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## Beliefs about hearing voices



Michael H. Connors<sup>\*</sup>, Serje Robidoux, Robyn Langdon, Max Coltheart

ARC Centre of Excellence in Cognition and its Disorders, Australia

Department of Cognitive Science, Macquarie University, Australia

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### ABSTRACT

People who experience auditory verbal hallucinations (AVHs) vary in whether they believe their AVHs are self-generated or caused by external agents. It remains unclear whether these differences are influenced by the “intensity” of the voices, such as their frequency or volume, or other aspects of their phenomenology. We examined 35 patients with schizophrenia or schizoaffective disorder who experienced AVHs. Patients completed a detailed structured interview about their AVHs, including beliefs about their cause. In response, 20 (57.1%) reported that their AVHs were self-generated, 9 (25.7%) were uncertain, and 6 (17.1%) reported that their AVHs were caused by external agents. Several analytical approaches revealed little or no evidence for associations between either AVH intensity or phenomenology and beliefs about the AVH’s cause; the evidence instead favoured the absence of these associations. Beliefs about the cause of AVHs are thus unlikely to be explained solely by the phenomenological qualities of the AVHs.

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“A hallucination is a fact, not an error. What is erroneous is a judgement based on it”

[Bertrand Russell, 1914, p. 173]

### 1. Introduction

Auditory verbal hallucinations (AVHs) – experiences of hearing voices – are one of the most common forms of hallucinatory experience and a characteristic symptom of schizophrenia (for a review, see [McCarthy-Jones, 2012](#)). AVHs are generally thought to result from a failure in self-monitoring of internally-generated thoughts, as distinct from other generated speech ([Moseley, Fernyhough, & Ellison, 2013](#); [Waters et al., 2012](#)). Patients who experience AVHs, however, vary in their beliefs about the origin of their voices ([Kinderman, 2011](#); [Larøi & Woodward, 2007](#); [Lera et al., 2011](#); [Thomas, Farhall, & Shawyer, 2015](#); [Wilkinson & Bell, 2016](#)). Some patients have insightful beliefs about their AVHs and acknowledge that their voice-hearing experiences are self-generated. Some do not espouse any firm beliefs and express confusion. A third group accept the voice-hearing experience as a veridical representation of external reality and adopt the delusion that the voices originate from some other agent.

These different beliefs about the voices can lead to other delusions (concerning, e.g., the intent of the “speakers”), affect patients’ levels of subjective distress and anxiety, and shape their subsequent behaviour, including whether they act on

<sup>\*</sup> Corresponding author at: Department of Cognitive Science, Macquarie University, NSW 2109, Australia.

E-mail address: [michael.connors@mq.edu.au](mailto:michael.connors@mq.edu.au) (M.H. Connors).

harmful command AVHs (Beck-Sander, Birchwood, & Chadwick, 1997; Chadwick & Birchwood, 1994; Junginger, 1990, 1995). As a result, patients' beliefs about their voices, and their hallucinations more generally, are a specific focus of clinical interventions (Chadwick & Birchwood, 1994; Gaudio & Herbert, 2006; Kingdon, Turkington, & John, 1994; Michail & Birchwood, 2011; Penn et al., 2009).

Although previous research has examined the consequences of such beliefs about AVHs on patients' behaviour and mood, it remains unclear whether some characteristics of AVHs increase the likelihood of delusions about the cause of AVHs (Garrett & Silva, 2003). Maher (1988, 1999, 2001, 2006) has written extensively about the role of anomalous experiences in explaining delusional beliefs. According to Maher, unusual experiences, such as AVHs, lead people to search for explanations for their experiences and it is these explanations that constitute delusions. A person hearing buzzing sounds, for example, might incorrectly infer that their head is filled with bees, when the sounds are actually due to pathology of the middle ear (Maher, 1988). Although various inferential processes are involved in shaping the specific content of the delusional belief, these are normal responses to unusual events and similar inferential reasoning occurs in people who do not have anomalous experiences. As such, a single pathology – an unusual experience – is sufficient to cause a delusion (by contrast, other theorists propose that a second pathological factor, such as a deficit in belief formation, is additionally required to account for a delusion; Coltheart, Langdon, & McKay, 2011; Langdon & Coltheart, 2000).

