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A psychotherapy approach to treating hostile voices

Dolores Mosquera[a] and Colin Ross[b]

[a]INTRA-TP, A Coruna, Spain; [b]The Colin A. Ross Institute for Psychological Trauma, Richardson, TX, USA

ABSTRACT

Hostile voices are a common problem in both dissociative identity disorder and psychosis. They may take the form of command hallucinations for suicide, or express negative thoughts and feelings about the self. The authors describe a psychotherapeutic treatment approach for hostile voices that converse with each other, keep up a running commentary on the person's behavior, or otherwise speak in intelligible sentences and paragraphs. This approach can be useful, in the authors' opinion, whether the diagnosis is a psychotic or a dissociative disorder. The authors provide clinical detail, with a case example, on the psychotherapy of hostile voices.

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The complex and multi-faceted relationship between dissociation and psychosis has been the subject of study in the dissociative disorders field for over thirty years (Bliss, 1980; Kluft, 1987; Laddis & Dell, 2012; Laferrière-Simard, Lecomte, & Ahoundova, 2014; Ross, 1997, 2004, 2007, 2014). Within the last six years, papers and books examining the role of dissociation in psychosis in general, and auditory hallucinations in particular, have begun to be published in the schizophrenia, psychosis and general psychiatric literatures (Alderson-Day et al., 2014; Bozkurt, Yanartas, Zincir, & Semiz, 2014; Braehler et al., 2013; Evans, Reid, Preston, Palmier-Claus, & Sellwood, 2015; Longden, Madill, & Waterman, 2012; Miller, 2015; Moskowitz & Heim, 2011; Moskowitz, Schafer, & Dorahy, in press; Moskowitz, 2013; Muenzenmaier et al., 2015; Ross, 2014; Ross & Keyes, 2009; Russo et al., 2014; Schafer et al., 2012; Tschoeke & Steinert, 2010; Tschoeke, Steinert, Flammer, & Uhlmann, 2014).

A key finding in this literature is the fact that Schneiderian first-rank symptoms of schizophrenia, including auditory hallucinations, are more common in dissociative identity disorder (DID) than they are in schizophrenia (Kluft, 1987; Ross, 1997, 2004). There are only a few qualitative differences between the voices in DID and those in schizophrenia (Dorahy et al., 2009; Honig et al., 1998; Ross, 1997, 2004): there are more often child voices and the onset of the voices is usually at an earlier age in DID than in schizophrenia, for instance.

There are three main psychiatric categories of patients that hear voices; schizophrenia (around 50%); affective psychosis (around 25%) and dissociative disorders (around 80%) (Honig et al., 1998). The decision to begin a trial of psychotherapy for psychosis using techniques from the DID literature, which we will describe below, need not hinge on the diagnosis, or a decision as to whether the Schneiderian symptoms are "psychotic" or "dissociative." We believe that, irrespective of diagnosis, patients presenting with hallucinatory voices that comment on one's thoughts or actions or that have a conversation with other hallucinated voices, can often be treated effectively with psychotherapy. On the other hand, voices that are merely mumbling, repeating single phrases, or are incomprehensible, are unlikely to engage in psychotherapy. Longden and coauthors have provided considerable guidance on the psychotherapy

CONTACT Colin Ross rossinst@rossinst.com

of auditory hallucinations, and we are indebted to them (Corstens, Longden, & May, 2012; Longden et al., 2012; Longden, Corstens, Escher, & Romme, 2012; McCarthy-Jones & Longden, 2015).

The effectiveness of psychosocial interventions for schizophrenia, including individual cognitive behavioral therapy, has been reviewed by Mueser, Deavers, Penn, and Cassisi (2013). Seikkula et al. (2006) provide an approach for working with voices in people who have received psychotic diagnoses, and Rosenbaum et al. (2012) have provided evidence for the effectiveness of supportive psychodynamic psychotherapy for individuals with psychosis.

