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Accepting and Working with Voices: The Maastricht Approach

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In Maastricht, the Netherlands, over the past 20 years psychiatrist Marius Romme and researcher Sandra Escher have developed a new approach to hearing voices, which we will call the 'Maastricht' approach, that emphasizes accepting and making sense of voices.[1] This approach has become progressively more influential, in Europe, Australia, New Zealand and elsewhere, and has led to voice hearers organizing themselves into networks, empowering themselves and working towards recovery in their own ways.

This approach contends that people hearing voices (hereafter referred to as 'VH' for 'voice hearers') can learn to cope with their voices and benefit from psychological and social interventions. It is based on three central tenets, that the phenomena of hearing voices is: (a) more prevalent in the general population than was previously believed, (b) a personal reaction to life stresses, whose meaning or purpose can be deciphered, and (c) best considered a dissociative experience and not a psychotic symptom (though it can sometimes occur in the context of psychotic symptoms, such as delusions; Moskowitz and Corstens, 2007). In addition to emphasizing understanding the purpose or meaning of the voices, a specific treatment model for working directly with a person's voices – emphasizing their dissociative nature – has been developed by adapting the voice dialogue method (Stone and Stone, 1989) for working with VH.

[1] In the professional literature, 'voices' are most often referred to as 'auditory' or 'verbal' hallucinations. We will, however, use the term 'voices' throughout, which we feel is far more 'user-friendly'.

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23.1 The History of the Maastricht Approach and of the Hearing Voices Movement

Starting from one patient who insisted that her voice-hearing experiences be taken seriously, Romme and Escher conducted several research projects and organized meetings and networks for VH and professionals in the Netherlands and other countries. Especially in the UK, this led to the development of a nationwide network of VH who found and elaborated ways of supporting each other. Many other countries also now have networks of voice hearers organized outside of the mental health system. These activities led to and became embedded in what we can call 'the hearing voices movement'.

The alternative model that Romme and Escher developed, in close collaboration with VH, was based on the premise that hearing voices is a normal human experience that has a personal meaning in relation with life history, which they seek to understand. In contrast, Western clinical psychiatry sees voices as symptoms of an illness, a meaningless pathological phenomenon. As such, their only goal is the elimination of the voices (voices that, in our opinion, harbour meaning in reference to peoples' lives); they have nothing to offer VH who seek their help other than medication. However, from our perspective, rejecting the meaning of voices is the same as rejecting the person.

Voice hearers who come to the attention of psychiatric services are often stuck in destructive communication patterns with their voices. The alternative approach is based on helping people make sense of their voices and learning to cope with them. We found that bringing together patient and nonpatient VH showed the relative lack of difference between the experiences of these two groups. Presenting the information of the nonpatients and patients who learned to cope successfully generated hope for voice-hearing patients. The stories of VH who had extensive experience with the psychiatric system and who (despite this) learned to cope with their voices were widely presented in conferences and network meetings. All kinds of explanatory models were welcome.

The foundation of hearing voices networks in the UK, Germany and the Netherlands have created possibilities for acknowledging and supporting VH and those around them. Yearly conferences in these countries spread the old (but forgotten) news that people can learn to live with their voices, and hearing voices was widely covered by the media. Some time later, cognitive behaviour therapy research showed that even people with the diagnosis of schizophrenia could change their attitude towards their voices (Chadwick and Birchwood, 1994). Gradually it emerged that many voice-hearing patients suffered from trauma, a neglected aspect of psychosis in general and the voice-hearing experience in particular (Romme and Escher 1989; Read and Ross, 2003; Read *et al*., 2005).

Giving meaning to voices, making sense of voices, became a new paradigm, constructively creating new treatment roads and ways of recovery.

