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Research Article

Facilitating Relationship Change Between Voice Hearers and their Voices through a Psychotherapeutic Intervention

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Abstract

Background: Hearing voices, formally known as auditory hallucinations, is a central symptom of psychotic disorders, but also seems to be encountered in persons without need of psychiatric care. In the last decades research has focused on the characteristics of the voice hearing experience, with emphasis on the relationship between voice hearers and their voices. The increased understanding of the function of the hearing voices experiences for the hearers has given rise to psychotherapeutic interventions for verbal hallucinations that aim to help the voice hearers better understand and cope with their voices, with promising results. This paper presents the change in the relationship between voice hearers and their voices that was achieved through a psychotherapeutic intervention based on the Romme and Escher model of voice hearing, coupled with cognitive-behavioural techniques.

Method: The intervention was conducted with 5 voice hearers, 3 men and 2 women, with diagnoses of psychotic disorders. It started when participants were hospitalized in an acute psychiatric unit and lasted over a year, totaling 25 - 30 sessions per intervention. It aimed to support voice hearers in making sense of their voices, through linking them with circumstances and events in their lives, and managing the voices, through developing more effective strategies for coping with them. Using grounded theory principles, the data was analysed through several analytical steps thematically, chronologically and comparatively, resulting in a model of therapeutic change.

Results: The final outcome of the study was a model of change in experiencing, understanding and managing voices, that depends on the phase of the hearing voices experience that the voice hearer was in the beginning of the intervention, in conjunction with the therapeutic strategies employed in the course of the intervention. In every case, the intervention seemed to help participants re-negotiate the relationship with their voices, cope better with them and, crucially, to move along to the next phase of the voice hearing experience.

Conclusion: The study verified the appropriateness of the Romme & Escher model for conceptualizing the voice hearing experience and guiding the direction of interventions aiming to bring about change in the relationship of voice hearers with their voices. It generally highlights the importance of relational understandings of verbal hallucinations and of tailoring interventions to the particular characteristics and stage of the voice hearing experience of each client.

Keywords: *Psychotherapeutic Intervention; Hearing Voices; Psychosis; Grounded Theory; Romme and Escher Model*

Introduction

Hearing voices, which in psychiatric literature is referred to as 'auditory hallucinations', is considered a central symptom of severe mental disorders included under the umbrella of psychosis [1]. However, there is increasing acknowledgment that voice hearing is experienced by non-clinical populations, especially under conditions of stress and fatigue [25].

In the last decades research has focused on the characteristics of the voice hearing experience, with emphasis on the relationship between voice hearers and their voices [11]. Benjamin [2] and Birtchnell [4,5] were of the first to argue that voice hearers develop patterns of interaction with their voices that resemble their interactions with familiar persons in their life. These interactions can be understood along the relational dimensions of power or submission and closeness or distance, similarly to interpersonal relationships [4,5,16]. Amongst the early proponents of the relational approach to voice hearing, Romme and Escher [38] also found that voice hearers have a special relationship with their voices, with the voices repeating patterns of interaction that the voice hearers had with significant people and in this way replay past significant events in the voice hearers' life. Additionally, Mawson., *et al*. [30] found that voice hearers personalize their voices by giving them a particular identity and, although the voices imitate the voice hearers' relationship with other individuals, they also exert distinct power and control over the voice hearers and influence their self image.

The balance of relationship between voices hearers and their voices seems to be mainly determined by the characteristics of the voices, which vary, from the voices offering companionship to the voice hearers to criticizing them and ruling over their lives [27]. Another very important factor that affects the relationship between voice hearers and their voices is the voice hearer's explanation regarding the nature and origin of the voices, which is in turn determined by the cognitive schemata that the voice hearer holds about their self and others [6,7], the cultural characteristics and religious beliefs of the voice hearer, and the attribution of the voices to past significant events, such as traumas [11,28]. The function of the voices in the voice hearer's life also plays an important role. For example, in some cases the voices have an adaptive function, as they compensate for the absence of social relationships [9,38] and the voice hearers have a positive relationship with them, while in other cases the voices are very intrusive and trigger distress to the voice hearers [18,39].