Internal conflicts and traumatic experiences

In research concerning people who hear voices it was found that in 77% of people diagnosed with schizophrenia, the hearing of voices was related to traumatic experiences. These traumatic experiences included being sexually abused, being physically abused, being extremely belittled over long periods from a young age, being neglected during long periods as a youngster, being treated very aggressively in marriage, and not being able to accept one's sexual identity (Romme & Escher, 2006).

The authors believe that in many of the cases that do not respond well to standard interventions, including medication, unresolved internal conflicts and traumatic issues could explain the maintenance of symptoms. The internal system of the person has organized itself into dissociated parts that hold thoughts, feelings, memories, and impulses that were intolerable for the individual. Some of these dissociated aspects of self are often angry and often converse with each other and with the part of self in executive control.

Psychotherapeutic treatment strategies

Understanding the internal conflict and avoiding messages that imply "getting rid of the voices or parts"

Many dissociative clients have difficulties with voices that are hostile and critical. The internal conflict is sometimes so strong that the person will even have difficulties carrying on an ordinary conversation with other people, including therapists. One factor that affects this conflict is how the patient deals with the voices or parts of the self. Patients who develop an understanding of the different aspects of self, including dissociative parts and voices, usually do better than those who are avoidant or despise aspects of themselves. Patients need help to learn to understand what the voices or parts are really trying to achieve with certain comments or behaviors. The authors believe that any approach that implies getting rid of the voices or ignoring them, only creates more internal conflict. The greater the internal conflict, the greater the dissociative barriers need to be and the less integrative capacities the patients develop.

Conventional approaches in psychiatry to the problem of voice hearing have been to ignore the meaning of the experience for the voice hearer and concentrate on removing the symptoms (auditory hallucinations) by the use of medication (Romme & Escher, 1989). Although antipsychotic medication can be helpful for some sufferers of psychosis, there is a significant proportion (30%) who still hear voices despite very high doses of or oral or injected antipsychotic medication (Ross, 2015). Further, anti-psychotic medication often interferes with emotional processing and therefore with understanding the meaning of the voices (Romme & Escher, 2000).

Strategies that involve ignoring or getting rid of the voices involve avoiding issues or emotions the voices are expressing. A key aspect of the work with hostile parts of the personality and voices is to listen and understand their function and the meaning behind their disruptive behaviors. The less we listen and the more the voices are ignored, the more they tend to scream or escalate their behaviors in a desperate attempt to be heard. If both clinician and patient understand this, we have the basic ground on which to begin building a good alliance with the whole system of parts and voices. Specific steps to do this, will be explained in the following sections of this paper.

Performing the therapeutic work from the Adult Self: fostering self-care and integration

The proposal to work with dissociative patients through the *Adult Self* is based on the work described by Gonzalez and Mosquera (2012) in their Progressive Approach model. In their model, the Adult Self is the *observer and reflective self*, who by the end of treatment, relates with compassion and acceptance to the *experiencing self*. The Adult Self represents an emergent set of self-capacities, which are not yet developed in any part of the personality; it is the integrated, healthy, well-functioning self, the *future integrated Adult Self*. We proceed, as the authors point out, from the implicit understanding that the future self is already present, as a seed.

The work through the Adult Self enhances metacognitive processes and integrative capacities. It increases self-reflection and aids in developing healthy self-care patterns in clients. All these ingredients promote autonomy and empower the client. Through consistently working with the Adult Self, we model a new way for patients to look at themselves. We foster their capacities to understand all the parts' needs, and to develop empathy and true communication with dissociative parts, when these are present.

Empowering the client: why not talk directly to parts?

