

*Simon McCarthy-Jones talks to Denise Winn about what is known – and what has been ignored – in explaining the experience of hearing voices*

# Hearing voices – who is truly listening?

## CONVERSATIONS

**WINN:** You set the scene perfectly in your exquisitely written book, *Can't you hear them? The science and significance of hearing voices*: "Voices are waiting to speak to you. They know your name. They could call it from the surrounds of sleep, on a bustling street or from your car backseat. Samuel Johnson, Sigmund Freud, probably you, and definitely me, have all had at least this fleeting voice-hearing experience. ... Many are called but few are chosen for more. Voices only speak more than a few words to a select percentage of humanity. Such hearers are diverse and their voices capricious. Voices deliver the mountaineer Joe Simpson down the Peruvian Andes and save his life. They depress the writer Virginia Woolf to a riverbed and end hers. They inspire the mathematician Françoise Chatelin but discourage the musician Brian Wilson. What causes people to hear voices?"

After that grabbing opening, it is no surprise that your sweep is wide, and your book is a highly informative and entertaining account of attitudes, beliefs, theories and research findings about why voice-hearing happens and the many forms they may take, ranging down the centuries to the present day. There is a clue, in what I have just quoted, as to where your own interest in this area comes from. Could you say a little more about that?

**MCCARTHY-JONES:** My own fleeting voice-hearing experiences, which have been limited to hearing my name called when no one was there and experiences on the edge of sleep, weren't really what drove my interest in this area. However, it did give me something of a sense of the absolute reality of the experience. When you hallucinate hearing your name called, you really *hear* it. It is a bona fide perception. My interest in this area actually stems from a much more mundane source: the Leeds branch of Waterstones. It was here that I found a great book on free will by Tor Nørretranders called *The User Illusion*. This put forward evidence that our conscious self is in some senses merely a passenger on a ship that it is not actually piloting. This then led me to a related book by the late Daniel Wegner called *The Illusion of Conscious Will*, which briefly mentioned voice-hearing. I then decided to build on these ideas in my postgraduate study. My research was initially confined to the proverbial ivory tower until the doors were irreparably blown off it by meetings with two people who themselves heard voices,

Peter and Kate. They let the light in. Parts of their stories are told in my book, and I am very grateful to them for teaching me so much and allowing me to share parts of their lives. If you read them, you will see why I was so affected and why this topic became much more than an academic interest to me.

**WINN:** I have indeed read them. You explore many individuals' harrowing experiences and you praise the Hearing Voices Movement, amongst others, for bringing attention to the relationship between voice hearing and child trauma. What is its ethos?

**MCCARTHY-JONES:** The Hearing Voices Movement has given people who hear voices a safe space to speak about their voices, and has allowed them to tell their life stories. It has also allowed them to examine if the two are related. This was not being done in a routine way by existing mental health services. There is obviously great diversity of opinion in the movement, but, in a paper I co-wrote (published in *Schizophrenia Bulletin*, and free to read),<sup>1</sup> we pulled out six core values that people tend to subscribe to. The first is the normalising idea that voice hearing is a common human experience. Second, voices are not random or meaningless utterances but may be understandable responses to things that have happened in one's life. However, one does not have to hold this view and, indeed, a third key value is that diverse explanations for voices are accepted, including biomedical explanations, if they help. The fourth is that voice hearers are encouraged to take ownership of their experiences and define them for themselves. Hearing voices groups often provide a safe space for this exploration. This links into the fifth: peer support and collaboration as a fruitful means of helping people to make sense of, and cope with, their voices. The final core value is that accepting and valuing voices is generally more helpful than attempting to suppress or eliminate them. However, again, people are free to choose the way that works best for them; empowerment comes before ideology.

