Simple coping strategies for people who hear voices

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High levels of stress are common among people who hear voices, but few receive help to cope with the problem. The reason for this appears to be that many mental health nurses are not aware that there are simple coping strategies that could be used to help these people. Some of these are explained in this article. They represent an example of providing person-centred care, which is at the centre of good mental health nursing.

Many mental health nurses find themselves caring for people troubled by voices. Research has found high levels of distress among people who have limited control over the voices and few coping strategies (Nayani and David, 1996). It is the role of professionals to help them (Knudson and Coyle, 1999).

There is a range of simple psychological interventions that can be used to help people who hear voices, yet somehow such techniques seem to be rarely used by mental health nurses. The strategies described in this article are practical and effective, and can be used even in a chaotic acute environment.

Psychological treatments

According to the National Institute for Clinical Excellence (NICE), psychological treatments for psychosis ‘should be an indispensible part of the treatment options available for service-users’ (NICE, 2002). The most common form of psychological treatment is cognitive behavioural therapy (CBT) (British Psychological Society, 2000), and NICE has recently decreed that anyone with persistent psychotic symptoms should be offered CBT (NICE, 2002).

There is a clear evidence-base in psychological therapy for using symptom-specific interventions, as they routinely form part of CBT (Nelson, 1997), humanistic counselling (Knudson and Coyle, 1999) and approaches that are based on social psychiatry (Romme and Escher, 2000).

If these simple coping strategies provide such a good opportunity to introduce people who hear voices to psychological treatment, why do mental health professionals not encourage the use of them? There may be two particular reasons. One is that nurses are still afraid to talk openly to people about hearing voices; it is as if they feel that doing so will open a Pandora’s box. A second reason may be that nurses do not know about the strategies that could be used. A recent report highlighted that many mental health workers are unaware of the advances that have been made in understanding psychosis, and that training in psychological approaches is needed (British Psychological Society, 2000).

Copings strategies for people who hear voices do not appear to be routinely taught to nursing students, and the emphasis of postgraduate training in psychosocial interventions lies elsewhere. Moreover, the literature that describes these techniques can be complex, written in an academic style and hard to access.

Symptom-specific interventions

Recent research has shown that voices are heard by many people who do not have mental health problems, and that hallucinations are considered normal experiences (Romme and Escher, 2000, Johns et al, 2002). Hearing voices can be triggered by bereavement, trauma, depression and sexual abuse. The view that voice-hearing is associated with a diagnosis of schizophrenia is becoming outdated, and a symptom-specific approach represents a profound change in mental health care.

Many mental health nurses will welcome this shift of emphasis from diagnosis-led treatment to a system of problem-solving for the individual patient. It is important to note that these simple techniques to help people cope do not represent a comprehensive therapeutic programme for people troubled by voices. Research suggests that people’s beliefs about the voices they hear and the power of those voices may be the most important factor in the degree of distress they experience (Chadwick and Birchwood, 1994). The simple techniques outlined in this article do not address such fundamental issues directly. Rather, they can be classed as ‘distraction techniques’, as opposed to techniques that focus on the voices (Haddock et al, 1998).

Focusing on the voices, listening to what they say, and engaging with them are probably necessary if those who hear them are to be able to address their difficulties (Davies et al, 1999). But research also shows that they become increasingly distressed if they feel they cannot control the voices (Johns et al, 2002). However, Nayani and David (1996) showed that increased control over the voices, coping with the experience, gaining insight into the problem and reduced distress tend to go together.

The interventions described here are straightforward, easy to understand and explain, and can be used by people outside of structured therapy. They are therefore suitable in any nursing environment and with people who are experiencing severe distress. Importantly, the techniques do not directly challenge a person’s own
beliefs about the origin of the voices. For example, if a person believes that the voices come from existing independent beings of some kind, for example, god, devils, evil spirits, ghosts, invisible people or dead relatives, the techniques can be suggested without threatening those beliefs. Thus, the interventions are therapeutically safe.

Some of the coping strategies described may appear ridiculously simple; one of them, for example, involves simply talking to people. However, it is important that both the nurse and the person hearing the voices understand and acknowledge even the most basic coping strategy. The aim should be that those who hear voices develop a range of techniques that they can consciously employ to manage them.

All people have coping strategies, but the more understanding they have of them the more effectively they can be used. The role of professionals who work with people who hear voices is to help them gain more control over their voices (Knudson and Coyle, 1999).

Not all people who hear voices will find a particular technique effective. For example, some may find that wearing an earplug makes no difference whatsoever, while others will find it useful. It is important to emphasise this when explaining the interventions. Therefore, rather than making promises, such as saying: ‘Wearing an earplug will stop your voices,’ the nurse should say that it may help: ‘Some people find that wearing an earplug will stop your voices.’

Many individuals find that the effectiveness of a particular technique wears off over time as the voices ‘shift the goal posts’. Finally, the nurse should remember that the voices may command the person to stop using a particular technique or forbid them to try it.

The strategies suggested below can be included in care plans for ward-based or community work.

**Some simple interventions**

**Social contact**

For most people who hear voices, talking to others reduces the intrusiveness or even stops the voices. Being around friendly faces and spending time with people can be very effective at pushing voices into the background. Thus when people troubled by voices seek out nurses or fellow patients to talk to, this may be a coping strategy.

If a person is clearly distressed by voices and unable to discuss this, a nurse can try approaching the individual and talking to him/her. The reasons why social contact helps a person hearing voices may be complex, but many factors are involved, including distraction, vocalisation and reassurance from the presence of others. Some particular interventions that involve social contact are shown in Box 1.