23.2 Relevant Research Findings

Epidemiologic data reveals that hearing voices is a common human experience (2–6% of the population; Tien, 1991, Eaton *et al*., 1991). Only a small minority fulfil the criteria for a psychiatric diagnosis and, of those, only a few seek psychiatric aid (Bijl, Ravelli and Van Zessen, 1998). In traditional Western psychiatry, hearing voices is often

linked to psychiatric disorders, predominantly schizophrenia. Selection bias is responsible for this hundred-year-old distorted clinical view because, until recently, psychiatrists didn't know about nonpatient VH in the community; treatment practice has been exclusively based on a disease model of hearing voices (Bentall, 2003). The differences between the experienced characteristics of voices of nonpatients, patients with dissociative experiences and patients with a formal DSM-III and DSM-IV diagnosis of schizophrenia are nonspecific (reviewed in Moskowitz and Corstens, 2007). In general, however, nonpatients feel less powerless and are less afraid of their voices (Romme *et al*., 1992; Beavan, 2006). What makes VH become patients is their reaction to their voices and the way they cope with the underlying problems that have evoked the voices (Romme *et al*., 1992). In their own research, Romme and Escher observed that, for 70% of the voice-hearing patients and 50% of the nonpatient VH, the onset of the voice-hearing experience was clearly connected to threatening or traumatizing daily life experiences (Romme and Escher, 1989). Similarly, for a group of 80 voice-hearing children, 85% linked the start of the voices to trauma or stressful events, such as sexual and physical abuse, long-term emotional neglect, chronic bullying at school, loss of a loved one (and, often, being denied normal ways of bereavement) and parents' divorce (Escher *et al*., 2004). Many, however, were able to cope with their voices on their own, without needing professional treatment.

23.3 Assessment: The Maastricht Hearing Voices Interview

One of the most striking aspects of the general attitude towards VH in Western civilization is that people, whether lay or professionals working in the psychiatric field, don't know how to relate respectfully to someone who hears voices. Typically, confrontation with a VH provokes either rejection or silence. In the medical model, the ultimate answer to patients hearing voices is to find a way to silence the voices. Communication about the voices between professional and VH generally is discouraged. This behaviour probably originates in the mistaken belief that talking about voices stimulates delusions and that emotions will get out of control. In Western societies, hearing voices is generally considered as 'mad', dangerous and abnormal. In other cultures, though, and in Western societies historically, hearing voices was often viewed as meaningful and normal for gifted members of society (Sidgewick *et al*., 1894; Smith, 2007; Watkins, 1998).

In our experience, talking with VH doesn't provoke psychosis. This is acknowledged by cognitive behavioural therapists working with people who suffer from psychosis, where it is common practice to discuss the experiences of the patients (Haddock, Bentall and Slade, 1996). Most VH find it liberating to be respectfully questioned about their voice-hearing experiences and feel acknowledged by it. For some, only this kind of assessment produces profound change.

The Maastricht Hearing Voices Interview[2] is a tool to structure information-gathering; it stimulates the VH to explore their own experience and create some emotional distance from the voices. This information gives clues to treatment planning.

[2]Available in *Making Sense of Voices: A Guide for Professionals Who Work with Voice Hearers* (Romme and Escher, 2000) or by request from the second author (d.corstens@riagg-maastricht.nl).

The interview consists of the following sections:

- the nature of the experience;
- characteristics of the voices;
- personal history of voice hearing;
- voice triggers;
- what the voices say;
- explanations for the origin of the voices;
- impact of the voices on way of life;
- balance of the relationship;
- coping strategies:
  - cognitive;
  - behavioural;
  - physiological;
- experiences in childhood;
- treatment history;
- social network.

23.3.1 The Nature of the Experience

Does the VH really hear voices? Sometimes it is difficult to differentiate one's own thoughts from voices. *Do you hear the voices in your head or from outside?* Many VH experience both. Are there other extraordinary experiences like visions, the feeling of being touched, smells, tastes and body feelings? Explore these and the connection with the voices.

23.3.2 Characteristics of the Voices

For each voice or group of voices ask: Do they have a name, what is their age and which gender? How do they speak? As loud as the interviewer, softly or do they shout? What is the frequency of every voice? Is there a hierarchy? What is the most important, the most malevolent, the most benevolent voice? *Do the voices remind you of someone that you know or have known?* Not only in tone but also in content (e.g. a VH heard a female voice that said the same things as her father did, so there is a resemblance in content).