**WINN:** That's refreshing to hear. Does a broad view also inform your own approach to research?

**MCCARTHY-JONES:** Actually, to have a broad view of anything is problematic within academia. Its funding structure encourages you to burrow into one specific area. Whilst I recognise the value in this, and the need for people to do important specialist work, a journey deeper and deeper down

into a specialism hole can obscure a wider view of any problem. We need more ways to facilitate the development of interdisciplinary researchers, who can mine all these holes for their insights and then assemble an overarching structure on the surface.

**WINN:** Yes, that is so very often missing. What have you focused on?

**MCCARTHY-JONES:** What voices are like, the history of the experience, cognitive mechanisms involved, the role of trauma, the involvement of the brain and genes, and how people distressed by voices can be supported. I have just received a grant from the US-based Brain & Behaviour Research Foundation to trial neurofeedback for voice hearing, and next year I will try to get funding for a trial of a psychological intervention to support people distressed by their voices.

**WINN:** A particular psychological intervention?

**MCCARTHY-JONES:** The type depends upon the team of people that can be assembled. Such work takes a village. It will likely be a study of compassion-focused therapy for voice hearing, following the trail that is currently being blazed here by psychologists Charlie Heriot-Maitland and Eleanor Longden, or a trial of the voice-hearing questionnaire called the Maastricht Interview.

**WINN:** I only wish you could research the human givens approach in connection with this. Many HG practitioners have done very successful work in this area. You make the point very powerfully that the links between schizophrenia and PTSD have been overlooked. One reason given in our extract from your book [overleaf] is the requirement that got established in the *Diagnostic and Statistical Manual of Mental Disorders* for symptoms of different conditions not to 'overlap', so trauma was 'taken', so to speak, by PTSD. But you refer to others, too.

**MCCARTHY-JONES:** There has been a wide range of pressures that have pushed us away from recognising the role of trauma in mental health problems in general. Neuroimaging has increased our understanding of the role of the brain in mental health conditions, but its clean, orderly and sterile technicolour images can seduce us into forgetting about the messy and disturbing world 'out there' that may have played a role in creating such brain changes. This has been facilitated by an either/or approach to causation; either your problem is caused by a neural deficit or by trauma, which overlooks how trauma can change the brain. As psychologist Vaughan Bell put it, people persist in seeing different levels of explanation as mutually exclusive.

**WINN:** You make it absolutely clear that voice hearing occurs in a wide variety of people not diagnosed with psychiatric conditions. You also refer to the fact that neuroimaging has now shown that neurological and psychiatric disorders are, indeed, separate disorders and voice hearing is different in both cases. Can you elaborate?

**MCCARTHY-JONES:** At first it may seem puzzling to separate neurological and psychiatric disorders, as it seems to imply that neurological changes are

not present in psychiatric disorders, which they clearly are. The neuroimaging study you refer to found that some regions of the brain tend to be altered only in people with neurological disorders; others tend to be altered only in people with psychiatric disorders, and yet others are altered in both.<sup>2</sup> One of the areas they found to be specifically associated with psychiatric disorders was the medial prefrontal cortex. This is involved in self-reflection and thinking about social situations. From this, we could speculate that voices in neurological disorders may refer less to the person hearing them, and have content of less relevance to the person's ongoing thoughts and concerns. There is some suggestion this may indeed be the case. However, this is not well studied at the moment, and we need to know more about voice hearing in neurological disorders such as the dementias, which are an increasing problem in our ageing society.

**WINN:** One of the many fascinating explanations for voice hearing that you discuss arises from the fact that the areas in the left hemisphere that light up on scans during voice hearing are similar to those that activate when people talk to them-selves silently in their heads. It is a phenomenon that has been linked with 'alien limb syndrome', where an arm reaches out or grabs something but its owner doesn't feel that he or she initiated the movement. Can you explain that?

**MCCARTHY-JONES:** People who have seen the film *Dr Strangelove* will know what we are talking about here. A person's arm can make purposeful movements, but without the person feeling like they were responsible for the movement. Limbs can go rogue. When we look at this condition we find problems in a part of the brain called the supplemental motor area. Similarly, people who hear voices also have altered activity of this area of the brain. This could be the reason why the voice isn't felt as being self-produced, leading to the experience of it as an 'other'.