When the same anomalous experience is present – AVHs in the context of this paper – an important issue for Maher's one-factor account to explain is why some patients accept the aberrant percept as veridical and believe that an external agent is responsible, while other patients come to believe that the voices are self-generated. One possibility is that the intensity of the hallucinatory experiences – whether this is conceptualised in terms of the amount of speech, the number of different voices heard, the frequency with which the voices are heard, or the length of utterances – might influence patients' beliefs. It might be the case that when the voices are many, frequent, and involve large amounts of speech, patients may be more overwhelmed by the voices and likely to attribute them to external agents; that is, to adopt delusional beliefs about the origin of their hallucinations. Such an idea was proposed by Maher (2006, p. 182):

For a delusion to develop, the experience must be repeated or continue over an extended period. It must also be vivid and intense enough to preoccupy the consciousness of the individual while it is happening. In short, it must create a compelling sense of reality.

In other words, the more intense or vivid the aberrant voice-hearing experiences, the more likely a delusional belief about how the voices originate.

Some preliminary support for Maher's account comes from a study in which psychotic patients experiencing treatment-resistant hallucinations (operationalised as: voices not modified in any way by treatment over the course of one year; voices present at least once a day; and patients' use of at least two antipsychotics) demonstrated less insight into their psychosis than patients who had experienced voices at least once and had responded to treatment and patients who had never experienced voices (Lera et al., 2011). Insight in this study was assessed, however, using the single 7-point insight item from the PANNS, a general measure of psychotic symptoms (Kay, Fiszbein, & Opler, 1987). This single rating does not take account of the multidimensional nature of insight, conflating, for example, insight concerning the presence of a mental illness, insightful beliefs about different psychotic symptoms, and acknowledgement of the need for treatment. Thus, it remains unclear whether there exists a relationship between the amount of speech heard and the degree of insight concerning the cause of voices.

Another possibility for why patients adopt different beliefs about the cause of their AVHs is that other dimensions of "intensity" or other phenomenological qualities of the hallucinatory speech influence whether the voices are believed to be externally generated. These qualities include, for example, the volume, intelligibility, speed, emotional tone, and "personification" of the voices – the perception of the voice as coming from someone of a certain age, sex, familiarity, and social class. Consistent with this proposal, Hustig and Hafner (1990) asked patients with persistent auditory hallucinations to complete daily diaries about the momentary qualities of their hallucinations, as well as their associated mood and beliefs. They found correlations between levels of conviction in delusional beliefs and the loudness and intrusiveness of the hallucinations. While these results are suggestive, it was not clear in this study if the authors were focusing on voices and whether the associated delusional beliefs related specifically to the agent(s) responsible for generating the voices or co-occurred with the voices (e.g., secondary persecutory delusions about "the speaker's" intent).

In another study, acute inpatients with AVHs were found to commonly describe discernible features of the voices that were similar to those of actual speech, including properties of speech that were different to the patient's own voice (e.g., a different age, sex, etc.), as well as the speed of the voices, and their emotional quality (Garrett & Silva, 2003). Commanding voices were also described as being generated by external agents by some patients in this study. However, aside from the descriptive results, the only characteristics of voices that were found to associate statistically with whether or not patients experienced their auditory hallucinations as caused by another agent were emotional and religious content. A third study found that patients who heard AVHs as located outside their head showed less insight into their psychosis than patients who heard AVHs as located inside their head (Lera et al., 2011), though, once again, this study considered general insight rather than insightful beliefs concerning the cause of the voices and other studies have not found evidence of this association (Copolov, Trauer, & Mackinnon, 2004).

In sum, despite some suggestive findings and the availability of detailed measures of the phenomenology of AVHs (Langdon, Jones, Connaughton, & Fernyhough, 2009; McCarthy-Jones et al., 2014; Nayani & David, 1996), comparatively little

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