Romme and Escher [37] observed that the balance of the relationship between the voice hearer and the voices changes in time and distinguished three phases of the hearing voices experience: the startling phase, the organization phase and the stabilization phase. During the startling phase, the voice hearer is overwhelmed by the new, unknown experience and does not know how to cope with the voices. When in the organization phase, the voice hearer accepts the voices and plans ways to deal with them. In the stabilization phase, the voice hearer has accepted the voices and has moved on to dealing with other issues in their life. Romme and Escher's work sparked interest in investigating the development of the relationship between voice hearers and their voices in time, and a few studies have followed. Jackson, Hayward and Cooke [24] found that hearing voices becomes a positive experience when the fear of the voices subsides, voice hearers understand and accept the voices as part of themselves and develop a sense of personal control over them. Milligan., *et al*. [33] outlined six phases of the hearing voices experience, which have similarities with the phases described by Romme and Escher [37], although they challenged the methodological rigour of the process through which the Romme and Escher phases were established. Kalhovde, Elstad and Talseth [26] also found distinct phases of coping with the voices, that are similar to those described by Milligan., *et al* [33]. Hayward., *et al*. [21] traced the changes in the types of coexistence between voice hearers and their voices -acceptance, hostility and avoidance- that voice hearers adopt through time. They found that the main factors responsible for the change of coexistence with voices were establishing dialogue with the voices and talking about them with others. Hayward., *et al*. [21] also challenged the three phases of the hearing voices experience reported by Romme and Escher [38], although they found some similarities, especially with the stabilization phase. De Jager., *et al*. [14] attempted to enrich the Romme and Escher model [38] and came to similar conclusions regarding the description of the three phases. The most recent study, by Bogen-Johnston., *et al*. [8], outlined the phases of the relationship between voice hearers and their voices, reaching similar conclusions with Romme and Escher [38] and subsequent researchers [14,33]. This study stresses the role of the voice hearer's change of beliefs about the voices as a key factor affecting the relationship with the voices. More specifically, changing

beliefs about the voices was found to be associated with acceptance of voices, understanding them and finally recovery, while maintaining unchanging beliefs about the voices was associated with continuing distress. In conclusion, this study highlighted the importance of therapeutic dialogues as a helpful coping strategy and stressed the need to continue working on a model of the development of the relationship between voice hearers and their voices over time.

In the last decades, a combination of pharmacological and psychological treatments is increasingly utilized for treating and managing psychotic experiences, and it has been found to be more effective than single approach strategies [35,41,44]. Many clinicians propose psychotherapeutic interventions for psychotic disorders that target single symptoms, such as delusions and hallucinations [3]. The psychotherapeutic interventions for verbal hallucinations aim to help the voices hearers cope with their voices.

The most widespread intervention approach for hearing voices is cognitive behavioral therapy (CBT) [34]. The first CBT models focused mainly on changing the dysfunctional cognitive schemata that are associated with the voices and reducing the emotional distress provoked by the voices through the use of coping strategies. Although CBT has been found to be effective in understanding the cognitive mechanisms that trigger the voices and the hearer's appraisals of the power of the voices, it seems to provide less benefit in terms of distress reduction [32]. In order to improve CBT interventions for voice hearers, new models have developed, known as third generation CBT, including Acceptance and Commitment Therapy (ACT) [15], Compassion Mind Training (CMT) [31] and Competitive Memory Training (COMET) [43]. These models focus less on changing cognitive beliefs about voices and more on accepting the hearing voices experience. Moreover, they aim to change the relationship between the voice hearer and the voices through mindfulness training, involving awareness and observation of the voices through keeping an emotional distance from them. CMT pays attention to parallels between negative voice content and negative views about self and others, that is considered to be due to traumatic life events, and encourages the voice hearer to develop self-compassion and compassion toward others. COMET attempts to strengthen positive memories that are not connected with the negative critical voices through the use of imagination [40].

