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### When soft voices die: auditory verbal hallucinations and a four letter word (love)

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## When soft voices die: auditory verbal hallucinations and a four letter word (love)

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Understandings of auditory verbal hallucinations (also referred to as “hearing voices”), and help for people distressed by them, are dominated by a biomedical framework. Yet, many people who have sought help for the distress and/or impairment caused by hearing voices express dissatisfaction with treatment solely within this framework, highlighting the need for a more rounded, biopsychosocial-spiritual approach. This paper examines the neglected role of a fundamental part of human experience, love, in the experience of hearing voices. First, we argue a lack of love is likely to play a causal role in voice-hearing experiences. Second, we demonstrate that a lack of love is central to the distress and dysfunction often caused by hearing voices. Finally, we show that love plays a core role in recovery. Given this centrality of love, we argue that an interdisciplinary approach to hearing voices involving the mind sciences and theology/religion may be fruitful. The relevance of this for psychotherapeutic interventions for people who hear voices is discussed.

**Keywords:** hearing voices; psychosis; schizophrenia

### Introduction

The experience of hearing a voice in the absence of an appropriate external stimulus, termed an auditory verbal hallucination (AVH) in psychiatric parlance, is listed in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) as being a symptom of a number of mental disorders. In this context AVHs are most commonly associated with a diagnosis of schizophrenia, with around three in four of such patients hearing voices. Yet it is important to note that there is no necessary association between AVHs and distress/impairment, with estimates suggesting that 10% of people who experience complex AVHs do not require psychiatric help (McCarthy-Jones, 2012). Such individuals have been termed “healthy voice-hearers” (Moritz & Larøi, 2008, p. 104). It may be speculated that the relatively low ratio of healthy voice-hearers to individuals experiencing AVHs in the context of a diagnosed psychiatric disorder is a reflection not of a necessary association between AVHs and psychopathology, but of a failure to understand the core

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emotional issues involved in many AVHs, and the inadequate provision of appropriate clinical interventions (e.g., Romme, Escher, Dillon, Corstens, & Morris, 2009).

The existence of healthy voice-hearers notwithstanding, the present paper will focus on individuals who are distressed and impaired by AVHs and for whom the development of improved therapeutic services is urgently needed. Before proceeding further, terminological issues require addressing. The term “auditory verbal hallucination” has been argued to be a colonising term with many pejorative associations (McCarthy-Jones, 2012) and is not used by many individuals who hear voices themselves (Karlsson, 2008) who instead refer to the experience using the terms “voice-hearing” or “hearing voices” instead. As this is also the terminology promoted by many consumer organisations (e.g., Intervoice, 2012; Hearing Voices Network New South Wales, 2012), we too will employ this nomenclature.

AVHs (henceforth referred to as “hearing voices,” “voice-hearing” or simply “voices”), have been shown to be associated with a number of structural and functional changes in the brain (Hubl et al., 2004; Jardri, Pouchet, Pins, & Thomas, 2011). This has led many to view them as “a symptom of brain disease just like blindness” (Stephane, Barton, & Boutros, 2001, p. 185). Such a perspective justifies clinical interventions for voice-hearing that are targeted at the underlying neurochemistry of the individual, with antipsychotic medication remaining the front-line treatment. Although recent years have seen national guidelines in a number of countries recommend the use of talking therapies, such as cognitive-behavioural therapy, for those hearing voices (e.g., NICE, 2009) such interventions, when available, are often viewed as only being an adjunct or augmentation to antipsychotic medication (although, see Hutton, Morrison, & Taylor, 2012). This predominant focus on the biology of voice-hearing forms part of a larger trend towards the prioritisation of the biological, with the President of the American Psychiatric Association noting in 2005 that, “as a profession, we [psychiatry] have allowed the biopsychosocial model to become the bio-bio-bio model” (Sharfstein, 2005, p. 3).

Clearly, there is an important place for a biological understanding of the experience of hearing voices. Indeed, if the dominant biomedical approach to hearing voices was able to successfully help all people complaining of distressing voices, and they expressed a high level of satisfaction with this paradigm, this approach would be sufficient. However, this is not the case, and the many limitations posed by a solely biomedical approach to treatment of voices make this approach, on its own, insufficient. First, around 25–30% of patients with a diagnosis of schizophrenia who hear voices are not helped by antipsychotic medication (Shergill, Murray, & McGuire, 1998). Second, there is mounting evidence that the content of some voices are meaningfully related to events and concerns in the individual’s life, suggesting the need to attend to and work with the content of voices and the voice-hearer’s own emotions (Corstens, Longden, & May, in press; Romme et al., 2009). Third, qualitative studies have highlighted the dissatisfaction of many voice-hearing patients with a therapeutic approach focussed solely on medication that does not treat them as a whole person; “they [the nurses] really only come around to give needles as though that’s all’s needed” (Warren & Bell, 2000, p. 199), “you are now a schizophrenic and we treat you with medication” (Thornhill, Clare, & May, 2004, p. 188), “I feel like a guinea pig” (Rofail, Heelis, & Gournay, 2009, p. 1492). Finally, many of the problems associated with hearing voices specifically, and psychosis more generally, at least in part flow from the frustration of basic human needs such loss of social relationships, hope, employment and physical and emotional safety caused by voice-hearing (McCarthy-Jones, Marriott, Knowles, Rowse, & Thompson, in press). This suggests that interventions for people who hear voices should go beyond targeting voices themselves to address wider existential needs as well, as part of a biopsychosocial-spiritual approach (e.g., King, 2000).

