AGNES'S JACKET

A PSYCHOLOGIST'S SEARCH FOR THE MEANINGS OF MADNESS

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Printed in the United States of America
Rodale Inc. makes every effort to use acid-free ♾, recycled paper ♻.

Interior design by Joanna Williams
Cover design by Gabrielle Bordwin

Library of Congress Cataloging-in-Publication Data

Hornstein, Gail A.
Agnes's jacket : a psychologist's search for the meanings of madness / Gail A. Hornstein.
p. cm.
Includes bibliographical references and index.
ISBN-13 978-1-59486-544-2 hardcover
ISBN-10 1-59486-544-2 hardcover
1. Mentally ill–Institutional care. 2. Mental illness–Alternative treatment.
3. Mental illness–Philosophy. 4. Psychiatry. I. Title.
[DNLM: 1. Mentally Ill Persons–psychology. 2. Attitude of Health Personnel.
3. Attitude to Health. 4. Mental Disorders. 5. Psychiatry. 6. Survivors–psychology. WM 29.5
H816a 2009]
RC439.H67 2009
616.89–dc22
2008029223

Distributed to the trade by Macmillan

2 4 6 8 10 9 7 5 3 1 hardcover

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In Memory of Ellen Keniston

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The Voice Hearer

London, England, 1996

Helen Chadwick disliked doctors. But routine visits to her general practitioner, Dr. Thomas, weren't that bad. Her office was in a large house, and the airy rooms and front garden were nothing like most National Health Service (NHS) clinics. On this particular day, beckoned by the bright sunshine that had finally broken a long spell of chilly May rain, Helen set out early for the short trip from her North London home to Dr. Thomas's nearby office.

She got off the bus at the corner of the doctor's street. The tree-lined row of neat stone houses looked just like those in her neighborhood. Tulips still bloomed in a few front gardens; the sun sparkled on a border of deep crimson dahlias. Helen walked slowly down the block, preoccupied by an upcoming meeting at work. She was chief cataloguer at a branch library in one of London's largest boroughs, and tight budgets were creating problems for everyone. Recent staffing cuts had left hundreds of books overflowing her office; she'd almost been hurt the day before when an avalanche of them crashed near the door. With any more layoffs, she'd be left with the work of a whole department.

Suddenly, a voice yelled, "Who the fuck are you?" Yanked from her reverie, Helen whirled around to see who was shouting at her. She saw no one. "Why ain't you at work?" the same man demanded in a booming tone. "You think doctors have time to waste on scum like you?" Helen froze, shocked that anyone on this quiet street would speak so rudely to her.

But where was the man? The street was empty. He was foul-mouthed, almost obscene, not the sort of person who'd live in a leafy neighborhood like this. He had to be in one of the houses, yelling through a window; no one was on the sidewalk. "Yeah, who the fuck she think she is, walkin' down the street 'stead a' goin' to work?" a woman's shrill voice rang out.

Helen swung around. She still couldn't see anyone. The sounds seemed to be coming from one of the smaller houses she'd just passed. But no one was at the windows; every door was shut. "Get your stinkin' ass out of here," the man snarled. Terrified, Helen began to run. Dr. Thomas's office was at the end of the block. Pushing open the gate so quickly she practically fell through it, she stood for a moment in the garden, trying to catch her breath.

Whatever had just happened, it was over now, she told herself. Besides, she was at a familiar, safe place, a place of help. Her heart still pounding, Helen rapped on the front door and then, when the buzzer sounded, walked unsteadily to the waiting room just down the hall. Other patients sat reading magazines or chatting quietly with relatives. Two small boys in the corner were giggling over a comic book. Helen gave her name at the reception desk and settled into a chair, trying to breathe deeply, as she'd once learned at a stress-reduction seminar. After a few minutes, she took the novel she'd been reading on the bus out of her small leather purse. Anita Brookner's deliberate prose seemed especially welcome at this moment. She read a few pages and started to feel calmer.