**Vocalisation**

Research shows that ‘sub-vocalisation’ accompanies auditory hallucinations (Bick and Kinsbourne, 1987). By this the authors mean that people use their own vocal cords when they hear voices. There is associated evidence that the physical act of talking – or using the vocal cords in other ways, such as singing – interferes with the process that creates voices, thus reducing the intensity of the hallucinations. Any vocal activity may therefore help. This could be singing, humming, counting, talking, reading out loud or sub-vocal speech. The latter involves talking quietly so that others cannot hear. Simply holding open the mouth can stop the sub-vocalisation and therefore stop the voices.

Singing under the breath is also possible, and for some people who hear voices this may be easier to sustain than talking sub-vocally. The key point is that different strategies will be suitable for different people in different situations; for example, reading out loud can be used in the privacy of a quiet room, while humming will be more appropriate when other people are around. People with religious faith often use prayer effectively. Examples of vocalisation interventions are shown in Box 1.

**Listening to music**

Listening on personal stereos to music or to the spoken word on the radio is a well-established way of reducing the frequency of auditory hallucinations. Almost all people who hear voices gain some respite using this technique. This may be because they switch attention from the voices they are hearing in their head to the music on the stereo or to the voices on the radio, or it may be because listening to music reduces stress. The more relaxing or pleasant the listener finds the music (or the more interesting the speaker/s), the greater the benefit should be to the individual. There is some evidence that aggressive music or violent lyrics can lead to increased levels of agitation (Nelson, 1997).

**Wearing earplugs**

Wearing an earplug in one ear (monaural occlusion) has been shown to be helpful to many people who hear voices. On initial use, it can reduce voice activity by nearly 50 per cent. The nurse may suggest experimenting to see which ear is the more effective. By wearing one earplug rather than two, the person is able to continue with normal social activities such as being able to hear other people, or the telephone, for example.

Some individuals find that the earplug seems to become less effective as a technique after some time.
Another difficulty is that the earplugs may be uncomfortable, or the person feels self-conscious using one in public. However, earplugs work well for people whose voices are particularly troublesome at night.

Concentration
Concentrating on something other than the voices will often help to obscure them. The focus can be on whatever is convenient or appropriate. The vital factor is the degree of the person’s interest or enjoyment in the activity. Puzzles or games can be effective, particularly word games, such as Scrabble, or puzzle books. Craft activities can also be introduced as coping strategies. Computer games can be very useful, and have the additional advantage of being part of the culture of younger people. If these types of activities are available in an inpatient environment, people can try them out for themselves.

Some people use household tasks, such as doing the washing-up or the laundry, as coping strategies. One strategy involving concentration is called ‘Stop and name’: the voice-hearer says ‘Stop’, looks around the immediate environment then names the objects that can be seen, for example ‘chair’, ‘television’.

Relaxation
Listening to a relaxation tape involves auditory stimulation and distraction, and encourages the person to concentrate on carrying out the exercises, thereby reducing anxiety and contributing to a reduction in the intensity of the auditory hallucinations.

Many people who hear voices find them particularly problematic at night, therefore playing relaxing music or a relaxation tape at bedtime can be helpful. Aromatherapy, massage and other relaxation techniques such as having a long soak in the bath can also help, as can exercise.

Identifying appropriate strategies
People who hear voices can usually identify particular situations, or times, when they find it most difficult to cope with them. These may be at night, in the afternoon, in a busy public place or when alone at home. Different coping strategies may be appropriate on different occasions. For example, some people who use an earplug at home or sing to themselves may feel self-conscious about doing this in public. Furthermore, talking to others may not be useful if the voices are troublesome at three o’clock in the morning, when potential conversation partners are asleep.

However, people can be helped to identify interventions that they can use on different occasions when the voices are distressing. An individualised ‘menu’ of interventions can be devised, built around the person’s most effective coping strategies. The interventions can be written on a card that can be carried in a pocket so that when the voices are difficult the person tries an intervention from the menu. The suggested interventions will often be very simple (Box 2). This method can address specific problems, such as voices that wake the person at night, voices occurring in a specific situation or the onset of a particularly distressing voice.

The discussion of coping strategies must be on an individual basis, and identifying the antecedents of voices is a vital factor in helping the individual cope effectively (Knudson and Coyle, 1999).

The nurse’s role
The simple strategies outlined here can also be used by nurses with very acutely distressed people who are not able to discuss their experiences; those in psychiatric intensive care for example. Of course, many of the interventions will already form part of good nursing care.

There are many ways in which this approach to working with voices is valuable. Most importantly, the patient takes the lead in deciding which techniques to try, and which work. The professional’s role is to encourage and support, taking the person’s experiences at face value and helping him/her along the path to becoming the expert in managing the voices.

This approach does not require the mental health nurse to subscribe to any particular set of beliefs about voices, or to any particular theoretical framework. It is irrelevant whether the nurse accepts the medical orthodoxy on auditory hallucinations, rejects it, or has no opinion at all. What matters is that there are simple interventions available that can help people to manage their own symptoms and to gain in understanding and confidence. The process involves open discussion and acceptance of the experience of voice-hearing. It is an excellent example of the pragmatic person-centred care that is at the core of good mental health nursing.

Conclusion
It is acknowledged that people who hear voices have high levels of distress. However, many could be helped to manage these by being made aware of some simple psychological interventions that can be used at any time and anywhere. They are therapeutically safe because they do not challenge the person’s beliefs about the origin of the voices. Furthermore, they do not require that mental health nurses subscribe to any particular beliefs about them. Because the strategies are introduced on an individual basis they are a means of offering person-centred care.

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REFERENCES