Other researchers [20,36] based on the findings of Benjamin [2], Birchwood., *et al*. [6] and Sorrell., *et al*. [39] about the social patterns of interactions between voice hearers and their voices mimicking human social relationships, argued that the distress triggered by the voices is linked to the interpersonal and social cognitive schemata held by the voice hearers. These findings mobilized further interest in psychotherapeutic interventions that target the relationship between the voice hearer and their voices [13,22]. More specifically, Corstens, Longden and May [10], starting from the understanding that the voices are parts of the voice hearer's self that were functional for the individual in the past, suggested engaging in direct dialogue with the voices, aiming to change the balance of the relationship between the voice hearer and the voices, and to reach a reconciliation between them. In this approach, through the change of relationship with the voices the voice hearer will be able to acknowledge and connect with parts of themselves, of which they have no insight at present. Similarly to the voice dialogue procedure, a computer program has recently been developed that facilitates voice dialogue through the creation of an avatar to which the individual attributes the characteristics of the voices they hear [29]. Avatar therapy proved to be more helpful than supportive counselling [12]. Hayward., *et al*. [20] introduced relating therapy for voice hearers with critical voices, that aims to change the balance of the relationship of the voice hearer to their voices in terms of power and proximity. This model includes an introduction to Birtchnell's [4] social theory, exploration of the patterns of the voice hearer's social interactions and finally role playing focused on developing more functional interaction with the voices. This procedure proved to be helpful for voice hearers with distressing voices.

Long before there developments, and along similar lines to the interventions mentioned above, Romme and Escher [38] suggested a therapeutic intervention that focuses on changing the balance of the relationship between the voice hearer and their voices through the use of a semi-structured interview, the 'Interview with a Person who Hears Voices', most commonly known as the 'Maastricht Interview'. The Interview includes questions that elicit and record information regarding the nature, characteristics, history and triggers of the hearing voices experience, the hearer's explanation for the experience, its impact on the hearer's life, the hearer's relationship with their

voices and the coping strategies they use. After collaboratively establishing the information regarding the characteristics of the voices and the relationship the voice hearer has with them, the procedure culminates with a case formulation that decodes the meaning of the voices for the voice hearer, their connection with significant persons in the voice hearer's life and the function that the voices serve in the person's life. The aim of the intervention is to facilitate the voice hearer's transition to the next phase of hearing voices and acceptance of the voices as parts of the voice hearer's self.

The intervention that will be presented in this paper was based on the systematic employment of Romme and Escher's [38] Maastricht Interview, coupled with CBT techniques. Through understanding the characteristics of the hearing voices experience and finding links between the experience and the hearer's life, the intervention aimed to facilitate a change in the balance of the relationship between the voice hearer and their voices and to integrate the hearing voices experience in the person's self and life.

Aim of the Study

The study reported here aimed to record and evaluate the implementation of a psychotherapeutic intervention with five individuals who heard voices and were in an acute psychotic phase. The intervention took place at a Psychiatric Clinic of a University Hospital, where the participants were treated, and lasted for one year, with weekly sessions during the first months and a follow up session two months after the end of the intervention for each participant. The goals of the intervention were, firstly, to assist participants in making sense of their hearing voices experience through linking it to circumstances and events of their lives, and secondly, to support participants in developing more effective strategies for coping with their voices. For the first goal, Romme and Escher's semi-structured interview was used in order to gather information about the voices, aiming to reach a report formulation. For the second goal, cognitive behavioral coping strategies were introduced and pursued in collaboration with participants. The study consisted of systematically recording the process of therapeutic change regarding the characteristics of the voices, the voice hearer's understanding of the voices and the coping strategies used by the participants. The overall aim was to evaluate the usefulness and appropriateness of the model proposed by Romme and Escher for voice hearers in an acute psychotic phase.

