Book Review: Hearing voices: the histories, causes and meanings of auditory verbal hallucinations

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not his concern. In 1921 Roheim was awarded the Freud Prize and there is a delicious irony that in 2011 Andy Tjilari and other ngangkar–i visited Sydney to have bestowed on them by the city of Vienna the World Council for Psychotherapy Sigmund Freud Award for ‘contributions to psychotherapy’.

And I believe that Andy Tjilari neatly sums up why this book should be prescribed reading for clinicians working in remote Aboriginal Australia, and a guide to anyone invested in cross-cultural cooperation:

So you have learnt about some of our understandings, observations about how and why people get sick. Western doctors often have difficulty understanding these things and the way we work. And so we hope the way we’re talking now helps both people understand something of our work, see how we do things. We hope the doctors will be able to understand something of An–ngangkar–i, of traditional healing, the things that we can do, and see the ways that we can work productively side by side, in harmony with each other. Hopefully we will work out good ways to support each other, the doctors doing their work, we doing our work. (p. 244)

References


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Hearing voices: the histories, causes and meanings of auditory verbal hallucinations

Simon McCarthy-Jones
Hardback. $135.00 AUD

McCarthy-Jones’ project is an investigation of the nature, causes (proximal and distal), and meanings of auditory verbal hallucinations (AVHs). A thorough investigation of this subject goes even to the nature of the self, thought and consciousness. What follows is an epic, systematic and comprehensive treatise which is both fascinating and informative.

The history of hearing voices has always included ‘two jostling discourses’: the biomedical, pathological story and the spiritual, meaningful story. These discourses have been subject to the politics of power and control. Socrates (469 – 399 BC) heard a voice, at a time when gods were thought to be able to communicate with humanity, but this process was effectively regulated so that priests, necromancers and oracles could hear a divinity, but ordinary persons could not. The term ‘hallucination’ derives from the Latin verb alucinari or hallucinari: to wander in mind, to talk idly, to rave. Alucinari dates from classical times and was used by philosophers Cicero and Seneca.

The Old and New Testaments firmly established hearing voices as a potentially divine experience and validated it as a way that God could contact humanity. Thomas Aquinas had a sophisticated understanding of voice-hearing, including the appreciation that voices could occur due to purely natural reasons, such as the use of herbs, or through natural and spontaneous physiological changes; and was sometimes associated with madness. Joan of Arc was burnt at the stake in 1431, because of the voice she said came from God. The voice, which she had heard from age 13, advised and commanded her, including forbidding her to answer certain questions at her trial.

John Locke (1632 – 1704) made disorders of perception (such as hearing voices) prominent signs of madness. Humanistic physicians battled to secure a monopoly over the care of the insane and to take power away from clerical doctors, astrologers, wizards and apothecaries. Robert Burton (1577 – 1640) not only advocated a medical account of hallucinations, but railed violently against religious explanations. William James, in The Varieties of Religious Experience (1902) noted that: ‘Medical terms become mere appreciative clubs to knock a man down with’. ‘A certain tolerance, a certain sympathy, a certain respect’ was called for, in dealing with such experiences. This would seem wise counsel, as evidenced by Rosenhan’s classic study.3 In the 1970s, eight pseudo-patients presented to different hospitals complaining that they had been hearing voices that said: ‘empty’, ‘hollow’ and ‘thud’. All were admitted to hospital; seven were diagnosed with schizophrenia on the basis of this single symptom.

Sidgwick et al.4 found in a general population sample of 17,000 a lifetime prevalence of 2.9% for hearing voices in a clear consciousness, and this finding was more recently replicated by Tien, in 1991.5 Voice hearing in a clear consciousness occurs in 2 – 3% of the general population and is even more common in children (5 – 32%). How then, to distinguish between pathological and healthy voice-hearing? Daalman et al.6 compared the phenomenology of AVHs in patients diagnosed with psychosis and ‘otherwise healthy individuals’. No differences are found in the perceived location, loudness or number of voices. Having control over the AVHs, hearing voices less than once per day, onset before 16 years of age and predominantly positive content are good predictors that the person does not have a psychotic illness.

Recent studies show that 60 – 83% of people diagnosed with schizophrenia hear voices. Estimates for the
prevalence of AVHs in bipolar disorder range widely: 7 – 37%. In a sample of 197 voice-hearers (81% with a diagnosis of schizophrenia) Copolov, Trauer and Mackinnon found 35% have voices located only inside their head, 28% only outside and 38% have both types. They also noted no difference between internally and externally-located voices in their perceived clarity, volume and tone. Although command AVHs were not more commonly associated with internal nor external voices, patients were more able to resist the voices they located outside their head. Voices are common in a number of psychiatric disorders: borderline personality disorder (approximately 32%); dissociative identity disorder (70 – 90%); post-traumatic stress disorder (50%); epilepsy, including post-ictal experiences (16 – 40%); alcohol withdrawal (65%); Parkinson’s disease (8%) and Alzheimer’s disease (12%).

McCarthy-Jones proposes phenomenological sub-typing of voices: Type 1 (Dynamic AVHs) are of two types: Subtype 1(a) (Hypervigilance AVHs), which are heard during exposure to unpatterned sound and are externally located; Subtype 1(b) (Ex nihilo AVHs): come from nothing in the external world and may be located in or outside the head. Type 2 (Static AVHs) are those either identified by the hearer as memory-like or as isolated fragments of voices that are unrelated to the voice-hearer’s actions and life. Type 1 ABHs may have their roots in inner speech and Type 2 AVHs, in memory. Spontaneous epileptic discharges in the superior temporal gyrus are unlikely to be a good model for all AVHs, possibly accounting for Type 2 but not Type 1 AVHs. A neuroanatomical model of AVHs can be built around impaired connectivity between frontal speech production areas and temporal/parietal regions involved in speech perception, and impaired interhemispheric connectivity between auditory association areas. Work is proceeding on synthesis of memories and inner speech models of AVHs.

Basing an account of AVHs in the fundamental structure of the auditory system is a laudable idea; however, it should supplement, not replace, a consideration of other causes based in life events or societal structures. Social factors such as isolation and loneliness also make a contribution in some AVHs. The voice-hearer’s social relationships and social rank have a major impact on how they experience and relate to their voices. There is a strong and likely causal association between traumatic events and AVHs, and this may be significantly mediated by guilt and shame.

There are two broad strategies voice-hearers use to deal with their experiences. ‘Sealing over’ involves dismissing the experience as being of little personal relevance, whereas ‘integration’ involves trying to establish its personal significance. Although medication has a role in recovery, pure biomedical approaches to treatment of AVHs risk increasing stigma and decreasing self-efficacy. Cognitive behavioural therapies have produced disappointing results. The pejorative connotation of the term ‘hallucination’ has service-user led organisations advocating the use of the more neutral terms ‘hearing voices’ and ‘voice-hearing’. Voice-hearers are now re-claiming their voices in a movement that has clear parallels to the women’s liberation movement and decolonisation struggles. Compassionate Mind Training and The Maastricht approach offer new approaches to coping with, making sense of, and recovering from voices.

References