**WINN:** Another curious finding is that lip and throat movements have been detected in people at the time that they are hearing voices.

**MCCARTHY-JONES:** In this research sensors were attached to people's lips and throats whilst they were hearing voices to see if their speech production system was working at a low level during the voice hearing. There is now reasonably good evidence that, at least in some people, this is happening. This has led to the suggestion that blocking the speech production system, through means such as getting people to open their mouths wide, or humming, may temporarily halt the voices. Any short-term coping mechanism can be helpful, although obviously this does not offer a long-term solution. Two single person case studies, one in the 1940s and one in the 1980s, attempted to amplify such signals to see if they could actually hear the voice speaking and they reported being successful at this. However, I would like to see some modern studies. Technological advances, such as a subvocal speech



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The short abridged extract (right) from *Can't You Hear Them? The science and significance of hearing voices* is drawn from chapters 15, 18 and 19, reprinted here with the kind permission of Jessica Kingsley Publishers.

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- 2 Crossley, N A et al (2015). *Neuro-imaging distinction between neurological and psychiatric disorders*. *British Journal of Psychiatry*, 207, 429–34.
- 3 Sommer, I E C et al (2008). *Auditory verbal hallucinations predominantly activate the right inferior frontal area*. *Brain*, 131, 3169–77.
- 4 Read, J et al (2008). *Child maltreatment and psychosis: a return to a genuinely integrated biopsychosocial model*. *Clinical Schizophrenia & Related Psychoses*, 7, 235–54.
- 5 Darves-Bornoz, J M et al (1995). *Sexual victimisation in women with schizophrenia and bipolar disorder*. *Social Psychiatry and Psychiatric Epidemiology*, 30, 78–84.

recognition system recently developed by NASA, may facilitate future work along these lines. NASA's interest in this area stemmed from wanting to allow astronauts to be able to control machinery, such as the Mars Rover, using only their inner speech: "turn left"; "stop"; "stay on target". Their technology has now advanced to the point that sensors attached to your throat can allow your inner speech to appear in front of you on a computer screen as you think it. Such a system could allow voices to directly communicate with the world. **WINN:** Astounding! Going back to theories you present as to what voice hearing actually is and why it might be experienced as such – you show how, in Broca, the brain area involved with speech, left Broca (so called because it is in the left hemisphere) produces words, and right Broca (in the right hemisphere) is more concerned with speech rhythm. However, if damage occurs to left Broca, right Broca gets the chance to speak, albeit in its own limited fashion. You describe fascinating research leading its authors to suggest that this might account for some voice hearing in normal brains too – ie it happens because there is a sudden spill over from right Broca and it is hard to identify this as from one's own brain, if speech input is coming from both hemispheres. Have I got that broadly right?

**MCCARTHY-JONES:** Yes, that's right. This idea has come from Iris Sommer's group in the Netherlands.<sup>3</sup> In normal speech, left Broca produces words themselves, and right Broca is involved in aspects of speech such as rhythm and musicality. You can see this most starkly if someone uses transcranial magnetic stimulation to temporarily knock out your left Broca's area. You would now not be able to say the words. "The hills are alive with the sound of music" but, sadly for all concerned, you could still sing them. Studies of speech in people who have suffered left hemisphere strokes that have incapacitated left Broca have found that right Broca can still produce some words, though. Such people often say repetitive, simple things including terms of abuse and swear words; this mirrors some voice-hearing. Given such findings, Iris Sommer and colleagues have interpreted voice-hearing as instances of right Broca's area speaking. The reason such output is experienced as the voice of another person is argued to be because it is harder for the brain to correctly determine the self-other source of speech when speech input comes from both hemispheres, and not just the left. There are notable problems with this account, but it is a novel idea, which may yet be proved correct in some cases.