"I told you to get out," the man hissed in her ear. Helen stopped breathing. How could she still hear his voice, the same one she'd heard outside in the street? It must be her memory playing tricks on her, replaying something he'd already said. She shook her head, as if to dislodge the thought. "Hey, cunt, I'm talkin' to you," the voice whispered. Helen jumped up. Her eyes darted to the waiting patients. Had one of them spoken? Had they heard the man? They all seemed occupied, as before. No one even glanced up. Helen crumpled into her chair. She felt odd, as if she were in an episode of *The Twilight Zone*, simultaneously in two worlds. Nothing this strange had ever happened to her. She was pragmatic and sensible, hardly someone given to experiences of the occult.

"Helen Chadwick." Suddenly Dr. Thomas was beckoning to her from the reception desk. Helen tucked the book back into her purse and slowly stood up. The doctor nodded and set off briskly for her office, two floors above. She was halfway up the stairs before Helen had taken her first step. "You got one more minute, you stupid cunt, to get out of here," the man screamed. Overcome with fright, Helen bolted to the door and shot outside. She was almost to the corner by the time a sweating Dr. Thomas caught up with her.

"What's going on?" the doctor asked.

"Someone told me to leave," Helen mumbled.

"What? That's nonsense. Come back to the office," said Dr. Thomas, gently steering them both toward the house. Helen numbly did as she was told, just as she'd done with the screaming man. Everyone seemed to be ordering her

about. She felt frightened, at the mercy of unknown forces. They were all so insistent that she couldn't refuse their demands.

"Are you all right? What happened? Were you hearing voices?" she heard Dr. Thomas ask from somewhere far off. Although she didn't work as a psychiatrist, Dr. Thomas had trained in the field, so she knew more about mental illness than the average GP. Helen felt as if she were in a tunnel. Sounds were tinny and there was an echo, distorting the words. "No," she murmured as a voice bellowed, "Don't tell her anything!"

Later, waking confusedly as afternoon sunlight streamed into her bedroom, Helen tried to work out what had happened. Had she been having one of those vivid nightmares, the kind that seem real even after you wake up? But why would she be sleeping in the daytime instead of being at the office? Then she caught sight of the bottle of pills Dr. Thomas had given her and realized with horror that the events of the morning had indeed occurred. What if those dreadful voices started up again? A terrifying thought. Was the stress at work getting to her? Did she have a brain tumor? An article she'd recently read about people with brain cancers had mentioned hallucinations as a symptom. Maybe she had some terrible neurological ailment. Or, even more frightening, what if she were cracking up? A colleague at work who'd studied psychology once remarked that nervous breakdowns can happen to anyone.

Not wanting to tempt fate, that evening Helen didn't say a word to her partner about her trip to the doctor. "I thought it was better to keep the whole bizarre experience secret," she told me later. "Talking about it might only bring it back or make me more frightened."

Helen didn't return the next week for the follow-up appointment Dr. Thomas had scheduled. For four months, she didn't tell anyone what was happening inside her head. The voices came and went—appearing several times in a day or mercifully being absent for a week or more. Sometimes it was the man alone; sometimes the woman joined him, or there was another man whose accent was Scottish. Their language was filthy. Helen had never heard anyone speak words like that aloud. She couldn't even repeat them to herself; telling anyone else about them seemed unimaginably mortifying.

But keeping the secret took its toll. Struggling not to respond outwardly to the voices or even to give any sign of hearing them when others were present exhausted her. It became harder and harder to concentrate on any task. Helen began avoiding friends and gave vague reasons for not going to work. On particularly bad days, she couldn't tell the difference between the voices in her head and those of her colleagues. Being out in the street was particularly distressing; she could never tell whether the voices she heard were inside or coming from people nearby. Sometimes, accosted by a voice

while in a shop, she would panic and run away, even in the middle of a transaction.

At home, her partner found her increasingly distracted and withdrawn. When guests came for dinner, Helen rarely spoke, and often she looked from one to another as if she couldn't follow the conversation. She started refusing to watch her favorite TV shows; if she happened to walk through the room when someone else was watching television, she stared at it intently, as if trying to work out its purpose.