Such a proposal is consistent with the recovery movement in mental health (SAMHSA, 2007). This has at its heart the concept of recovery-oriented practice, which differs from traditional care by focussing primarily on the person with the mental distress, rather than on complaints such as hearing voices, or diagnoses such as schizophrenia (Davidson, Tondora, O'Connell, Lawless, & Rowe, 2009).

One way to improve upon the effectiveness of existing interventions, and to address the concerns of people who hear voices that current practices do not address important aspects of their lives, is to probe deeper into what the core human problems associated with voice-hearing are, as part of a biopsychosocial-spiritual approach to hearing voices. As a step towards this, the present paper will focus on one fundamental part of the human experience, not typically considered in relation to hearing voices, or psychopathology generally. This aspect of the human experience, a simple four letter word, has been more effectively excluded than any expletive from contemporary psychiatric texts on hallucinations, with a shift occurring over the past century from this word simply not being indexed in such influential historical works such as Bleuler's (1919) *Dementia Praecox*, Jaspers' (1963) *General Psychopathology*, to not featuring *at all* in many otherwise excellent contemporary books on hallucinations (e.g., Aleman & Larøi, 2008; Blom & Sommer, 2011). The experience we refer to, is love.

What is love? One of the better definitions may be that of Erich Fromm (1956); "Love is the only sane and satisfactory answer to the problem of human existence" (p. 133). The Ancient Greeks had many words which we can translate as love including eros, philia, storge, thelema and agape (Davidson, 2011). *Eros* is what we would recognise as the feeling someone expresses when they say they are in love, an erotic, bodily love, with accompanying thoughts and feelings. *Philia* is love in the sense of brotherly/sisterly love, a deep bond of friendship and fellowship. Less well-known terms for love today, but still widely recognised experiences are *storge*, a natural affection such as that felt by a parent for their child, and *thelema*, the desire to do something, to participate, to contribute, and to recognise oneself as a worthwhile person based on these contributions. *Agape* is harder to define, and is a form of deep spiritual love, or a selfless love of one person for another. When St John writes "God is love" (1John 4:8) the Greek word he uses is agape, and this is also the word St Paul uses in his famous tract on love (1Cor13). Pope Benedict XVI in his Encyclical letter *Deus Caritas Est* (God is love) characterises agape as descending love, an other-worldly, spiritual love descending from God to man, a forgiving love. A similar form of love can be found in Eastern traditions under different terms, such as *karuna* in the Buddhist and Hindu religions. The distinction between these different forms of love is helpful as it can aid an analysis of how love may be involved in any given human experience, in this case the experience of hearing voices.

Given that Fromm (1956) and many others propose that love is at the heart of existence, we should not be surprised that tears of this central thread in the fabric of life may be both cause and consequence of psychiatric problems, and therefore also be central to recovery. Love is likely to be a particularly key concept in relation to voice-hearing due to the high rates of physical and emotional traumas suffered by people who hear voices (McCarthy-Jones, 2011a; Read, Agar, Argyle, & Aderhold, 2003; Romme et al., 2009). Whilst, in addition to love, a range of other emotions are also likely to be involved in the aetiology of voice-hearing, including shame, guilt (McCarthy-Jones, 2012) and anger (Romme et al., 2009) these emotions invite love as part of the solution. Developing a better understanding of the role of love in the aetiology and maintenance of voice-hearing should therefore improve the ability of mental health services, friends, and family to help those

struggling with distressing voices, as well as helping people hearing voices to help themselves.

This paper will begin by examining the role that a lack of love appears to play in the aetiology of voice-hearing. It will then scrutinise the roles of love in what we term the “Descent into Impairment by Voice-hearing Experiences” (DIVE) and “Towards Healing and Recovery from Impairment by Voice-hearing Experiences” (THRIVE) phases. Given the centrality of love to nearly all spiritual disciplines, we will conclude by arguing that an interdisciplinary partnership between the mind sciences and religious/spiritual disciplines is the most appropriate way to put a consideration of love back at the heart of both the study of voice-hearing and therapeutic assistance for people hearing voices. Although we are most familiar with Christianity, and this is the primary religious affiliation of the persons with whom we have experience, leading us to focus our specific considerations on the interaction between the mind sciences and this religion’s theology, we fully expect that investigators from other religious and spiritual traditions will also be able to fruitfully add to this developing area of research.

### **Before voices: love and the causes of hearing voices**

Initial evidence that a loss of love, specifically of *philia* and *eros*, may play a role in the aetiology of voice-hearing can be garnered from studies of bereavement. Instances of hearing a voice following bereavement are reported cross-culturally with these experiences being viewed as more normal in countries such as Japan than in the UK (Rees, 1971; Yamamoto, Okonogi, Iwasaki, & Yoshimura, 1969). In an early study Rees (1971) found that 13% of bereaved people had heard the voice of their deceased spouse. The longer the marriage had been the more probable hallucinations of all forms were. In a later study of 50 people in their early 1970s whose spouses had died within the previous year, Grimby (1993) found that one month after bereavement, 30% were hearing the voice of their partner. Notably, hearing the voice of the dead partner was found to be more frequent in the very lonely and “severely crying” participants, and also among men with low self-esteem. Thus, not only may a loss of *eros* and *philia* involving others facilitate the onset of hearing voices, but being unable to have fellowship towards oneself (e.g., self-compassion) may also be a contributing factor.

