gave in to voices demanding that she go shopping without washing her hair, or buy, or even shoplift things she didn’t need. Another participant explained that it was difficult to do as she wanted sometimes because:

They [the voices] take hold of my will. . . . One time, when I was at work I kept thinking the whole time that I am well, . . . then they [the voices] came and sort of [said] ‘you should do the opposite [of what you are doing]’.”

She avoided meeting the customers' eyes in fear of revealing her inner struggle. In the middle of demanding meetings at work, another participant frequently heard voices nagging her about tidying the kitchen, although it was not her responsibility. Often she hurried to the kitchen before she returned to the meeting. One participant was currently overeating because voices were constantly telling her to eat. Another participant felt physical pain resembling electric jolts if she ate too much: "if I took the wrong piece of a cracker they jolted me." She perceived the pain as punishment from the voices she constantly heard.

Relating to others was complicated because of the voices. The participants were aware that their complaints were concealed and thus difficult for others to understand. One said, "I might not seem very troubled, but I am." Nonetheless, participants often believed that the messages reflected how others saw them or sometimes thought others could hear the voice messages. When encountering people she met randomly, one participant said, "I felt those voices told persons and strangers about me," whereas the voices said, "you demand so much of others" or "they don't love you" in relation to relatives and health care providers. Another participant heard messages on certain radio channels that mocked him about his unfulfilled dreams and ambitions. When the participants spoke of the voices to others, the voices frequently became more intense and sometimes threatening. One participant heard voices claiming that if she told anyone about them "people would die, disappear or become seriously ill." She had recently discovered that these threats resembled those of her assailants.

The participants reported that finding rest at home was often difficult. One participant fled his home because he believed that his neighbors were trying to get rid of him. "I couldn't stay in that apartment because it sounded like they were knocking at the floor, at the walls, something like that. I thought it was to me." Another participant was unable to relax in her living

room. When she, e.g., attempted to watch TV, angry voices would start pecking at her shortly after by saying that she did not deserve to sit there. Most participants were increasingly troubled by voices when going to bed or in their sleep. One participant heard voices “almost every night.” Hence, she often skipped classes because she was so tired and anxious during the day.

If they were unable to get enough rest and sleep, weary participants worried that this would create a downward spiral with increasingly troublesome voices. When they were more intense and vivid, the voices required the participants’ constant awareness and responses, and the participants became more susceptible to the voices. Intense periods could last for days and, for some participants, even years. One said about a period that lasted three months “it made me very exhausted mentally . . . there was something hanging over me.” Another said, “I couldn’t get what people were saying, concentration was awful.” Those participants who were attending school when intense periods occurred lost entire semesters or school years and had to start again. Most participants had taken indefinite pauses from school and work.

### **Comprehensive Understanding and Reflections**

Our overall understanding of the narratives was that the intentions of others resounded intrusively in the participants and disrupted their lives. The participants were often involved in daily discouraging and exhausting struggles with puzzling, recurrently intrusive and opposing voices. These opposing voices were varyingly perceived as someone else or something originating within the participants. The participants were often uncertain as to whether the voices would reemerge or subside and feared losing control over their minds and lives. Consequently, they lived in a state of apprehension, even when they seldom heard voices. When the participants dealt with challenging circumstances and felt bad, the voices intensified and seemingly echoed and amplified their suffering and despair. The participants’ capacities for daily activities,

outwardly engagement, reflection, rest, and sleep were affected accordingly, and their lives were disrupted and constricted.

The participants established that the voices were unusual sensations because they were not corroborated by other senses. Sound itself is a dynamic event, and only the cause of the event of sound can be located. When hearing, one immediately envisions the event leading to the sound and seeks to corroborate it through sight, motion (Jonas, 1954, p. 509), and the perspectives of others. The participants did not perceive the voices as mere fantasies, recollections, thoughts, dreams, or emotions; however, most acknowledged that the voices were closely related to all of these experiences. These findings agree with results reported by Hoffman, Varanko, Gilmore, and Mishara (2008), which revealed that voice hearers with schizophrenia discern between verbal thoughts and hearing voices. Commenting on Hoffman et al.'s (2008) results, Larøi (2009) noted that “verbal content, degree of control and the non-self ‘sound’ of the speaking voice” are particularly important characteristics to differentiate voices from thoughts.

Turning to the phenomenological perspectives of Merleau-Ponty (Merleau-Ponty, Darmaillacq, Lefort, & Ménasé, 2010) on sensation, we found it possible to understand the participants’ experiences of voices as deriving from both someone else and themselves. Merleau-Ponty contended that we are both actively directed to the world and passively receptive of the world; we hear and are heard, see and are seen. These reversible aspects coalesce in “a creative operation within being itself” and belong neither exclusively to the perceiver nor the world (Morris, 2010). We will explore how these reversible aspects might be understood in relation to the participants’ experiences of voices and sounds unheard by others.