Although talking directly to parts is one way of doing the work, the authors found that in some of the most debilitated clients this might foster regressive states and dependency on the clinician. When clients lack integrative capacities, it is more likely that they will switch frequently. Clinicians can spend years of therapy working with child parts for example, without any integration taking place. If the Adult is not present and has no awareness of the work that is done in therapy, integration will likely take much longer. In the authors' clinical experience, the integrative capacity is enhanced by keeping the Adult present. Consequently, in this approach, we do not talk directly to the parts, but instead we show the Adult Self how to talk and communicate with these parts. The idea is to model and help the Adult Self learn how to understand what the parts might need, how they feel and how the client, from the Adult Self, can take care of them. By doing this, clients develop their capacities for self-care and self-soothing, and become capable of using these capacities outside the consultation. In clients with very dense amnesia and little or no co-consciousness, some direct interaction with parts may be necessary or may occur due to spontaneous switching during sessions. Even in these cases, however, our goal is to orient parts to the body and the present, and then to work with the Adult Self.

First steps towards the work with hostile parts and voices: establishing a good alliance

As mentioned above, the main goal is to reduce the conflict among the voices or parts. There are several steps we can keep in mind to organize the work with hostile voices in a way that is perceived as non-judgmental:

(1) Acknowledge the protective function the parts had, still have and will have.
(2) Remember they protect how they learned to protect; they cannot see a different way of functioning because nobody taught them.
(3) Underneath all the the defenses there is a lot of pain.
(4) The parts are afraid of disappearing.
(5) The parts believe that therapists will never want to work with them; nobody, including the rest of the parts ever showed any interest in them.
(6) The parts will think that therapists want to destroy them or get rid of them (in many cases previous therapists told clients to ignore them or tried to "get rid of them" with medication).

One of the key messages that will need to be repeated many times, is that voices are important parts of the Self and we don't want to get rid of them. Also,they can keep control and won't become weaker or lose strength if they cooperate; we believe they can learn new ways of managing their emotions which

will make them even more useful and powerful. Another relevant message is that we are interested in their needs and what they have to say; this implies that they can complain, be upset and ask for help.

Goals in the work with hostile voices and parts

Keeping in mind the main goal: to reduce conflict and increase empathy and understanding, can help clinicians achieve intermediate goals that will allow this. The following is a list of goals that may be useful in working with hostile voices:

- Avoid insults and negative comments and rename negative parts. Patients will frequently have negative names to refer to the voices or parts. This will only maintain the conflict. It is not likely that a voice that is named "bastard", "asshole", "devil", or "bad" will be interested in cooperating.
- Increase healthy curiosity and identify the adaptive function of each part. By renaming the negative names or messages that were implicit in the previous paragraph, we can begin building healthy curiosity about what the voices and parts have to say or what they might need. An interesting way of doing this is try to find out the adaptive function of each part.
- Promote dialog instead of arguments or fights. By achieving the previous two goals, we will be modeling a new way of relating to the self that excludes arguments or fights. This would lead to the next goal:
- Promote empathy, cooperation and negotiation (compassion and understanding are crucial).
- Identify and promote the available resources. As soon as we find out the adaptive function of each part we can begin identifying existing resources within the system.

By doing all of the above, integration is promoted from the first session as we can see in the following case example:

Case example 1: a voice tells me to hurt myself

This is an example of an intervention that can be done following the previous steps that lead to understanding, compassion, cooperation and stabilization. A hostile voice tells the client she is "bad" and encourages her to self-harm. The client is afraid of her reactions (she has banged her head until she bled and hit herself with a stick causing severe wounds). The client's therapist is on vacation. Another member of the same team sees the client. During this intervention the therapist will try to help the client understand what the voice might need. Our hypothesis is that the voice probably internalized and learned to repeat these negative messages in the client's childhood, and does not know how to think differently. This conversation below is a transcription of therapy session that illustrates this approach; the client has read the transcription and provided written consent to its being published. Any relevant personal information has been changed to keep confidentiality.

P: I cannot understand what she is trying to tell me.

T: Does this voice appear when you feel good?

P: No.

T: So she appears when you feel bad.