Turning now to people who hear voices which cause them sufficient distress and impairment to attract a psychiatric diagnosis, a population the rest of this paper will focus on, here a lack of love appears to play a role in the genesis of such voice-hearing. Specifically, experiencing a lack of love through neglect in childhood (Read et al., 2003), or undergoing traumatic experiences such as childhood sexual abuse (McCarthy-Jones, 2011a), which has more to do with power than *eros* (Hermans, 2003), instead of (or in spite of) other loving relationships, have been highlighted as potentially causative factors in many instances of such voice-hearing. For example, Romme and Escher (1989) found that 70% of people who hear voices stated that their voices began after a traumatic or emotional event (e.g., physical or sexual abuse, bullying, or parental divorce). Such traumatic experiences appear to have a dose-response relationship with voice-hearing, with Shevlin, Murphy, Dorahy, and Adamson (2007) finding that having one of four potential types of childhood trauma (neglect, physical abuse, rape, molestation) was associated with a 1.62 times increased probability of having auditory hallucinations. This probability increased to 2.36 times if someone had two of these traumas, and 4.15 times if someone had three of these traumas.

Whilst quantitative studies examining the evidence for a causal relationship between voice-hearing and specific types of abuse, such as childhood sexual abuse, provide highly suggestive evidence of a causal relation, such studies often fail to control for potentially confounding variables, and more work remains to be done in this area (McCarthy-Jones, 2012). However, personal accounts of voice-hearing by individuals who have suffered and survived childhood abuse offer powerful indications that the relation is causal (see Romme et al., 2009). Such accounts also show that not only may childhood trauma be followed by the development of tormenting, critical voices, but that supportive, benevolent voices may also begin to be heard following abuse experiences. These voices may offer the love and support that people in the external world have failed to give, and could be viewed as an adaptive survival mechanism. For example, Dillon (2012) describes how following childhood abuse where she was treated like “a dirty little bitch, evil and unlovable, treated with cruelty and contempt by anyone who can get their filthy hands on her,” she began to “hear voices; voices that talk to her, talk about her, who comfort her, protect her and make her feel less alone . . . One of the first voices that she hears is that of “the great mother.” She is a very powerful maternal figure, who is beautiful and kind, a beneficent figure who is always there comforting and soothing her.”

Thus, a failure to experience forms of love ranging from *philia* to *storge* and *agape* (e.g., not experiencing the unconditional love of a parent or care-taker), experiencing horrific alternatives to love, and consequential alterations to the way one conceives of loving relationships, seem likely to play a key role in the later development of voice-hearing. It appears that this may operate in part through the mechanism of attachment (Read, Perry, Moskowitz, & Connolly, 2001). For example, people in the general population with high attachment anxiety, characterised by either a sense of self-worth dependent on gaining the approval and acceptance of others, or a negative self-view, a lack of trust in others and subsequent apprehension about close relationships, have been found to be more prone to hallucinations (Berry, Wearden, Barrowclough, & Liversidge, 2006). Thus *philia*, both in relation to self and others, appears likely to play a role in the later development of voice-hearing. As we will return to later, the effects of such early experiences on the way an individual feels and expresses love are likely to be of particular relevance for therapeutic interventions with people who hear voices.

Another way in which a lack of *philia* in particular may play a role in the development of voice-hearing comes through the loss of meaningful social relations. As part of his social de-afferentation model Hoffman (2007) has argued that loneliness and absence of social contact may play a causal role in the development of hearing voices. Drawing a parallel with Charles Bonnett syndrome in which the absence of visual stimuli can lead to bizarre visual hallucinations, Hoffman argues that a lack of social stimuli can lead the brain to recreate such experiences in the auditory modality, resulting in voice-hearing. However, to see such experiences as causative due to the lack of “social stimuli” in which they result may miss the wider meaning of these experiences. The analogy of a computer which is not receiving input may be misleading here, as the social nature of humans makes it possible that it is a loss of the feeling of belonging, of *philia*, that is playing an important causal role. These two competing hypotheses are empirically distinguishable, with the “*philia*-theory” proposing that one-way speech (e.g., patients listening to spoken word audio tapes) should not reduce the extent to which a person hears voices in the long-term, but that meaningful communication (e.g., phone calls with a befriending volunteer) would.