In September, four months after her original visit to Dr. Thomas, Helen Chadwick signed herself into a mental hospital at the urging of her distraught and mystified partner. Dr. Krishnan, the psychiatrist assigned to her case, barraged her with questions. "Where are you? What day is it? Who is the prime minister? Do you have headaches? Problems eating? Night sweats? Double vision? Do you hear voices?" As soon as she mumbled yes to that last one, he ended the intake interview and she was prescribed Haldol, an antipsychotic medication. It had a slight dampening effect on the voices, making them sound as if they were coming from a long metal tube. But they made her so dopey she could barely shuffle from the toilet to the dayroom. Besides, the voices were still there. The drug made it impossible for Helen to read or follow the action in even the simplest TV show, so the net effect of the treatment was that the voices were more of a torment. They might be fainter, but now there weren't any ways to escape from them.

After a few weeks, Helen stopped thinking that the voices might be real people speaking to her from some unseen place. She knew they were in her mind, but this "knowing" was theoretical, like knowing the earth is round. It doesn't *look* round. The voices didn't seem like they were inside her; they sounded as though they were coming from across the room or down the street. She heard them through her ears; they were nothing like thoughts or talking to herself. And because they didn't sound remotely like her, because they constantly said words she never uttered, it was difficult to conceive of them as her creation.

Helen Chadwick's first hospitalization lasted more than a year. Neither the medication nor the electroshock treatment she was given made the voices disappear. Removed from her job on grounds of disability, she spent most of her time tormented by the demands of screaming people inside her head. Helen could no longer travel into Central London on the Underground; one of the male voices kept daring her to jump onto the tracks as a train approached. If she went for a walk in her neighborhood, the shrill woman urged her to dart into traffic at busy intersections. For much of the past decade, Helen's life has been a nightmare of fear and persecution from people others can't hear.

Yet compared to many mental patients, she is fortunate: Her partner c more than thirty years has loyally stood by her, and Helen lives in Britain, th worldwide center of the Hearing Voices Network (HVN).

TRADITIONAL PSYCHIATRIC VIEWS CLASSIFY VOICE HEARING as a "auditory hallucination," a neurological event that is invariably pathologica and should be stopped if possible. An underlying disease process like schizo phrenia is assumed to cause this kind of brain dysfunction. Asking a patien about the speakers or the content of the voices is seen by most psychiatrists a dangerous or useless, a way of "colluding" with the illness that can't possibl help the patient. Aside from asking the few questions necessary to determin that the experience is taking place, physicians rarely talk to patients abou their voices.

"For the seventeen years that I was treated unsuccessfully for 'auditory hal lucinations,'" one patient commented recently, "my psychiatrists seemed t view my voice hearing experience as nothing but the random fluctuation o neurotransmitters in my brain. No one ever asked me about it." Having turned to physicians for help in understanding these confusing or frighten ing mental states, patients often find their doctors' lack of interest perplex ing. Simply being told to take their medication and ignore what's happening in their minds makes them feel more alone and strange. And those for whom the medications don't work at all—a sizable percentage—feel frustrated by their physicians' insistence that they keep taking them anyway.

NEW YORK CITY, 2002

ON A SUBWAY TRAIN IN MANHATTAN, the voice of a woman announces every stop, and then a man's baritone booms out, "Stand clear of the closing doors, please!" Two men near me murmur quietly in Spanish; a mother scolds her whiny child in the seat opposite. I am alone, so nothing distracts me from what all these voices are saying. They surround me. I find this exhilarating. It's one of the things I love most about big cities.

The voices I'm hearing are nothing like Helen Chadwick's or the ones in *Welcome, Silence,* the book I'm reading. It's the story of a woman named Carol North, who was tormented for years by people who taunted and threatened her. No one else could hear the people Carol heard in the way everyone in this subway car can hear the voices I'm listening to. And hers certainly weren't exhilarating; they terrified her. They criticized everything she did, gave ominous warnings, and never stopped harassing her. She couldn't just walk away to stop hearing them, the way I can with the voices on this train. Carol North's

voices tortured her day and night—at school, in bed, while walking down the street. They were unrelenting and everywhere.