**WINN:** On a similar theme, then, I would like to ask your view – and I know it will only be a view – on this possibility, theorised many years ago by the co-founders of the human givens approach, as a result of observation and patients' reported experiences. Many people report a psychotic episode as like being in a waking dream. Indeed, several characteristics of schizophrenia are similar to those of the REM state in dream-

## Can child abuse cause voice hearing?

MUCH of what we know from voice hearers screams out that suffering child abuse may cause people to hear voices, including, importantly, in the context of a schizophrenia diagnosis. So why isn't child abuse at least strongly mooted as a potential risk factor for voice hearing? More to the point, why is this idea more muted than mooted?

That this idea has been at best neglected and at worst suppressed is suggested by John Read and colleagues, who recently found that only 0.3 per cent of schizophrenia research has investigated the roles that child abuse and neglect may play in its development.<sup>4</sup> Claims that voice hearing was related to child abuse could once upon a time be dismissed because everyone 'knew' voices were caused by schizophrenia, and schizophrenia was a genetically determined brain disease. Yet it turns out that people diagnosed with schizophrenia do not incorrectly allege sexual assault more than the general population does,<sup>5</sup> and that their reports of trauma tend to be consistent over periods of years and unaffected by how severe their psychotic symptoms are.<sup>6</sup> In fact, evidence suggests that people diagnosed with schizophrenia are likely to *under-report* child abuse.<sup>7</sup>

No one is saying that child abuse is the only cause of voice hearing or schizophrenia or that it should be the only thing we talk about, but when someone proposes, in this century, that "the most important etiological agent [cause of schizophrenia] may turn out to be a contagious cat",<sup>8</sup> and then proceeds to write a book on schizophrenia in which the words 'rape', 'incest', 'sexual abuse' and 'child abuse' do not feature in the index, then it is clear that something has gone horribly wrong.

Research shows that, for every person diagnosed with schizophrenia who hears voices, there will be another person with PTSD who hears voices, another person diagnosed with borderline personality disorder who hears voices, and one, if not two,

ing – limited sensory perception about the body, resistance to pain, unquestioning acceptance of bizarre occurrences. It seems psychosis is almost always preceded by extreme stress, anxiety and depression, which is characterised by excessive REM sleep. So hearing voices in such a state could be because the individual's brain, if in a waking dream state, is dominated by the right hemisphere, so they make sense of activity in the left hemisphere (thoughts) as voices.

**MCCARTHY-JONES:** I like any theory that comes from careful observations and listening to people's experiences. That is a great place to start from. Before coming onto your main point, I should note that I am sceptical of the idea that people diagnosed with schizophrenia have a greater tolerance to pain. It would be hard to

people who hear voices in the absence of any psychiatric disorder. Culture, life events, brains and genes are all interlinked in an ouroboric circle of causation that creates us. There is a temptation for some to dive straight into this circle of causes at the level of genes and brains. However, an education in genetics and neurology can be like a recreational drug; an unpleasant world fades into the background and is forgotten. For example, a study published in 1977 involved female quadruplets who all went on to hear voices and be diagnosed with schizophrenia.<sup>9</sup> The authors estimated that this would happen only once in every 1.5 billion births. A clear cause of the women's voice hearing leaps off the pages of this study, yet the authors, dazzled by DNA, didn't see it. Instead, they laid the cause of the quadruplets' experiences solely at the door of a 'schizophrenic genotype'.

The four girls experienced a horrific childhood. Two were found "engaged in mutual masturbation" and, at the recommendation of a doctor, were circumcised and their hands tied to their beds for 30 nights. Another of the girls was molested by her father, a threatening drunk. It seems unlikely he sexually abused only her, as all four girls suffered from bedwetting and incontinence, potential signs of child sexual abuse.<sup>10</sup> The quadruplets started hearing voices in their early 20s. One heard the voice of a man who had made sexual advances towards her when she was alone and frightened; another heard voices after the brother of another hospitalised patient engaged in sex play with her. Menstruation was a trigger for hallucinations in all the girls, as was getting ready for bed at night.