**Love and the DIVE: the loss of love resulting from voices**

Given the presence of trauma in the early lives of a significant percentage of people who hear voices, many may already inhabit a world where they are starved of love. For those in such positions, the onset of voices may further exacerbate this. For those fortunate enough to grow up in a loving and nurturing environment, voices may cause the loss of some of these experiences of love. Although benevolent, positive voices are experienced by the majority of individuals who also experience destructive, negative voices (Jenner, Rutten, Beuckens, Boonstra, & Sytema, 2008), the effects of negative voices often lead to a downward spiral, beginning with fear and confusion and ending in severe impairment due to the frustration of basic human needs (McCarthy-Jones et al., in press). This phase, which we term the “Descent into Impairment by Voice-hearing Experiences” (DIVE), can be deeply disruptive of one’s ability to maintain meaningful social relationships and achieve *philia* (Robertson & Lyons, 2003; Wagner & King, 2004). One particular reason for this is the problem of dealing simultaneously with the voice in one’s head and one’s relationships in the social world (Gee, Pearce, & Jackson, 2003). Voices often lead to withdrawal being used as a coping mechanism (Judge, Estroff, Perkins, & Penn, 2008), further reducing the potential for experiences of the various forms of love. Through others in the voice-hearer’s social world not understanding what they are experiencing, isolation is further encouraged as communication is too burdensome (Chernomas, Clarke, & Chisholm, 2000; Gonzalez-Torres, Oraa, Aristegui, Fernandez-Rivas, & Guimon, 2007). The impossibility of communication that runs through the work of Samuel Beckett is here realised in the world of psychosis, with Skodlar, Tomori, and Parnas (2008) finding that, for patients, communication became “so burdensome and stressful, and the consequential solitude so unbearable that they began to consider or even planned a suicide” (p. 483).

In addition to the voice-hearing person severing relationships themselves, friends and acquaintances may also abandon them (McCann & Clark, 2004). A world which potentially offered the hand of *philia* to an individual can now, through the pervasive stigma of a diagnosis of schizophrenia generally, and that associated with the experience of hearing voices specifically, offer the opposite. As one participant in a study by Rice (2008) put it, they now felt viewed as “bottom of the totem pole, very lowest of the low, scum of the earth.” Stigma, social isolation and discrimination can all hence lead to a world in which hostility, hate, and contempt, replace feelings of love and belonging, and in which social relationships and love are lost (Schulze & Angermeyer, 2003). The content of people’s voices can often reinforce these views of others by abusing and denigrating them (Rhodes, Jakes, & Robinson, 2005). This stigma is then internalised, leading the person to judge “themselves as useless, incapable or insane” (Wagner & King, 2004, p. 143). This in turn negatively influences the probability that one feels one could be loved by others.

With respect to mental health care, professionals not offering *philia* and not treating the voice-hearing person as a human being to be loved, can also contribute to a lack of love (J. Bassett, Lloyd, & H. Bassett, 2001). Humberstone (2002) reports a patient stating how services “can treat me like a little child, they can treat me like a spastic, they can treat me like a nothing” (p. 370). Similarly, people hearing voices can report a lack of interest from mental health professionals in them as a person, the history of their mental health problems (Schulze & Angermeyer, 2003), and experience a focus on symptoms and medication “to the exclusion of everything else” (Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003, p. 73).

This coupled with a loss of hope can lead to a depressed, demotivated and demoralised state (e.g., Bassett et al., 2001), with one participant in McCann and Clark’s (2004) study

when asked what they saw themselves doing in the next five years, simply replying “nothing” (p. 789). Here we see a loss of thelema, the desire to do something, to participate, to contribute, and to recognise oneself as a worthwhile person based on these contributions. This loss may also be caused by a loss of employment itself resulting from not being able to cope with hearing voices. This can result in a “vicious circle, cause you don’t have any work and you don’t bring in an income and it gives you no self-esteem and then you don’t want to get up and go get a job” (Bassett et al., 2001, p. 68), demonstrating the spiraling of negative interactions between loss of philia and loss of thelema.

Hearing voices in the DIVE phase can also lead to a loss of love in the sense of eros becoming less achievable. Psychosis generally has been found to be seen by people experiencing it as being a “barrier in the formation, and maintenance, of romantic relationships” (Redmond, Larkin, & Harrop, 2010, p. 158), due to worries about the perceived risks of stress resulting from relationships potentially ending badly, “being used,” and loss of privacy, (Chernomas et al., 2000; Redmond et al., 2010). Living in group homes due to psychosis can also be a barrier to the formation of relationships, with Warren and Bell (2000) noting one participant asking “how can I bring a girl back to a group home – what would she think about me then?” (p. 199). Volman and Landeen (2007) also found that people hearing voices felt psychosis profoundly impacted on their sexuality, with one problem being medication-related weight gain. Other reported problems include worries about medication-related sexual dysfunction impairing sexual relations (Chernomas et al., 2000; McCann & Clark, 2004). As voices tend to strike at the voice-hearing persons’ key worries and doubts (Romme et al., 2009) it is not surprising that romantic relations come to be targeted. For example, one participant in Volman and Landeen’s (2007) study stated that although her partner “tells me that he loves me . . . the voices tell me different” (p. 414). In terms of eros resulting in sex for the purpose of reproduction, Gonzalez-Torres, Oraa, Aristegui, Fernandez-Rivas, and Guimon (2007) found that mental health professionals often discouraged this, with one participant diagnosed with schizophrenia saying “You mention to the psychiatrist that you want to have a child and he says ‘no, that’s not possible, don’t even think of it’” (p. 19), advice which some participants later regret having followed (Chernomas et al., 2000).