They began when she was six years old and turned her ordinary life in a midwestern American town into a frightening test of endurance. She could barely hear her teachers over the din inside her head. Nights brought hours of cowering under the sheets to avoid their attacks and threats. Carol also had horrifying images. The birds she passed on her walk to school seemed to be dive-bombing her. She saw fires burning in her house; "interference patterns" swirled in the air around her.

At first, Carol's terrors attracted the attention of her parents and pediatrician. But because she was so young, and because she'd always been a "sensitive" and unusually imaginative child, her doctor dismissed her voices and visions as "attention seeking." He told her parents to ignore them and reward her for behaving "normally." Carol learned to lie about how she was feeling, and she made it through school on sheer determination.

Suddenly, the subway train jolts and stops abruptly. I look up from my book. The woman sitting across the car is eyeing me suspiciously. She says something to the woman next to her. They both frown and glance in my direction. If I were Carol North, I'd worry that they could see inside my mind, could hear the voices criticizing everything I did. But this isn't what I think. I think they're a coincidence, these comments and glances. I don't think the women are talking about me at all. I'm still enjoying the sound of voices everywhere around me, even though reading Carol North's book reminds me of how frightened she or Helen Chadwick might be feeling at this moment.

HELEN FIRST HEARD OF THE HEARING VOICES NETWORK while she was still in the hospital. "It was a terrible time," she told me later. "I'd been battered with shock treatments. My psychiatrist relentlessly gave me drugs I didn't want to take. My head felt as if it were filled with custard. Reading was impossible; the print just danced on the page. We passed our time on the ward doing little but sitting around in a drugged haze.

"Then one day, all the doctors were away at a conference, so the intern came in to check on me. There was a shortage of nurses on that ward, and for a few minutes, he and I were alone in the room. He told me he'd heard that there were self-help groups for people who heard voices. He thought I might benefit from attending one. But he didn't give me any idea of how I'd contact them, and I was too confused to think to ask him. A few months later, though, I came across a copy of *Equilibrium,* a newsletter published occasionally by the NHS for psychiatric patients. There was an article about the creation of a hearing voices support group right here in North London.

"When I finally got out of hospital months later, I telephoned to inquire about it. It turned out that a group was just starting at my local day centre. A staff member there gave me a book called *Accepting Voices* by a doctor in Holland called Marius Romme. Someone came down from Manchester to help our group get organized. He said he was from the national office of the Hearing Voices Network, and ours was one of 150 voices support groups across Britain. I thought I'd faint. I had no idea there were so many other people struggling with the same problem as I was."

MARGERY KEMPE HEARD VOICES, TOO. Hers were frightening like Helen's, but they were also wonderful and awe inspiring. Margery heard the voice of Jesus. He spoke to her lovingly, called her "my daughter," and said he would guide her life onto a more spiritual path. Margery came from a prosperous English family just as Helen did, but their fates were radically different. Margery lived in the fourteenth and fifteenth centuries, so her voices made her a visionary, not a mental patient.

Margery Kempe was a deeply pious woman living at a time when pious people routinely had unusual experiences that marked them for special treatment. But unlike many of her contemporaries across Europe—Bridget of Sweden, Catherine of Siena, Julian of Norwich, Joan of Arc—Margery was not a cloistered nun or a celibate or a recluse surrounded by others immersed in prayer and abnegation. She lived in Lynn (now King's Lynn), a center for trade near England's eastern coast. Her father, John Brunham, was the foremost citizen of the town, five times its mayor and a prosperous merchant. At twenty, Margery married John Kempe, a successful tradesman, and went on to have fourteen children with him. She was a busy, enterprising woman, running a household and working occasionally as a miller of grain or a beer brewer. Nothing about her early life suggested a future as a mystic.