P: Yes.

T: Is it when you feel overwhelmed, anxious …?

P: When I am sad.

T: When you are sad … maybe there is a part of you that is afraid of feeling sad? And she doesn't know what to do when you are sad.

P: Yes.

T: How did people react when you felt sad as a child? I know you don't remember many things, just answer from your sensation. How did others react when you felt sad?

P: My mother didn't pay much attention to me.

T: Aha.

T: Maybe she couldn't be there maybe she (mother) didn't know how … Did she (mother) have any problems?

P: Her relationship with my father was not good.

T: And she had many difficulties.

P: Yes.

Psycho-education: helping the Adult Self to understand where the part learned to do that

T: If when you felt bad, there was somebody who didn't tolerate it, or who didn't know what to do with this, it's possible that a part of you, when you are sad, reacts in a similar way, because she didn't learn to do it in a different way. This voice may need to understand that she can help you in a more effective way; she can learn different ways to respond. Do you think that she knows how bad you feel when she says these things to you?

P: No, she probably doesn't.

Exploring how the voice experiences our message

T: Does this make sense to this voice too?

P: Yes.

T: While we are talking about all these things did you notice if the voice was getting calmer, or if she was getting nervous? What do you notice?

P: She probably copied my mother's behaviors, but I don't remember that.

The client connects with other memories

P: There was a situation (fearful situation from childhood), and I talked about it and immediately after I told those things, my mother … she always added something, she said: "You are so exaggerated, it was only 5 min."

She used to leave me alone for "5 min", and I didn't realize this before, but the other day I remembered it after something that my therapist told me, about babies and their reactions to their mothers … I think, 5 min are not the same for an adult and for a little child. I remember that I placed myself close to the window, just in case somebody came, to have a way to escape. I always did the same thing when my mother left me home, I was very afraid … The fear of somebody coming into the house, is something that must be fixated inside me in some way … and the fear of being alone, missing my mother, for a long time…

Being careful about parts who idealize caregivers

T: This is not about judging your mother, it's not about blaming her, you realize she has problems … this is just about understanding.

P: So I can understand things that have happened to me or happen now.

Searching for an adaptive function for the voice; more memories come in

T: This voice can help you in a more practical way but we need to help her so she can learn how. How could this voice help you?

P: Well … she doesn't know … It would help if she doesn't tell me that I am "bad", and she doesn't blame me. When I was a child I was called "bad" without doing anything bad. I wasn't doing bad things. For example, if I cried they would tell me "you are bad" just because I was crying, or when I was afraid of going to some places, things like that.

Introducing psycho-education and an adult perspective

T: It's important that you, as the adult you are now, can realize that a little girl is not bad because she is crying. A little girl may cry because she is sad, afraid, hungry, she can cry for many reasons, because she is feeling frustration … a little girl does not cry for no reason or because she is bad. The fact that you can understand this will probably help this voice to understand it as well, and to try to change the things she says.

Client nods (paying attention)

T: How could this voice help you? What type of messages would be helpful?

P: Well … that … That she understands me, that she understands what is happening to me, but in order to do that it would be necessary to investigate the past, to know what happened to me before.

T: This will be approached when the time is right. I imagine your therapists and you have talked about this.

P nods

T: We will work on the things from the past when the time is right and in order to know what happened, all of you (parts) need to agree.

P: In attunement, yes.

T: It's important that you all work as a team, and they may have different emotions, insecurity, fear … Maybe this voice is not ready for this work now because if you notice this (part getting triggered) … is related to the new memories that you have been getting, right?

P: Yes and no.

Understanding the relevance of respecting the rhythm of the whole system

T: Does the voice have memories?