The authors do not comment on the utterly, staggering, blindingly obvious reason why all this should be. They finish the paper by saying, "If we listen intently to what these 'voices' are telling us, we may achieve a better understanding of the mechanisms that underlie them". The authors may have listened intently, but they didn't hear a damn thing. This is not a problem restricted to decades ago.

Another contributor to the minimisation of the role

factor out not only the numbing effects of anti-psychotics but also the other myriad factors that alter your pain threshold, such as coming to believe you will have a lonely life. Anyway, coming back to your question, I personally don't see a compelling argument that voice hearing is due to a waking dream state. If neurological parallels could be shown, an effective therapy predicated on this idea, or, more generally, if this idea is used to create falsifiable hypotheses which stood up to testing, then I would certainly be keen to hear more.

**WINN:** We'll keep you posted. In fact, the idea of *psychosis* as a waking dream state does have support – from a French neuroscientist who showed that the same chemical pathways are common to dreaming and schizophrenic states. He

of child abuse in voice hearing has been the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, referred to as the bible of psychiatry. The first edition of *DSM*, published in 1952, included the term 'reaction' in the name of diagnoses (eg schizophrenic reaction, psychotic depressive reaction) to acknowledge the simple fact that people often have mental health problems because bad things happen to them. In later versions of the *DSM*, the term 'reaction' was removed, ostensibly "to be neutral with respect to theories of aetiology". ... Instead, the *DSM* encouraged a biological and decontextualised understanding of the causes of voices. The key exception to this was PTSD. The first problem here was that this became the trauma diagnosis. If you were given a diagnosis of schizophrenia, this could be taken to suggest that trauma wasn't a causal factor in your experiences. A further problem was that voice hearing was not, and is still not, listed as a symptom of PTSD, further shepherding voice hearing into the open arms of schizophrenia.<sup>11</sup> There may also sometimes be a time lag between abuse starting and mental health problems, including voice hearing, manifesting. For example, Teicher and colleagues found that depression and PTSD did not typically occur immediately after child sexual abuse started but took almost a decade to emerge.<sup>12</sup> Such a lag would make causal relations harder to see.

Voice hearing is strongly associated with child abuse. A 2012 study of the general population by psychologist Richard Bentall and colleagues found that experiencing multiple childhood traumas (two or more of the following: sexual abuse, physical abuse; bullying; being taken into care) was associated with voice hearing to an extent comparable to the association of smoking with lung cancer.<sup>13</sup> This bears repeating: *experiencing multiple childhood traumas is associated with voice hearing to an extent comparable to the association of smoking with lung cancer.* ●

actually got in touch with us to say so,<sup>14</sup> – I'm emailing you his paper now.

**MCCARTHY-JONES:** The author seems to argue this based on a proposed involvement of dopamine in both sleep and schizophrenia. However, a recent study by Oliver Howes and colleagues, which I give a chapter to in my book, found no evidence of altered dopamine activity in healthy people who heard voices.

**WINN:** Fair enough. I'm moving about at random here but, according to your book, research shows that people diagnosed with schizophrenia who hear voices have worse memory for context than those diagnosed with schizophrenia who do not hear voices. Could you enlarge on that and what might be inferred?