The negative tone of the voices was essential to how powerfully their messages resounded in the participants. The participants were immediately struck by the meaning, and most were convinced that the voices conveyed how others saw them. Reflecting on our own lives, we find that the tones in which others speak to us in are essential in determining their intentions, the quality of our relationship and how we understand ourselves. Often, tone conveys more than what is said with words or even something other than the words that are spoken (Løgstrup, 2000). The demeaning tone of the voices might be understood to echo and amplify family attitudes toward the participants and the general population's prejudices toward people with mental illness.

Numerous researchers have shown that critical comments from significant others (i.e., family and health workers) can be closely linked to an increase in psychotic symptoms and relapse of illness (cf. Butzlaff & Hooley, 1998 on expressed emotion; Keith, 2008 on perceived criticism). The media have often propagated the common notion that people with mental illness are unstable and dangerous. In several studies, researchers have suggested that recovering from mental illness is impeded when the person with mental illness internalizes these negative and stereotypical views. People with mental illness believe that they are devalued members of society and anticipate social rejection (Livingston & Boyd, 2010, p.2151). Based on our results, we suggest that the participants were aware of these prejudices and had encountered them. Furthermore, we revealed that the participants had similar prejudices themselves.

Most participants experienced the voices as echoing and amplifying previous, mainly traumatic, experiences. A number of researchers have shown that hearing voices is associated with trauma, such as bullying (Lataster et al., 2006), sexual abuse (Beavan et al., 2011), and loss (Olson, Suddeth, Peterson, & Egelhoff, 1985; Rees, 1971). Notably, some participants also

experienced the voices as companions of sorts that amplified hope and support. Leudar and Thomas (2000, p. 137) reported on a woman who developed a supporting voice while recovering from being mentally ill. This voice resembled both the voices of supportive health care providers and her own voice. Our lives are inherently entangled with the lives of others (Løgstrup, 2000), and social encounters might resound throughout our lives, some doing so more strongly than others. The participants' voice experiences in this article might be understood to echo and amplify this prereflective entanglement and to encompass, in Merleau-Ponty's words, "several significant layers of truth" (Merleau-Ponty et al., 2010, p. 208).

Hearing intense and negative voices and sounds disrupted the participants' daily lives by forcefully reorganizing their experiential field. The projects of everyday life became too demanding or unimportant to them. These findings corroborate those studies of, e.g., chronic pain (Thomas & Johnson, 2000) and studies suggesting that unusual neuronal brain activity interferes with the ability of those diagnosed with schizophrenia to divert their attention to their surroundings (Larøi et al., 2012). The results revealed that getting on with daily life became the object of the participants' explicit willpower. The voices re-emerged episodically; thus, the presence of the voices was continually reasserted on the participants. The continued awareness required by this presence was exhausting and contributed to a process in which the voices re-emerged, becoming stronger and more negative, and the participants became more susceptible to their messages. These findings might be understood in light of studies that have shown the important role that sleep plays in diminishing the "emotional tone of memories" (Kyung & Douglass, 2010, p. 404).

The participants' weariness and diminished ability to sleep also corroborates the findings by researchers who showed that a reduced quality of sleep is common among those with

disorders such as schizophrenia, PTSD, anxiety (Kyung & Douglass, 2010), and chronic illness in general (Öhman, Söderberg, & Lundman, 2003). Withdrawal from others and the inability to initiate and follow through with plans among voice hearers have, from a diagnostic point of view, traditionally been viewed as decreases in basic functioning and been categorized as negative symptoms of schizophrenia (Mueser and Mcgurk, 2004). Le Lievre, Schweitzer, and Barnard (2011, p. 1338) elucidated how people with schizophrenia experienced transitioning into “emotional shutdowns” and voice hearing in relation to exhausting reflective processes about confusing and disappointing encounters with others. The relationship between hearing voices and exhaustion has, to our knowledge, not been explicitly explored.

Serious illness emphasizes one’s vulnerability and dependency on others (cf. Öhman et al., 2003). Based on our results, we revealed that the participants were attentive to the voices and exceedingly attentive to how others might perceive them. This attentiveness often hindered them in interacting with others, talking about and being challenged by opposing perspectives on the voice experiences, and talking about themselves. Researchers have shown that people with chronic illness have invisible plights that are a barrier between those who are ill and others (Thomas & Johnson, 2000; Öhman et al., 2003). Citing Updike, Leder (1990, p 74) used the analogy of a filthy window to illustrate the pain induced by the divide between the sufferer’s sense of reality and others’ senses of reality. Health care providers and others have often reinforced this barrier by focusing on the voices as unreal perceptions (Beavan, 2010; Harrison et al., 2008). A participant in a previous study (Kalhovde, 2005) compared the interview with consultations with health care providers and made this reflection: “we never, like, talk about these things, as I might wish.” He was referring to the daily life experiences of hearing voices.