Method

Participants

The demographic and clinical characteristics of the participants are presented in table 1. The interventions are ordered and numbered according to participants' age, which also roughly corresponds to the number of years of hearing voices and the phase of the voice hearing experience the participants were at in the beginning of the intervention. The five participants, as mentioned previously, were in an acute psychotic phase at the start of the intervention. Three of them were hospitalized in the Psychiatric Clinic, and the other two were awaiting hospitalization. All participants were hospitalized and treated voluntarily at the start of the intervention. Two of them had more than one psychiatric hospitalizations in the past. All participants were treated with neuroleptic medication throughout the duration of the study.

Data collection

The intervention took place at the Psychiatric Clinic of a University Hospital in Athens, Greece, where the participants were customarily treated. Permission for the study was granted by the Scientific Council of the University Hospital. Candidate participants for the study were suggested by the Clinic Director, were informed about the therapeutic intervention and the study, and those who agreed to participate signed a consent form. The intervention was implemented by the first author, who is a clinical psychologist, under the clinical supervision of an experienced clinical psychologist, specialized in psychotherapy with psychotic patients, and the research supervision of the second author and supervisor of the research study. The sessions were recorded, following informed consent by the participants. Emphasis was placed on upholding ethical principles regarding both clinical and research practice at all the phases of the intervention and the study overall.

Participants/ Interventions	Gender	Age	Diagnosis	Years of hearing voices	Phase of hearing voices	Number of sessions
1	M	21	Schizophrenia	2	Startling	29
2	F	26	Schizophrenia	1	Startling	26
3	M	35	Schizoaffective disorder	19	Organization	27
4	M	42	Schizoaffective disorder	34	Organization	24
5	F	48	Schizophrenia	29	Stabilization	24

Table 1: *Participants' demographic and clinical characteristics.*

Data analysis

The session material was transcribed and all personal information of participants was removed to ensure anonymity. The data were analyzed, following grounded theory principles [23,42] in four stages. Initially, the data from each intervention were analyzed separately. The initial line-by-line coding was followed by several stages of selective coding, during which the initial codes were gradually organized to first, second and third level categories, ending with the formulation of the central themes, that were repeated between sessions. In the second stage, the third level categories of each intervention were organized chronologically. One table for each intervention was created, which presented on separate columns information on the therapeutic goals, the therapeutic processes, outcomes and the therapist's clinical observations, for each phase of the intervention. Subsequently, the data that emerged from the longitudinal analysis of each intervention were organized in tables, vertically per phase of the intervention and horizontally per axis of the intervention. This enabled a schematic depiction of the changes recorded on every axis in each phase of the intervention. Finally, the five interventions were compared regarding, firstly, the characteristics of the hearing voices experience and, secondly, the therapeutic process of the intervention.

The reliability of the analysis and its groundedness on the session data was ensured through triangulation, by blind analysis of randomly selected parts of the data conducted by another researcher, also trained in qualitative data analysis. The second author and supervisor of the research also monitored the analytical process at each stage.

Results

From the five thematic categories that emerged from the data analysis, we will present more extensively those that concern the relationship between the voice hearer and the voices and its change in the course of the intervention, which is the focus of this paper. The rest of the categories will be presented only in brief.

Onset and characteristics of the voices

For all the participants, the experience of hearing voices began around the time of a change in their lives, often a sudden or traumatic event. The voices caused distress upon their emergence only to two of the five participants. The three male participants link the emergence of voices with anxiety about their performance and the need to please their family, while the two female participants link their voices with guilt about their sexuality. Already from the time of their onset, the voices seemed to function for some participants as a reminder of the life changes or traumatic events they had experienced and for the rest as a coping mechanism to deal with the impact of the traumatic events. For all the participants, the characteristics of the voices were closely connected with the life problems that were at the origin of the voices.

All the participants described a range of dominant and secondary voices, with varying identities. In the intervention, emphasis was placed on the identity and characteristics of the dominant voices as well as to the participants' relationship with them. In the course of

the intervention, discernible changes were recorded in the characteristics of the dominant voices of all but one of the participants. Most changes concerned the intensity and frequency of the voices. The identity of the voices seemed to be the most resistant to change. As will be see below, most participants started perceiving the dominant voice as part of themselves towards the end of the intervention.