Perhaps one of the most overlooked areas of psychosis and hearing voices is its impact on storge, that is, its impact upon the ability to experience the bond of love between parent and child. Diaz-Caneja and Johnson (2004) found mothers diagnosed with psychosis were concerned at having to cope with both with their children and their mental health problems, especially when medication impaired their ability to look after their children by slowing them down and reducing their concentration. Both mothers and fathers with psychosis become worried their children may “inherit” their mental problems (Diaz-Caneja & Johnson, 2004; Evenson, Rhodes, Feigenbaum, & Solly, 2008). There is also the great fear of children being taken away (Chernomas et al., 2000; Diaz-Caneja & Johnson, 2004). As one individual put it “they’re gone, and you don’t think you have a reason to live,” (Diaz-Caneja & Johnson, 2004, p. 1519). Thus, although variants of such fears are expressed by all parents, these seem to be heightened in individuals hearing voices in the context of a diagnosed psychotic disorder due to the widely discussed genetic heritability of conditions such as schizophrenia, the impact of specific side-effects of antipsychotic medication on the ability to care for one’s child, as well as any challenges presented by the psychiatric condition itself (David, Styron, & Davidson, 2011).

It should be noted though that Pawlby et al. (2010) have found evidence that challenges previous conclusions that mothers with a diagnosis of schizophrenia have deficits in their interactions with their babies. It is also worth noting that given the high rates of childhood

abuse suffered by people who hear voices (McCarthy-Jones, 2011a), this may make many such individuals even more concerned and determined to ensure a safe childhood for their own children, and make storge hypersalient. Furthermore, the voices themselves may be helpful, with Dillon (2012) reporting that the voice she hears which she terms “the great mother” turned out to be “central in supporting the girl [Dillon] to survive [her abuse experiences] with her humanity intact and she also enables the girl to become a loving and compassionate mother to her own daughters, when the time comes.”

Very little work has been done on how the experience of agape is linked to the initial DIVE phase. Some people who hear voices report an initial increase in experiences which take the form of a loving, spiritual connection with the world, which have parallels in the Native American and Taoist traditions. For example, Rohnitz (as cited in Romme et al., 2009) reported that after a suicide attempt birds and trees started to talk to her. This, she notes, “was a spiritual experience, which stimulated me. The birds told me that I was their friend, that I was part of the universe. This experience was positive” (p. 105). However, it appears that the fear, confusion and isolation often associated with hearing negative voices will likely impair the ability to experience such spiritual connection. Despite an increasing interest in the relationship between spirituality and mental distress (Cook, Powell, & Sims, 2009) much more work remains to be done here.

### **Love and the THRIVE phase: regaining love and achieving recovery**

Recovery from the DIVE phase, which may be termed the “Towards Healing and Recovery from Impairment by Voice-hearing Experiences” (THRIVE) phase, is multifaceted. In terms of the voices themselves, recovery may be defined by the person hearing voices as the elimination of their voices, or simply the ability to cope better with their voices without their elimination being desired. The first way in which love, specifically in the form of *philia*, is involved in the THRIVE phase, is through the voice-hearer changing their relationship with negative voices. Many people who hear negative voices may become stuck in a relationship with them which involves mutual hatred; the hatred of the voice(s) for voice-hearer, and the hatred of the voice-hearer for the voice(s). By attempting to introduce *philia* into this relationship, this cycle can be broken. For example, Müller (as cited in Romme et al., 2009) encountered a Shaman who taught her to talk to her aggressive voices in a friendly way, and by talking “in this friendly, slow way to the voices, they slowed down and became quieter” (p. 116). Similarly, Lampshire (as cited in Romme et al., 2009) also reports how “I changed my attitude to them [the voices], so, instead of being fearful of them . . . I embraced them as friends . . . As a consequence, my fear reduced, which in turn alleviated the distress I felt” (p. 131). Reiterating this point, Dillon (as cited in Romme et al., 2009) describes how she began to realise that her hostile voices were “dissociative selves that were internalised representations of the world that I grew up in . . . What they really needed was my unconditional love and support, much in the same way a loving parent supports a child” (p. 192).

Aside from the role of love in the relationship between the person hearing voices and their voices, the THRIVE phase is associated with regaining the ability to meet a range of basic human needs (McCarthy-Jones et al., in press) with love being central to many of these. Firstly, love in the form of *philia* to and from family and friends is central through its role in relighting of the torch of hope (e.g., Perry, Taylor, & Shaw, 2007; Wagner & King, 2004). For example, Schon, Denhov, and Topor (2009) observed that enduring friendships with old friends were described by participants diagnosed with psychosis as a

sign that there was hope of recovery. Likewise Knight, Wykes, and Hayward (2003) found that solidarity with others was important, with one participant referring to their peer-support group for people who heard voices as giving “solidarity in people” (p. 217). *Philia* hence appears crucial in aiding the initial steps towards recovery.