**MCCARTHY-JONES:** This came from the work of

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Flavie Waters and colleagues in Western Australia, who found that voice hearing was associated with problems with ‘intentional inhibition’ – the ability to keep information out of consciousness. Now, if you only had reduced intentional inhibition, then you would simply experience thoughts coming into your head that you would recognise as your own, but could not stop. This should lead to OCD-like experiences, rather than voice hearing. Therefore, Waters and colleagues proposed that a second problem was needed for voice hearing to manifest. This involved context memory; the ability to remember the context in which an event happened. When they then looked at both intentional inhibition and context memory, they found that 90 per cent of people diagnosed with schizophrenia who heard voices had problems with both of these abilities, compared with only 33 per cent of their counterparts who did not hear voices. Thus in their model, voices are intrusions from memory which aren’t recognised as memories and hence come to be experienced as voices.<sup>15</sup>

**WINN:** Your book is all about voice hearing, of course, and doesn’t purport to cover anything else, but I wonder if you have any thoughts about how other hallucinatory experiences fit into the picture – for instance, people who see things or sense a presence?

**MCCARTHY-JONES:** This is a problem we (and by ‘we’ I mean the wider hallucinations research community) are trying to answer. Hearing voices has perhaps received undue attention relative to hallucinations in other modalities. That said, in a recent study I was involved in, we found that in people with schizophrenia spectrum diagnoses in Ireland, 64 per cent had experienced auditory hallucinations, 23 per cent visual hallucinations, 9 per cent tactile hallucinations, and 6 per cent olfactory hallucinations. This perhaps explains why auditory hallucinations have received the bulk of research attention. It is not at all clear why this different pattern of prevalence by modality exists, though. One possibility, which builds on the work of Vaughan Bell and Sam Wilkinson, is that hallucinations in schizophrenia are unusual forms of social communication and, given the primary role of language in social communication, this may explain the excess of auditory hallucinations over others.<sup>16</sup> This is still a question in search of an answer, though, and if anyone has any bright ideas, please let me know!

**WINN:** Talking of research, you have said that much current research is “shallow” – a lot of it done by professional university-based researchers driven by the need to have something to publish, to get further research grants, to get tenure, etc. It is something we have commented on often in our journal. Meanwhile, people with the ‘lived experience’ get sidelined. So what areas of re-search, if any, do you think are still

not being looked into enough?

**MCCARTHY-JONES:** I first heard of the deep/shallow research distinction in a great speech that Nev Jones, co founder of the Chicago Hearing Voices, gave at the 2016 International Consortium on Hallucinations Research in Chicago. There is a much greater need for research into questions that people with lived experience want addressed, and there should be dedicated funding mechanisms to allow this work to be done. To give an example of this from another (albeit related) area; a number of us from academia are currently working with Irish sexual abuse charity One in Four, to simply try to identify from the ground up what the issues are, what we need to research together, and how we can use research to drive meaningful change.

That said, a number of voice-hearers have raised concerns about what change evidence can actually drive. There are some who feel evidence of the effectiveness of alternative interventions, including those designed by voice-hearers, may still not lead to acceptance. For example, psychiatrist Loren Mosher’s Soteria trial compared outcomes for people newly diagnosed with schizophrenia, half of whom were randomly assigned to

a psychosocial treatment, a respectful homely community-based residential treatment with only minimal antipsychotic use, and half who were given standard medical care, where antipsychotics were the principal treatment. Two years on, not only did the two groups have comparable outcomes on a number of measures, but the Soteria group actually had significantly better outcomes on some measures, such as the ability to live independently.<sup>17</sup> Yet the findings were ignored by the mainstream.

**WINN:** So what empowering message can you convey about recovery?

**MCCARTHY-JONES:** I would not give you my message but rather refer you to the message of people who have themselves recovered. For example, Eleanor Longden’s TED talk is a towering and inspiring monument to recovery. There is a ‘but’, though. The existence of a number of prominent people who have recovered should not lead us to forget those who are still struggling. In many cases, voices may be accompanied by other problems. The good news is that we have more ways than ever before to help people cope with their voices, although these need to be further evidence based and made available. There is a great community of voice-hearers, therapists and researchers out there who are committed to trying to facilitate recovery. We are definitely progressing, and we are doing it together.

**WINN:** I wholeheartedly recommend your book to our readers and wish you well with your important continuing research. ■

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