23.3.3 Personal History of Voice Hearing

What were the personal and social circumstances when the (different) voices appeared for the first time? Did they develop or change in content and influence? Did the voices disappear or did new voices appear and what were the circumstances? The interview schedule lists circumstances VH mentioned in the research as related to the onset of their voice-hearing experiences. This makes it possible to differentiate between events related to and not related to that experience. It is likely that trauma evokes so much emotion that VH don't remember what was happening at the time that they started to hear voices. We recommend using the Dissociative Experiences Scale (Bernstein and Putman, 1986) before the Maastricht Hearing Voices Interview in order to get some indication of the severity of dissociation in response to trauma.

23.3.4 What Triggers the Voices?

The interview asks for places, situations and emotions that trigger the voices, provoke them to 'make their presence known'. The interview lists a number of emotions: anger, sadness, sexual feelings, loneliness and so on. Ask not only which emotion triggers the voices but also how the voices react. For example, when the trigger is anger, how do the voices respond?

23.3.5 What do the Voices Say?

We ask what every voice is *literally* saying. We ask for sentences or exact words. Sometimes VH are so ashamed or feel so guilty because of what the voices say that they don't dare say it out loud. Voices can forbid telling what they say. Many VH avoid concentrating on what the voices are saying. We noticed that the more control over the voices a VH has, the easier it is to talk about what the voices say.

23.3.6 How do You Explain the Origin of the Voices?

In this section we explore which explanations the VH has for his experience. Some VH are very explicit (e.g. paranormal experiences, entities, God(s), Devil(s) and so on). Others don't feel the need for specific explanatory models. The interview schedule lists possible explanations. The explanatory framework of the VH should be accepted and not challenged during the interview.

23.3.7 What Impact do the Voices have on Your Way of Living?

Here we ask for the influence of the voices on the VH's life. The impact can vary considerably between the voices. What do the voices ask? Do they demand or command things,

or do they even 'blackmail'? *Do you feel you have to obey the voices? Do you believe what they are saying?* Do the voices give advice and how useful is this? How much are the voices hindering social contacts and work in daily life? Are the voices always right in what they say?

23.3.8 Balance of the Relationship

How do you relate to the voices? Can you communicate with them or not? How do these dialogues develop? Do the voices listen to you? Do they respect you? Do they agree with you? Can you send them away? What kind of relationship do the voices want and do you agree?

23.3.9 Coping Strategies

What do you do when you hear voices?

- Cognitive: do you use your mind/your thoughts to cope with them?
- Behavioural: do you go somewhere or do something to cope with them?
- Physiological: do you use anything that gives a physical reaction like medication, drugs, alcohol, yoga, meditation and so on?

Is what you do when you hear voices effective?

23.3.10 Your Experiences in Childhood

Was your childhood safe or not? Did you feel wanted and supported? In the interview schedule, a list of possible negative experiences is given, which includes sexual abuse, harsh or strange punishments, neglect and so on. Some experiences are emotionally so overwhelming that a person does not like to speak about them. Don't rush or force them.

23.3.11 Your Treatment History

Who did you ask to help you with your voices? Which kind of therapist? Why that kind of therapy? Did the therapist accept the voices? What did the therapist say? What did he do? Did he talk about your voices? Did it help you or did it worsen the voices? Did you get medication? For what? Did it help?

Were you referred to a self-help group? An alternative therapist?

23.3.12 Your Social Network

With the nonpatients we saw that they got support from their social network and people who accepted their experiences. We therefore make an inventory of the social network. Who are the significant people in your life? Do they know about your voices? Do you talk with them about your voices? Do they support you?

It is important to build up a relationship before starting the interview by showing a broader interest in the person and her problems. An experienced interviewer generally takes one and a half hours to conduct the interview. It is also possible to use the interview in clinical practice in a more extensive form, mixed with positive examples of other VH experiences, in order to motivate the person to talk about his/her voices. It can also be motivating to give information about VH who were never in the mental health system and about VH who learned to cope with their voices.