Making sense of hearing voices

In the course of the intervention, participants 1 and 3 connected the voices with anxiety about their performance in their studies and work, starting considering them as expressions of problems in the relationship with their family and came to understand the voices as part of themselves.

Participants 4 and 5 initially understood their voices as supernatural divine beings. For both of them the voices had a protective and guiding role, and they continued to have this role throughout the intervention. Participant 4 came to understand the voices as his own thoughts, which he related to insecurity about the future and to his father's high expectations of him. Participant 5 understood the voices as an extension of her father's wishes for her to be modest and humble.

Participant 2 also initially understood her voices as supernatural divine beings. However, in contract to the other participants, she saw the voices as punishing, as enforcing a process of purification from sin, connected with the shame she felt regarding a previous relationship with an abusive partner. This understanding of the voices, as well as the characteristics of the voices and the function they played in her life, remained unchanged in the course of the intervention.

The characteristics of the voices, the function they had in the voice hearers' life and the life events with which they were connected influenced in turn the relationship of the participants with their voices.

Relationship between the voice hearer and the voices

The participants of interventions 1 and 2, who were at the startling phase of hearing voices in the beginning of the intervention, described a negative relationship with their voices, which was retained throughout the intervention.

More specifically, participant 1 reported that the voices triggered distress, criticized him and negatively commented on his actions. The content of the voices negatively influenced the participant's perception of and relationship with other people, whom he thought that he was annoying, leading to social withdrawal from adolescence onwards. As the intervention progressed, the participant started to gain personal control over the voices, the distress caused by the voices was reduced and his feelings about the voices changed, but not the content of the voices and his relationship with them. In the final phase of the intervention, he accepted the voices and they did not cause him negative emotions anymore. In the follow up, he reported that one side of himself became stronger and he developed inner voices, that he identified as supportive. Although the external dominant voices became threatening, he still accepted them. Social isolation was maintained in all phases of the intervention and intensified at the end of the intervention.

The participant of intervention 2 also described a negative relationship with her dominant voices and with some secondary voices, that reinforced the negative cognitive schemata she held about herself and the world and caused her negative feelings and fear. She also described a positive relationship with some secondary positive voices, that helped her maintain positive beliefs about herself. The relationship she developed mainly with the dominant and secondary negative voices determined the way she related to other people, whom she experienced as threatening and hostile towards her. Through the intervention, it became clear that the onset of the hearing voices experience was related with past traumatic events. The relationship with the voices remained negative throughout the intervention but towards the end the participant gained more control over the voices through the implementation of coping strategies which challenged the omnipotence of the voices and their ability to harm her, and she proceeded to accepting the experience. She also understood the voices as an emotional response to past traumatic events.

The participant of intervention 3, who was at the organization phase of the hearing voices experience in the beginning of the intervention, achieved the biggest changes in the balance of the relationship with his voices. In the beginning, he described a negative relationship with his voices, especially with the dominant voice, that disoriented and threatened him, made fun of him and reinforced negative cognitive schemas about himself. The dominant voice also determined the way he perceived other people as threatening. Although the participant had a negative relationship with the dominant voice, he did not feel fear and had already developed a dialogue with the voice. During the intervention, through the implementation of coping strategies, with voice dialogue being the most effective, the balance of the relationship with the voices changed positively. Towards the end of the intervention, the participant perceived the voices as a part of himself; the dominant voice acquired characteristics similar to his own and was perceived as the voice of himself. At the same time, the participant's relationship with his family and other people changed. He negotiated his personal boundaries regarding other people, joined a self-help group and started making new friends.