But after the birth of her first child, Margery fell into a state of profound despair. She barely moved; she spoke to no one for several months. At times she seemed close to death. Then she began having fits of violence, screaming that she was being tortured by devils with mouths of fire. She publicly denounced her husband and father, the two people closest to her. She bit her own body, tried to tear off her skin with her nails, openly lusted after other men. Finally, she had to be tied up to prevent her from killing herself.

One day, Jesus appeared at the side of Margery's bed. He was in the likeness of a man, clad in a mantle of purple silk. He said, "Daughter, why have you forsaken me, when I never forsook you?" Then the sky opened and Jesus gradually ascended. Margery's mind was calmed. It was as if she had just awakened from a coma and been fully restored to her life as a loving and effective wife and mother.

From then on, Jesus visited her regularly, speaking at length and asking

that she proclaim his message to the world. Margery Kempe became a public figure. Like Julian of Norwich, a prominent mystic living in a nearby English town, Margery felt singled out for a special role as a holy figure.

Her intense religiosity put her at odds with her husband and neighbors. She prayed constantly, dressed only in white, and refused meat and wine, two staples of her diet. She chastised neighbors for lax living or swearing in public. She cried and wept so noisily during church services that people refused to sit near her. Her "roaring," as she called it, was often so loud it drowned out the sermon. When her paroxysms of piety grew even more extreme, her parish priest tried to ban her from worshipping at his church.

Margery's loud declamations in public caused her to be repeatedly arrested and brought before the authorities. They did not challenge her claim of hearing voices; visions and spirits were an essential part of the Christian experience in the Middle Ages. The question was whether the voice speaking to Margery Kempe was actually that of Jesus or whether the devil, through trickery, had appeared to her *in the disguise* of God.

The bishop of Lincoln and the archbishop of Canterbury, the two most distinguished figures in the English church hierarchy, evaluated Margery and authenticated her claims. She was not, they declared, a crank or a heretic as her neighbors and local priest had charged, but a truly pious woman proclaiming the word of God.

With the protection of church authorities, Margery continued to speak out. After her children were grown, she made pilgrimages to sacred places all over Europe. She traveled to Jerusalem and to other shrines in the Holy Lands. She was often shunned, even by other pilgrims, for her "boisterous" weeping, her wearing of sackcloth, and her public denunciations of those who swore, lied, or gossiped. She demanded that her husband agree to live a celibate life with her, and he consented.

In her old age, Margery was commanded by God to "make a book" describing her experiences "so that His goodness mayeth be known to all the world." Since she could not read or write, two priests served as scribes and witnesses to her voices and visions. *The Book of Margery Kempe,* written in 1436, remained undiscovered for five centuries. Finally published in 1934, it now exists in many editions and is hailed by scholars as the first autobiography to be written in English. Margery's book is still widely read for its "electrifying" account of a woman transformed by voices into one of the most powerful figures of religious life in medieval Europe.

I HAVE AN APPOINTMENT to meet Helen Chadwick on March 20, 2003. She and the manager of her local mental health center in North London have agreed to tell me about their support group for voice hearers. After

months of fruitless phone calls and Internet searches, they're the first people I've found who are actually part of the Hearing Voices Network. Ever since I'd heard it mentioned on the Mental Health Testimony Project videotapes at the British Library, I'd been trying to learn more about the network. I'm excited, but have no idea what to expect from this meeting with Helen.

The day begins in an unsettling, even frightening way, with a 6:00 a.m. radio bulletin announcing the start of the Iraq War. Two hours later, as I set out for a nervous journey on the Underground, I wonder if this is an auspicious moment to be traveling across London to meet my first voice hearer.