P: Well, actually, yes, she appeared when I remembered those childhood situations saying "you are bad" … so it makes sense…

T: So, it's possible that this voice has some of the memories that you don't have and maybe she thinks that it is not a good moment to work with those memories, maybe because your therapist is not here, maybe because many things happened recently and you are more nervous; it could be for many reasons, maybe she is afraid or maybe she is trying to help you avoid getting in contact with those memories and in order to do this, she says what she has learned to say.

Exploring the system's reaction to the intervention

T: How are you inside (internal system) now, after our conversation?

P: Better.

T: Is this enough for you?

P: Yes.

T: It is?

P: I am much calmer because I know that we will discover relevant things.

The therapist repeats the relevance of respecting the timing

T: When the time is right, ok?

P: Yes.

T: Remember that when there is an internal conflict, if one part is afraid of how you can feel, if you get more memories … we need to work with this part so she can feel secure enough and know that there is control and there is containment … It's important for her to know that we won't go into any place without a complete agreement from all of you and not until all of them want to and are able to.

P nods

T: We will work with all those things, but when the moment is right for all of you.

P: Ok.

T: Do you have any questions? Or is there anything else that you need now?

P: No, no … I liked this final part.

T: Ok, great.

In this vignette, we illustrated several principles of working psychotherapeutically with voices. The therapist works with the client through the Adult Self to regard the voice as a dissociated aspect of self with feelings, needs, thoughts and a viewpoint. The client is encouraged to take the voice's needs into consideration, to think about the voice as an aspect of her survival strategy, and to balance her perspective with that of the voice, in order to reduce conflict and begin forming an inner team that can cope with life in a less conflicted and more functional manner. There are several aspects to the work with hostile parts and voices that can guide our work during the different stages of therapy as we describe in the following section.

Working with hostile parts and voices: basic aspects to keep in mind

The work with the dissociative system might be more cognitive than emotional in the beginning, since dissociative clients will not be ready to feel emotions in early phases of treatment. Some of the basic things clinicians need to keep in mind for this type of work are the following:

- Our messages should keep in mind the whole system
- It is important to respect the feelings and thoughts of all parts
- We do not take sides
    - This would only increase the conflict
- Use the client's language (parts, aspects, things in me, voices …)
- Each part has a role and a function
- Even the more hostile parts or voices are trying to help in some way
- We rename the parts when these names are negative, disrespectful or threatening
- It is important to understand why parts need to be separate
    - If we don't understand we are less able to promote integration
- Remind clients that parts are not different people
    - They represent different aspects of a person
- When we explore the internal system of parts
    - We should be sure we include all parts and voices, even the ones who cannot show themselves
- We make sure we don't ignore any parts, especially the hostile ones

    - Clients tend to avoid them. We should not do the same
- We accept how the client experiences what happens without necessarily agreeing with it

Clinicians will need to remember and remind patients, that hostile voices and parts are usually trying to protect and help but they usually repeat the behavior they learned from the childhood perpetrators. They may be holding anger and traumatic memories for the host personality; trying to generate suspicion in the host personality in order to maintain vigilance and identify potential perpetrators in the present; or trying to adopt the perpetrator position in order to not be in the victim position (Blizard, 1997; Ross, 1997; Ross & Halpern, 2009). Hostile or aggressive parts need to know that the present is safe and there is no need to defend themselves now. New ways to protect the self are usually well received by all parts, including the most hostile and suspicious ones.

Conclusions

A psychotherapy approach for psychosis that includes procedures from the DID literature and the Adult Self Model can be used to treat hostile voices, in a subset of cases meeting criteria for psychosis. The principles of this treatment approach have been illustrated through a case example, discussion, and lists of techniques and approaches.

Reducing the conflict between parts/voices can lead to more understanding, compassion, acceptance and cooperation among them. The approach we have described leads to a safer way of relating to the self and eventually to integration. We know that the therapy is on the right tack when empathy among parts is developing, phobic avoidance is decreasing and there is increased awareness of traumatic events without flooding or regression, combined with an empathic understanding of how different parts and voices aided in survival.

Disclosure statement

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