To sum up, for participants 1 and 2, the change of the relationship with the voices was achieved through, firstly, increase of personal control over the voices and distress reduction through the implementation of coping strategies, and secondly, making sense of the hearing voices experience through the case formulation. For participant 3 change in the relationship with the dominant voice was achieved through the use of voice dialogue. Also, the case formulation enabled him to understand the experience of hearing voices as connected with problems in the relationship with his family. Participant 3 achieved, through the intervention, major changes in the relationship with his voices, that reverberated in his relationship with his family and with other people. We assume that this was made possible because participant 3 was at the organization phase of hearing voices and had already developed a dialogue with his dominant voice.

The participant of intervention 4 described a positive relationship with the dominant voices. The voices were a personal guide and their main function was to strengthen his belief that he is special and superior. The dominant voices forecasted events that were going to happen and directed the participant's actions. At the same time, the participant had a negative relationship with the secondary voices, that reinforced the belief that he was crazy. The relationship with the secondary voices resembled and influenced the relationship he developed with other people. The participant's relationship with the dominant voices worsened in the middle of the intervention, because the medical staff in the treatment facility challenged his belief of being special. The voices pushed the participant to hurt himself, reminded him of negative events and strengthened his insecurity about the future. At the end of the intervention, the dominant voices softened and the participant connected them with his personal insecurity for the future and with the high expectations of his father about him. The secondary voices remained unchanged. At the end of the intervention, the participant developed some social contacts.

The participant of intervention 5 also described a positive relationship with the dominant voices she heard. The voices were perceived as an extension of herself. They determined her self-image, reinforced the belief that she was superior to other people and set protective limits between herself and other people. The participant's relationship with the voices remained consistently positive and the relationship with other people remained distant throughout the intervention.

In conclusion, participants 4 and 5 had positive relationship with their voices. They both perceived the voices as a personal guide and the voices reinforced the sense of superiority they held about themselves. Both participants maintained a negative relationship with other people, that was influenced by their relationship with the voices, in distinct ways for each of the two participants. For participant 4, the dominant voices reinforced a sense of superiority but the negative secondary voices reinforced negative cognitive schemas about the self. The connection of the voices with dysfunctional cognitive schemas about the self and others through the intervention resulted in the participant developing some social relationships at the end of the intervention. For participant 5 the voices had only a positive function, to keep her safe and distant from others, and were part of her identity. This, we think, is the reason why the relationship with the voices remained unchanged and the participant did not develop social relationships.

Intervention strategies for changing the relationship with the voices

In the beginning of the intervention, participant 1 had no coping strategies towards the voices and considered suicide as the only solution. Participant 2 had developed some religious rituals, that were partially successful. Participant 3 was using cannabis and had dialogues with his dominant voices. The coping strategies that were implemented in collaboration with the therapist for participants 1, 2 and 3 aimed to help voice hearers gain control over the voices and re-interpret the experience of hearing voices as related to life events and parts of the self. Thus, already from the start of the intervention participants were encouraged to try out distress reduction coping strategies and to keep voice diaries, recording the voice characteristics, in order to understand them better. Participant 2 also implemented reality testing strategies in order to challenge the belief that the voices can harm her. Participant 3 was encouraged to continue the dialogue with the voices. For all three participants, the increase of personal control over the voices through the implementation of coping strategies contributed to a change of the voice characteristics in terms of their frequency and intensity and to the reduction of negative emotions caused by the voices. However, for participants 1 and 2, the relationship with the voices remained negative throughout the intervention, while for participant 3 there was a positive change. In terms of making sense of the hearing voices experience, participants 1 and 3 connected the voices with their thoughts and with important life events. Participant 2 maintained the same interpretation of the voices as supernatural beings aiming to punish her because of her sins, but she also enriched her interpretation of the voices as an emotional response to past traumatic events.

The participants of the interventions 4 and 5 had a positive relationship with their voices from the start and therefore did not wish or need to implement strategies to deal with them. The intervention focused on understanding the hearing voices experience and encouraging social engagement. Both participants by the end of the intervention connected the voices with important people and life events, but only participant 4 re-engaged with social life.