The need for *philia* from others during recovery from impairment by voice-hearing is underscored in multiple studies (Humberstone, 2002; McCann & Clark, 2004; Schon et al., 2009). Lampshire (as cited in Romme et al., 2009) notes that she had to move from a position of having relationships solely with her voices to “take the risk of inviting real people into my world... It proved to be pivotal to recovery... As I put more time and energy into these relationships the negative voices receded” (p. 132). Indeed, nearly all participants in a study by Schon et al. (2009) reported having a friend who had contributed to their recovery from psychosis, and a family member who was beneficial to it. The importance of such relationships is underscored by the findings of Skodlar et al. (2008) who found that relationships with significant others were the only commonly reported reason for why participants did not, and would not, commit suicide: “Since my parents still live, I won’t do it for sure. For later, I cannot make any guarantees” (p. 485). Dillon (as cited in Romme et al., 2009) also describes how “I would not be here if it were not for the love of good people” (p. 193). As well as being loved, resuming one’s love for others also can give people a reason to recover. Laithwaite and Gumley (2007) found one participant stating that “I want to get back on my feet and get outside and be a support for my wee brother” (p. 312). Storge too can play a key role in motivating recovery, with one participant in Gioia’s (2006) study stating that “raising my daughter actually gave me something to live for” (p. 182).

*Philia* also appears to play a crucial role in the successful therapeutic bond between therapists and voice-hearing clients. Nixon, Hagen, and Peters (2010a) observed that the majority of participants in their study (who were recovering from psychosis) highlighted that mental health professionals were instrumental in their recovery, mentioning the friendship aspect to their relation with helpful professionals. One participant described how her psychologist did not act as a condescending expert, but “talked like a friend to me.” Cook and Chambers (2009) also found that benefits came from *philia* in therapeutic relationships, with one participant diagnosed with psychosis describing, “the actual feeling that they [staff] are there and that they are sort of looking out for me” (p. 244). Similarly, O’Toole et al. (2004) found that being “treated like a human being” (p. 321) by mental health professionals was a key to recovery for people diagnosed with psychosis. A return to work can also help such individuals rediscover *philia* (Perry et al., 2007). In Woodside, Schell, and Allison-Hedges’ (2006) study, all participants described a social connection at work which left them feeling “comfortable, welcomed, and respected” (p. 41). This in turn can also enable and encourage the return of *thelema*.

Many studies highlight that regaining *philia* and *thelema* is not easy, however: “Writing e-mails, making new friends - it is such hard work” (Mauritz & van Meijel, 2009, p. 254). Individuals diagnosed with psychosis report that it is hard trying to reconnect with people in a “psychologically, physically, and emotionally safe” way (Schulze & Angermeyer, 2003). Side effects of medication such as numbness can also impair rebuilding relationships (Krupa, Woodside, & Pocock, 2010). For example, McCann and Clark (2004) found medication side-effects could impair remaking social relationships; “When I first started taking it, my mouth went really funny... I couldn’t talk.” (p. 792). Possibly most importantly, the stigma associated with both voice-hearing and schizophrenia, as noted in the previous section, is also a key barrier to reestablishing *philia*.

In the THRIVE phase the need to regain romantic relationships and an experience of eros is also important. Volman and Landeen (2007) found that “participants identified their sexuality as being an essential part of their lives” (p. 413), but that “it was not an uncommon practice for clinicians to assume that there was nothing to address” (p. 415). Such experiences of eros can also signify “less identification with psychosis and more with normality” (Redmond et al., 2010, p. 159). Going beyond eros, storge and the desire for it is also important to recovery, with Wagner and King (2004) finding that many patients diagnosed with schizophrenia expressed a need to marry and have their own family and children, and Laliberte-Rudman, Yu, Scott, and Pajouhandeh (2000) finding such individuals highlighting the importance of having children, and a relationship in which “you grow together, you learn together, you go through things together, phases.”

A spirituality, a connection to a higher power and a resulting sense of belonging in the universe, which we may view as involving a form of agape, can also play an important role in the THRIVE phase through providing a sense of hope, inspiring and facilitating recovery (Humberstone, 2002; McCann & Clark, 2004). Drinnan and Lavender (2006) noted one participant in their study of psychosis stating that “If I had no faith, I don’t know how I’d get through it. No faith, no hope, no light at the end of the tunnel. I would end it” (p. 323). Similarly, Nixon, Hagen, and Peters (2010b) found that some patients with psychosis noted the help of spirituality to their recovery, and as a result viewed their psychosis retrospectively as a spiritual gift. However, as noted above, there is a paucity of research in this area, and more work is needed investigating how rediscovering agape can play a role in recovery.

Finally, a number of studies have found how people who emerge from voices and psychosis have their awareness of, and capacity for love and compassion, enhanced. One cannot read the 50 stories of recovery presented by Romme et al. (2009) without being struck at how many people who hear voices come, as part of their recovery, to be involved in offering peer-support for other people who are going through similar experiences. Similarly, Nixon et al. (2010b) found participants volunteered to try to help others with mental health concerns, or became advocates for other service-users, reflecting their increased compassion, with Robertson and Lyons (2003) also finding greater understanding for others’ suffering. Gee et al. (2003) also found improved family relationships, with one participant stating “I can talk much more to them now, we’re closer now than we were.”