When the interview is finished the interviewer writes a report summarizing the information given about each heading in a way that can be easily remembered. The VH is then asked to read the report and comment on it. Possible gaps or misunderstandings are discussed. Participating in this way can be a first step in eliminating emotional and cognitive avoidance that is so common in VH. The written report of their experiences also can stimulate the VH to discuss and find other strategies for dealing with voices and emotions. The interview can also reveal practical and social issues that may be hindering recovery. We have often found that the interview itself was a big step in the process of recovery because VH became aware of the meaning of their voices, the relationship with their emotions and important issues in their lives, and felt stimulated to try other coping strategies. The interview often has a therapeutic effect. We emphasize that the *systematic* use of the interview is necessary to structure the experience and become aware of important aspects of the voice hearing experience.

23.4 Formulation: Making the Construct/Breaking the Code

The main causal factor for hearing voices are traumatic experiences that made the person feel powerless and couldn't be solved by him or her. However, there are many people in our society who hear voices and do not become psychiatrically diagnosed. This indicates that there are certain reasons that some people become 'mentally ill'. We believe that hearing voices in itself is not pathological but the inability to cope with the voices produces illness and illness behaviour.

Because hearing voices is a very strange experience at the beginning, people easily become overwhelmed and ashamed by it. In our society, hearing voices is associated with madness. Because of this societal ideology, a number of VH don't relate their voices to their life history at all.

In response to threatening experiences and the overwhelming emotions related to trauma, people react with dissociation or repression of emotions. Such responses are often built on an upbringing of emotional neglect and denial of emotions. Typically, hearing voices is the end result of the sequence: trauma – overwhelming emotions – provoking dissociation or repression – extra provocation of emotions – coping fails – hearing voices start. When this pattern can be traced, the experience can then be identified as a signal of

specific problems (i.e. when coping fails, the voices take over). In children, we also find a shorter sequence, as hearing voices for them is often a direct response to the traumatic experience, as part of a dissociative reaction. Typically, the voice is 'protecting' the child. For example, during years of sexual abuse, a voice supports the child telling her that she is not bad, but good. Also common is that the voice resembles the characteristics of the abuser. There the voice can be viewed as a 'warning signal', on the one hand, expressing the dangerous and threatening behaviour of another person and, on the other hand, serving to split off the overwhelming feelings of fear and annihilation.

Making sense of voices acknowledges the connection of the voices to traumatic experiences. It requires an open and empathic attitude combined with a systematic approach in observing and gathering significant information. In order to retrieve the relationship between the voices and the life events, 'the code' of defence needs to be broken (i.e. what the voices say may not adequately represent their purpose). This 'code' in patients hearing voices often involves a destructive way of communication and an exaggerated and negative way of expressing individual emotional problems.

This systematic and open search for meaning leads to a psychosocial dynamic formulation that Romme and Escher (2000) have called 'the construct', which is an understanding of the purpose of the voice negotiated between the interviewer and the VH. Sections of the Maastricht interview particularly emphasized in making sense of the voices and forming the construct/breaking the code are: *Identity, Characteristics,* the *History* and *Content* of the voices, *Triggers* and *Childhood history*.

Two questions are to be answered from the information in the report in order to formulate the construct: *Who do the voices represent?* and *What problems do the voices represent?*

23.4.1 Who do the Voices Represent?

In traumatic events, other people are involved as well as emotions that the person finds difficult to cope with. How the voices relate to the VH often resembles the identity and the characteristics of significant individuals related to the trauma in a literally or in a metaphorical way. For example, the voice might have the same name as the person who abused the VH in the past, or the characteristics of the voice (sex, age) and the way the voice speaks to the person resembles the person involved in the trauma. Or, the content the voice is almost the same as the words said by someone who bullied the individual. The voice relates to the life history, which the VH may not, or may only partly be, aware of, but can often easily recognize when the connection is worked out with them. Voice hearing is a reaction to actual social problems on the basis of the vulnerability of the individual. The identity, content and characteristics of the voices and their history of origin might indicate whom they represent. Sometimes collaborative imagination is needed in order to find the 'who' behind the voices.