Discussion

For all the participants, the voices began after a trauma or a transition to a new life situation, see also Romme and Escher, [38]. Participants 1 and 3 from the beginning of the intervention connected the voices with parts of themselves, but participants 2, 4 and 5 considered their voices as supernatural divine beings [28]. The supernatural identity of the voices was influenced by participants' religious beliefs and the interpretation they give to their voices as punishing them for their sins or guiding them. This interpretation of the voices did not change during the intervention.

All participants distinguished the voices into dominant and secondary. The dominant voices were those with which they formed a relationship and which influenced the cognitive schemata they had about themselves by reinforcing existing negative and positive core beliefs. The dominant voices also influenced the participants' emotions and behavior. The voices affected the way the participants perceived other people and also their beliefs about how they were perceived by other people, see also Birchwood., *et al*. [6,7]; Mawson., *et al*. [30]. The relationship with the voices for participants 1, 2 and 3 was negative in the beginning of the intervention with the voices provoking anxiety and fear (See also Hayward., *et al*. [19] and Sorrell., *et al*. [39]). On the contrary, the relationship with the dominant voices for participants 4 and 5 was positive and the voices provided guidance for important decisions, protection from other people, or they functioned as a substitute for social contacts, see also Chin., *et al*. 2009 [9] Karlsson [27] and Romme and Escher [38].

During the intervention, changes were recorded in some characteristics of the voices, such as their frequency and intensity, and the secondary voices weakened. The identity of the dominant voices remained unchanged throughout the intervention, for most participants. Most participants, however, connected the dominant voices with important people in their lives and parts of themselves, see also Birchwood [6]; Hayward., *et al*. [17].

For four of the participants, the intervention was effective in bringing about changes in their relationship with the voices. Only for participant 5 the characteristics of the voices and her relationship with them remained unchanged. For participants 1 and 2, who described a negative relationship with their voices in the beginning of the intervention, the relationship with the voices remained negative throughout, but their feelings toward the voices changed and they finally accepted the voices. Furthermore, participant 1 also developed inner voices, which he connected with himself, as an empowered side of himself, see also Romme and Escher [38]. For participants 4 and 5, who had a positive relationship with their voices, the intervention focused on understanding the experience and connecting the voices with parts of themselves, with a successful outcome. However, increasing personal control over the voices, accepting the hearing voices experience and re-interpreting it led to the development of social relationships only for participants 2, 3 and 4. They did not appear to have influenced participants 1 and 5, who continued to have negative beliefs about other people, in contrast to the model proposed by Birchwood., *et al*. [6].

As an overall evaluation, it seems that the intervention helped participants who were at the startling and the organization phase move along to the next phase of the hearing voices experience, as outlined by Romme & Escher [38], through accepting the experience and integrating it in their life. With participants at the stabilization phase, the aim was to assist them with developing a more workable understanding of the hearing voice experience that does not hinder their life; this was achieved only for one of the two participants. It appears that most participants experienced changes in their relationship with the voices through the intervention. It is important to note that the changes concerned mainly accepting the hearing voices experience, having a more positive emotional reaction to the voices and developing a better understanding of their function in their lives.

Limitations of the Study

This study was applied to a small sample and its findings cannot only be generalized with caution. Also, the follow up was two months after the intervention, which limits the time scope and does not allow for evaluation of long-term maintenance of progress.

Contribution/Conclusion

The present study highlights the complex links of the relationship between voice hearers and their voices with the characteristics and function of the voices, the hearer's self-schemata and the relations with their significant others. Through a series of case studies, it records the processes through which changes in the relationship of voice hearers with their voices can be affected through targeted psychological interventions. Moreover, it provides directions and can be the basis of recommendations regarding the types of interventions that can be employed by therapists in order to facilitate changes in the voice hearers' relationship with their voices, with an emphasis on matching the interventions to the phase of the hearing voices experience and the type of relationship the voice hearer has already established with the voices. Overall, the study highlights the importance of adopting a relational approach in order to understand voice hearing and to assist voice hearers to better integrate the experience in their lives.

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