## Discussion

Love is at the heart of all aspects of the experience of hearing voices, likely playing a role in the causation of some people’s voices, and having a central role in the DIVE and THRIVE phases of most people who hear voices. What are the implications of this for interventions designed to help people who hear voices? First, as we observed that a key part of the THRIVE phase was being able to introduce *philia* into one’s relationships with angry, aggressive, destructive voices it appears profitable for therapists to focus on this. Forms of innovative therapy such as Relating Therapy for people who hear voices (e.g., Hayward, Overton, Dorey, & Denney, 2009) and Voice Dialogue (Corstens, Longden, & May, in press) are beginning to undertake such tasks, finding therapeutic benefits of changing voice-hearer’s relationships with their voices. Second, Davidson (2011) has recently called for abandonment of the traditional therapeutic stance of abstinence in favour of a more engaged and compassionate stance which falls under the broad rubric of “love” in

therapeutic relationships with patients diagnosed with psychosis. The findings of this paper suggest that this would be an appropriate stance for therapists to take towards their clients who hear voices. This is of course not to suggest eros, but rather philia or agape. In addition to facilitating healing from distressing voices, such a loving stance may be required in helping people regain a basic sense of personhood, of self, which has been compromised, if not altogether destroyed, by experiences associated with psychosis (Davidson, 2011; McCarthy-Jones et al., in press).

The importance of love to recovery also suggests that clinicians should focus on the degree to which persons hearing voices are engaged in loving, and being loved by, other people in their lives. Traditional concepts such as “social support” fall short of capturing the amount of work, and depth of affection, involved in truly loving relationships, and are perhaps inadequate for encouraging practitioners to have high expectations for the quality of the relationships persons who hear voices are deserving of. But it is not a matter of simply having social relationships, regardless of their quality. To be sufficiently healing, persons hearing voices should be encouraged to invest themselves fully in their relationships with selected others, and practitioners need to be confident of their ability to do so. Yet this is likely to be a complex process as it also must take into account the potential vulnerability of such individuals. It should also be noted that the elimination of voices through the successful use of antipsychotic medication may cause a loss of philia in terms of the loss of valued relationships between the voice-hearer and their voice(s). If, as appears to be common in psychosis (McCarthy-Jones et al., in press), people have become socially isolated, then there is an important need to ensure that the loss of philia caused by a voice-hearer’s loss of their relationship with the voices themselves is replaced by the introduction of loving relationships with people in the external world.

In addition to re-introducing the idea of psychotherapy as a loving relationship, and focusing on the importance of other loving relationships, we may also ask how specific types of therapy may be employed that already have concepts of love at their heart. Love is central to the recently developed Compassionate Mind Therapy (CMT: Gilbert & Irons, 2005) which builds on the idea that people with high levels of shame find it hard to be self-supporting or self-reassuring, in part because they have never learnt to be this way, due to their history of being shamed and criticised. By helping such people to develop self-compassion and self-soothing, perceived threats can be reduced. In one small-scale pilot application of this technique to people who hear voices, Mayhew and Gilbert (2008) found that CMT “had a major effect on voice-hearer’s hostile voices, changing them into more reassuring, less persecutory and less malevolent voices” (p. 133). This technique fits well with the childhood trauma that many people who hear voices will have experienced, addressing how this may have impacted upon their attachment, and hence their ability to experience both giving and receiving love.

To be clear though, we are not arguing here that a focus on love alone will be a panacea for those with distressing voices. Love without understanding, in this case understandings of contemporary models and interventions for voice-hearing, is likely to be as perilous as understanding without love. It will not simply be the case that “love changes everything,” and a focus on a person hearing voices’ past, present and future experience of love will supplement existing biological and psychological interventions, rather than replace them. Nevertheless, the Soteria project has already shown the power of simple human interactions to help patients diagnosed with schizophrenia. Soteria (from the Greek for deliverance/salvation) was a community based, experimental residential treatment run in the San Francisco Bay area in the 1970/80s. It drew on the power of human relationships,

was not run by doctors and nurses, tried to use antipsychotic medication as infrequently as possible, ideally not at all, and offered an alternative for patients to hospitalisation (not a follow-up to it). The nonprofessional staff aimed to provide a simple home-like atmosphere, and were taught, and believed, that human involvement and understanding were critical to healing interactions. They were not there to observe in experimental fashion, but were there to “be-with” patients, and everyone was to be treated with dignity and respect, have sanctuary, quite, safety, support and protection. The results of this rigorous scientific study were that first-episode patients diagnosed with schizophrenia assigned to Soteria and those assigned to standard medical treatment both showed significant improvement, and to a comparable degree (Mosher & Menn, 1978; Mosher, Vallone, & Menn, 1995). This study can be interpreted as demonstrating the clinical effectiveness of philia to those with psychosis.

Given the centrality of love to the experience of hearing voices, we may ask what other disciplines specialise in the experience of love and may hence aid the mind sciences through the development of an interdisciplinary approach to love and hearing voices. The centrality of love to many spiritual and religious traditions means that this is one relevant discipline that is likely to have much to offer clinicians and mental health professionals. We will focus here on the Judeo-Christian tradition primarily, due to our greater familiarity with this tradition, but encourage practitioners and investigators from other spiritual backgrounds and traditions to also consider how their theologies and expertise may add to this developing area of research. Another reason for our focus on Christianity here is that as although elements of other religions such as Buddhism have had a profound and acknowledged effect on the development of both cognitive-behavioural therapy (e.g., Kumar, 2002) and acceptance and commitment therapy (Hayes, 2002), there has been a reluctance to examine equivalently how aspects of Christianity could aid and inform therapeutic practice.