23.4.2 What Problems do the Voices Represent?

This question goes to the circumstances or events that lie at the roots of the voice-hearing experience. The problems, situations and events were so overwhelming that it exceeded the

individual's coping strategies. How to cope with trauma depends also on the childhood. We learn in childhood how to cope with stresses in life and with internal and external conflict. Many VH have been emotionally strangled in their youth by their parents or during their education. They have very low self-esteem. The more vulnerable a person is the more problematic it will be to learn to cope with stressful events. Problems at the root might also be severe conflicts at work, the home situation, sexual identity, loyalty conflicts and so on, and the voices tell about those problems. Figuring this out allows for the development of a focused treatment plan.

23.5 An Example: Maureen

Maureen is 30 years old and hears three voices.

The identity of the voices. The voices have their own names: Ina, Anna and Johanna.

The characteristics of the voices. Ina is seven years old, cries a lot or shouts if Maureen doesn't want to listen to her. Anna is 19 and thinks of Maureen as worthless and is aggressive towards her most of the time. Johanna is of the same age as Maureen and is a positive voice who helps her.

The history of the voices. Ina came when Maureen was seven years old. It was the age when she began to be sexually abused by an uncle. This abuse lasted till she was 12 years old. Anna showed up when Maureen was 19 years old. At that age Maureen wanted her parents to help her to officially accuse the uncle and start a trial. While they initially agreed, just before the formal accusation, the parents changed their minds and withdrew. Then the voice of Anna came. Johanna entered the stage when Maureen had therapy; this voice helps Maureen to cope with the other voices.

The content of the voices. Ina wants to tell Maureen what happened with her when she was abused and will cry or shout when Maureen doesn't listen to her. Anna accuses Maureen of not being strong enough and of not being persistent when she should defend herself against other people. Anna brutalizes Maureen and tells her to kill herself because she is 'such a wimp'. Johanna gives advice, such as, not to listen to the other voices and to look for something that distracts her.

Triggers. For Ina, triggers are visits to Maureen's parents and confrontations with sexuality in her life. Triggers for Anna are when Maureen has to take a stand and doesn't dare to do that, or when Maureen visits her family or when she contacts men, because Anna doesn't want her to relate to men. Johanna comes when the other voices, especially Anna, are very aggressive and Maureen is afraid of them or thinks that she will do what Anna is telling her to do.

Childhood history. Maureen had a very protected upbringing where she didn't learn how to stand up for herself and was not allowed to be angry.

23.5.1 The Construct

Who do the voices represent? The voices Ina and Anna don't represent real people but are emotionality related to the sexual abuse. Johanna represents the helping part of Maureen herself.

What problems do the voices represent? Maureen agrees that all the information points to her difficulties with coping with the sexual abuse in her past.

In her treatment, her therapist first focused on acquiring more control over the voices by advising Maureen to schedule time for the voices during the day. The next areas focused on were learning to talk about the sexual abuse, recognizing the related physical complaints as signals of stress and anxiety, and dealing with her confusion about her own contribution to the abuse and her belief that she had let it go on for so long. The 'grooming' techniques of the perpetrator were also discussed. Later her own choices regarding sexuality and sexual identity and accomplishing her own goals in her life were emphasized.

'Breaking the code' is not an isolated activity of the professional but results from a collaboration between VH and professional, The 'code' can also be broken (or 'construct' generated) in a group of VH and professionals; it can be very useful for an individual to hear the range of associations that come out of such a group. Experienced VH can be of great support in this process and can act as professional helpers.

23.6 Treatment Plan

From the information of the construct a treatment plan can be developed, focused around three goals: (1) to identify the most hindering aspects of the voices, choose a strategy and practise this method, (2) to improve the voice hearer's relationship with difficult emotions and adopt alternative coping mechanisms for dealing with those emotions, and (3) to deal with the historical events that have been difficult to accept, and work through the associated anxiety and guilt.