Based on our results, we revealed that the voices not only amplified past and present experiences, but also the existential magnitude of the participants' situations (e.g., the inability to continue school or work). The fact that the participants had contemplated or attempted suicide revealed the gravity of their suffering and fear of the future. Researchers have shown that mourning the loss of significant opportunities in life and being depressed can increase psychotic symptoms and suicidal thoughts and behavior. Furthermore, enduring long-term illness can lead to chronic demoralization, a "persistent state of deep hopelessness and existential distress" (Hausmann & Fleischhacker, 2002, p. 91). Researchers have shown that the majority of voice hearers are depressed by the distressing voice experiences (Birchwood, Iqbal, Upthegrove, 2005). For most participants, the voices amplified existential anguish; nonetheless, some participants also experienced the voices as conveying a sense of belonging and being a part of something greater than themselves. These findings correspond with those of Hustoft, Hestad, Lien, Moeller, and Danbolt (2012).

Most participants distinguished between hearing voices and being psychotic. These findings corroborate the perspective that the hearing of voices is not necessarily a symptom of mental illness (Escher and Romme, 2012). This perspective might also be understood to coincide with Pierre's (2010) suggestion that hearing voices can be compared with coughing, although he made the comparison to illuminate the differences between those with and without a mental disorder. A cough can be both a normal reaction and a sign of a serious illness; coughs can also be a reaction to both external and internal processes. This comparison could, however, obscure the multi-layered processes involved in hearing voices.

### *Methodological Reflections*



The trustworthiness of the findings lay in the research process and the results (Whittemore, Chase, & Mandle, 2001). Along these lines, we find the following: (a) the participants were open and reflective, and the breadth and depth of the related experiences led us to believe that the quality of the interviews and the number of participants was sufficient to achieve our aim; (b) we concluded the text analysis when the interpretations of the wholes of the texts and the parts of the texts corresponded (Fleming et al., 2003), and a thorough and mutual understanding between the authors was developed over a generous time period (Gonzales, 2006); (c) other voice hearers, relatives and health care providers have confirmed that the preliminary results were relevant and valid and, in addition, have provided reflections that challenged the authors' preconceptions. The process of understanding is indefinite; fresh sources of error are continually excluded, and new sources of understanding emerge (Gadamer, 2004, p. 298). Nonetheless, we trust that this article can enrich the understanding of how hearing voices, and sometimes sounds, might be experienced in the daily lives of people with mental illness.

### **Concluding Reflections**

We found that the participants were repeatedly struck by the tones and messages of the voices and sounds, which seemingly echoed and amplified significant and mainly negative matters in their lives. Based on the results, we suggest that voice experiences are woven into the fabric of the participants' unfolding lives and represent potentially valuable sources of insight for the voice hearer and others. These results corroborate other studies, and we suggest that health care providers should encourage and engage in dialogs about service users' everyday experiences of hearing voices. We also suggest that health care providers should recognize the importance of addressing the matters that the voices and sounds echo and amplify (i.e., relations within the families of the voice hearers, issues related to work, trauma and stigma). Further research should

explore the variations, from uncomplicated to distressing, in the experiences of hearing voices over a persons' life span; this research should include the daily life experiences of benevolent voices in both people with mental illness and healthy people. Both researchers and health care providers should pay closer attention to the relationship between exhaustion and the inability to rest or sleep and the hearing of voices and sounds.

## **Notes**

1. Kindly see Leudar & Thomas (2000) for a description and discussion of Schneider's first-rank symptoms of schizophrenia in relation to hearing voices.
2. About 25-40% are troubled by psychotic symptoms such as hearing voices (Mueser & McGurk, 2004).

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## **Bios**

**Anne Martha Kalhovde**, MsN, RMN is a PhD student at the University Hospital of North Norway Division of General Psychiatry, Tromsø, Norway

**Ingunn Elstad**, Mag.Art, RN is a professor at the Department of Health and Care Sciences,  
Faculty of Health Sciences at the University of Tromsø, Tromsø, Norway

**Anne-Grethe Talseth**, PhD, RN is an associate professor at the Department of Health and Care  
Sciences, Faculty of Health Sciences at the University of Tromsø, Tromsø, Norway

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