The relationship between Christianity and the experience of hearing voices is a long and complex one (McCarthy-Jones, 2012). The reduction of Christian input into the treatment of those hearing voices can be traced back to the end of the eighteenth century and the interactions between theology and the fledgling discipline of psychiatry at this time (McCarthy-Jones, 2012). The start of the nineteenth century saw the emerging discipline of psychiatry attempting, and succeeding, in establishing its authority to treat people hearing voices, but only after having to wrestle this authority away from retreats and treatments given by religious figures. The alienist Pinel’s concept of moral treatment appropriated ideas from existing work being done with the mentally ill by Charlatans (uncertified practitioners). For example, the Catholic Brothers had set up a number of hospitals specifically for the insane where the monks were to be courteous and gentle to the patients, and where there were regular and constant visits from staff, in a one-to-one situation (Goldstein, 2001). The Christian philosophy of love for one’s fellow man was conducive to this approach, with Christian treatments aiming not to suppress pain, but rather at helping the person to cope by aiding hope and courage (Goldstein, 2001). In the early decades of the nineteenth-century individuals like Xavier Tissot were actively fighting for a religious version of moral treatment over a medical version (Goldstein, 2001). Yet by stressing the physical aspects of mental disorder physicians came to gain authority over the mentally distressed. Two centuries on, it now seems appropriate to bring psychiatry and both Christianity specifically (as well as other forms of religion/spirituality more generally) back together, to see how theological understandings of concepts such as love, can help us better understand core facets of recovery generally, and the journey through the experience of hearing voices specifically.

We may also ask how other concepts from various religions/spiritual disciplines may be useful in helping the development of effective care for people who hear voices. As Worthington (2005) notes, for centuries forgiveness has been associated with many of the major religions and is particularly central to Christianity. Large-scale research into the relationship between forgiveness and voice-hearing has not yet been undertaken. However, empirical studies of forgiveness and post-traumatic stress disorder (PTSD) have found that difficulty forgiving oneself (as well as difficulty forgiving others) is associated with more severe PTSD symptomatology (Witvliet, Phipps, Feldman, & Beckham, 2004). Such findings are likely to be applicable to people who hear voices. Suggestive evidence for this comes from some studies of Christian-based forms of therapy for people who hear voices. For example, in a study of Christian cognitive-behavioural therapy with a 32-year-old Brazilian Christian woman who was hearing voices, Garzon (2009) noted the importance of self-forgiveness in the resolution of this person's voice-hearing. This importance was also recently stressed in a first-person account by Johnson (in press). More generally, given what appears to be a clear role for perceived guilt and shame in the aetiology of many cases of voice-hearing, a focus on self-forgiveness is likely to be clinically useful (McCarthy-Jones, 2012).

Yet whilst forgiveness of self implies one has committed a moral transgression, it is likely to be important to move beyond this to address situations where one has been made to feel guilty for events which were not one's fault. Here it is the realisation of innocence, rather than the seeking of forgiveness which is appropriate. This may be particularly applicable with people who hear voices given the high prevalence of childhood trauma in this population. For example, a number of people who hear voices have stated that a key part of their recovery was when they were able to find themselves "not-guilty" in relation to the abuse they had suffered. As Coleman (2000) puts it in regard to a fellow voice-hearer, Jenny, he was working with; "she had to find herself innocent of any fault within the abuse... It did not matter that I like many others told Jenny that she was the victim in this situation what mattered is what Jenny thought... [she] had to put herself on trial and in order to do this had to go through the experience again and again from every conceivable angle until she could say with real conviction I am innocent" (p. 76).

Finally, forgiveness may also be sought from the voices themselves. Gehrke (as cited in Romme et al., 2009) reports that "It was only when I recognised that lot of what the voices were stating was actually right, that I was able to forgive them... I made myself ask the evil voices for forgiveness and then slowly, my depression started to lift" (p. 110).

In conclusion, the experience of love lost and found is central to the journey of many people who hear voices, being implicated in the causes of voice-hearing, the DIVE phase, the THRIVE phase, and the transition between these phases. As such, the mind sciences need to first to better understand and operationalise the range of love experiences, and to examine how these affective states interact with cognitive processes in their potential roles as both cause and consequence of hearing voices. By placing such concepts back at the heart of a person-centred approach to care, in conjunction with existing biological interventions, we may be able to offer people who hear voices a more meaningful and satisfying therapeutic experience, and to expedite their recovery. Although we have used illustrative examples here from Christianity, the ability of a range of religious and spiritual traditions to inform the therapeutic process, through their expertise in the concepts of love, compassion and forgiveness (and their parallels), are likely to be of great benefit to the development of such an interdisciplinary approach. We hence encourage those from a

range of religious and spiritual traditions to partner the mind sciences in a truly bi-directional partnership (McCarthy-Jones, 2011b, 2012) to aid people who hear voices. Our journey to better understand voices, and to improve the journey to recovery, will leave more than one set of footprints in the sand.

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