23.6.1 Dealing with the Difficult Voices

Voices can command, demand and be destructive. Often they disturb all day long, capture the VH in isolation, passivity and destructive activities. Voices tend to get stronger when the individual sets no limits. Most voices threaten when the VH tries to disobey them. Supporting and helping VH is a creative endeavour, comparable with helping people in couples therapy where divorce isn't an option. Voices have their own (but often limited) strategies to keep the VH in their power. The VH can develop new strategies to address the voices and has to learn to set his or her own limits.

Acquiring more control through anxiety reduction and decreasing the frequency of the voices are the first goals. Giving reassuring information can decrease the anxiety level considerably. Creating hope in a situation that appears devastating empowers the VH. Sometimes, temporarily prescribing medication may also be helpful in reducing anxiety. Antipsychotic medication, however, seldom has a lasting effect on voices (Honig, 1993). It reduces the person's emotionality which is useful in the short term but diminishes recovery effects because coping with emotion is not learned. Alternatively, benzodiazepines can be prescribed (short term) to diminish anxiety. When depression triggers the voices, antidepressants may also help.

Creating 'space' is something the VH can achieve by setting time for listening to the voices instead of trying to avoid every confrontation with them. The difference between *hearing*, *listening* and *obeying* is clarified, where *listening* (the goal) is asking neutral

questions and not reacting too emotionally. This can be practised in a session with the VH. *Obeying* is not a viable option, unless it is the voice-hearer's own choice. Sometimes voices give good tips. Time-limited listening should be coupled with neglecting the voices at other times of the day (which we called *hearing*). Instead, voices can be referred to the 'consulting-time' later on. Answering the voices, making one's own choices, searching for alternatives to the commands of the voices and writing a diary about the voices are all means to acquire more distance between the voices and the VH. Discussing the ways in which the VH interprets their voices (e.g. as paranormal, spiritual or religious experiences) is often not very fruitful, unless it occurs as a sort of Socratic dialogue, as is done in cognitive behavioural therapy. Their interpretations can, however, suggest underlying emotional themes. Finally, the VH should learn to throw off the victim role and take responsibility for his or her own life. This is stimulated when the code is broken and the meaning of the voices in relation to one's life history is made clear.

23.6.2 Finding New Ways of Dealing with Difficult Emotions

Often certain emotions are severely repressed in VH. Examples are anger, guilt and sexual feelings. The anger of the voices represents the disowned anger of the VH. Practising expressing these emotions in social situations, as is done in assertiveness training, or support with socializing, helps the VH to express difficult emotions. Participating in hearing voices networks is usually welcomed by VH, because stigma is minimized and acceptance as a VH, instead of as a psychiatric patient, increases self-esteem. In these networks, VH help other VH, supporting further integration in a social environment. Many VH express the need to build another identity, to find a new way of relating to others and be accepted as VH.

23.6.3 Accepting the Past and Working through Associated Anxiety and Guilt

As already stated, VH have often suffered from traumatic experiences. They often re-experience traumatic memories, partly in their voices, but also in (other) dissociative complaints like depersonalization, derealization, numbing (often interpreted as so-called 'negative symptoms'), amnesia, re-enactments and nightmares. Many people who are identified as 'psychotic' are restrained from ordinary psychotherapeutic intervention based on the false belief that talking to them about their voices (or other 'psychotic symptoms') will worsen their symptoms. Of course, psychotherapy should be conducted by experienced psychotherapists who are used to dealing with trauma and with strong transference reactions. Also important is creating a supportive social environment in a hearing voices network, self-help groups and other social support which increases the capacity to work through traumatic memories, as well as difficult and overwhelming feelings like anxiety, guilt and despair.

23.7 Working with the Voices

Voices are a personal reality. Getting rid of the voices is an aim many VH (and professionals) get stuck in. Our experience has taught us that a more realistic objective is to

learn to accept and cope with the voices. In the dissociative disorder literature, it is generally accepted that making contact with the split-off parts of the personality is important to achieve therapeutic change and ultimately integration. Inspired by the practice and method of voice dialogue (Stone and Stone, 1989), and guided by an experienced voice dialogue therapist, Robert Samboliev, we developed a method to talk to the voices of VH who can communicate with their voices.

In the voice dialogue method (designed for working with nonpatients), every person is viewed as consisting of many individual selves or subpersonalities, each with its own personal history, physical characteristics, emotional and physical reactions, and ways of perceiving our lives and the world (Stone and Stone, 1989). These selves are organized in opposites, the so-called *primary* and *disowned* selves. Voices, more specifically ego-dystonic voices, could be interpreted as disowned selves, relating to difficulties in bearing emotions and other experiences in the life history of the VH. In voice dialogue practice, the facilitator (not referred to as a 'therapist') makes contact – talks – with the subpersonalities in an exploratory way by asking ordinary questions, similar to those we would ask when we want to get to know someone to whom we've just been introduced. Questions like 'What is your task?, What would happen if you left?', evoke a good understanding of the specific subpersonality and create energetic contact. Exploring the subpersonalities, initially the primary and then the disowned, creates space in the person and a kind of *meta-position* that is called an 'aware ego', an operating ego of sorts that bridges the tension between the opposite selves and makes the person aware of the different selves he contains. Change is not the aim but a by-product. Awareness creates distance and choice. In the process of voice dialogue this awareness supports a more conscious use of the capacities one has.

The theory of voice dialogue offers an easily understood explanatory model of voices as different subpersonalities or selves, and its accepting and nonpathologizing attitude presents a nonjudgemental way for VH to relate to their voices (the original book was called *Embracing Our Selves* (Stone and Stone, 1989)). The interpretation of the primary selves as protective, although manifesting in a harsh and rigid way, offers a comparative and positive image of voices.

In our 'working with voices' approach, we directly or indirectly (i.e. through the VH) talk with the voices by asking the voices questions about their aims and trying to discover their original protective functions. Often this protective function has become submerged and distorted when the VH didn't know how to cope with reality and his voice. The facilitator tries to help the VH recognize and acknowledge the original positive purpose of the voice, and change their attitude to it in order to create a more fruitful relationship (see Moskowitz and Corstens, 2007, for more details).

23.8 Recovery

Recovery is a personal process in a supportive environment. Recovery is learning to express one's own personal story and to validate oneself for who one is. For VH, self-help groups, supporting others and learning to communicate about their own voices is an important step in becoming victor instead of victim (Coleman, 1999). Accepting the voices, finding positive ways to communicate with them and viewing them as warning signals of emotional problems is the road to solving emotional and social problems. This process often ends

in a change to a more positive relationship with the voices. VH can learn to have pride in their experiences and to give their voices a personal and positive meaning. Other VH learn to cope with them effectively and create a life of which the voices become a part. They learn to no longer be dominated by their voices and to make their own choices. Recovery, ultimately, is about dealing with life and its problems. Voices challenge this process, but can be modified towards working to deal with one's own emotional problems. In this process, support from family, friends, other VH and professionals is needed. For professionals, we believe it is our task to facilitate such an environment by individual, community, social and political support.

23.9 Summary

The Maastricht approach to hearing voices offers an alternative to the traditional attitude in psychiatry where eradication of the voices is the aim. Voices are seen as meaningful human phenomena originating in the personal history of the individual who was overwhelmed by emotions in threatening circumstances. Voices made sense in those situations. Systematically interviewing the VH, making a report of this interview and formulating a construct in order to discover who and what problems the voices represent, breaks the code of defence, promotes communication with the voices and clears a path for a treatment plan leading to changes in the relationship between the voices and the VH. Several techniques to encourage the VH to take more control over their voices and their lives can be applied, including, for those who can engage with their voices, techniques derived from voice dialogue. Empowerment and recovery are key objectives. The psychotherapeutic attitude is embedded in a social psychiatric approach where social support is promoted by positive information, an encouraging attitude towards VH and networks of VH who discover the strength of mutual support and creative ideas.

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