Haringey is a heavily Muslim area in far North London. I leave the Tube station with relief after a half hour's ride and set off down Turnpike Lane toward the Clarendon Day Centre. I feel as if I've just arrived in Karachi. Women in full burqas are buying melons from farmers perched on open-backed trucks. Construction workers erecting scaffolding on a huge building shout to one another in Urdu. Cafés overflow with tea-drinking men jabbing at newspapers. For once, I'm grateful that mental health facilities are usually relegated to poor, ethnic neighborhoods. On a day like this, it feels a lot safer to be in Haringey than in the tourist districts of Central London, obvious sites for a terrorist attack. I may be the only white woman walking down this busy street, but I feel reassuringly invisible amidst the flurry of activity that surrounds me.

I'm buzzed into the day center and sit for a few minutes in a crowded entrance area. Patients mill about; staff confer behind a counter piled haphazardly with files and papers. The place smells of unwashed bodies and the cabbage cooking in the cafeteria. I read the bulletin board listing the schedule for that afternoon—"Print Making. Video Group. Hearing Voices"—and wonder how hallucinating has become a planned activity. The manager arrives and escorts me to a small conference room. A stocky woman in her fifties, neatly dressed in a knit top and gray slacks, looks me over warily. "I'm Helen Chadwick," she says carefully.

For the next hour, Helen tells her story. She speaks in the mellifluous tones of a BBC commentator. The eldest of four children, she'd been raised in a prosperous community in southern England. Her musical talents had been discovered early on, and she'd studied cello at a special school. "But when I hit puberty, I just completely lost my ability to play in public," Helen says, still apparently bewildered by this turn of events. She moved back home, attended the local preparatory school, and then entered the university. She lived the quiet, uneventful life of a hardworking student. Then something terrible happened: Helen's best friend killed herself. Because they'd argued in a telephone conversation the previous evening, Helen felt overwhelmed with guilt at her friend's death. She couldn't confide in anyone and just spent

most of her time alone in her room. When she stopped going to classes, coming to meals, or talking to her parents, they consulted a psychiatrist.

He sent her to the nearby mental hospital, where she was heavily medicated and given shock treatments (without benefit of anesthetic, a common practice in the 1960s). At one point, she tried to hang herself. "I felt such terrible guilt that I hadn't rescued Catherine. What right did I have to be alive when she wasn't?"

Suddenly Helen stops speaking. She looks around, blinking rapidly, as though trying to remember where she is now. "It must have been a terrible time," I say quietly. She takes a sip of tea from the plastic cup in front of her. "Yes, it was. But what I don't understand is why I didn't hear voices then. The diagnosis I was given at nineteen, psychotic depression, is the same one I have now. But at no time during that early breakdown, or in the subsequent twenty-five years since I recovered from it, did I ever hear voices. It's only since that day I told you about, walking to Dr. Thomas's office seven years ago, that they have been tormenting me."

Like anyone who's had a strange experience, Helen struggles to understand how her mind could produce such odd sensations. She sees a clear link between her own harsh standards and the voices' taunting comments. "The day it started, I was feeling very guilty about not going to work," she says. "In retrospect, I can see why that first voice spoke to me so critically. I was brought up with this appallingly difficult Protestant work ethic, and my mother was very unforgiving about the whole notion of anyone having a day off school or work."

"But a person can feel guilty and not hear voices," I interject. "Where do you think voices come from, specifically?"

"I can't really explain it." She shakes her head. "It frightens me a great deal because it seems so inexplicable. I know that a lot of time I have hideously low self-esteem, but I can't explain to myself why these feelings translate into an experience that sounds, for all the world, as though somebody is speaking to me. Why would a person's deep-seated sense of inadequacy and worthlessness come across in the form of three separate voices? I hear people make statements about me. It isn't a dialogue. I don't talk back to them. It just seems as though somebody is making a series of critical statements directed at me and about me, and I can't explain why my mind does this."

Helen crumples her cup and reaches over to place it carefully in the rubbish bin. "Everyone occasionally goes back over conversations they've had," she says. "If a conversation's been unsatisfactory, we think about what we might have done or said differently. I know what that's like, and I know what it's like to think aloud. But this business of actually hearing things in my head strikes me as very, very different. Sometimes the voices absolutely shout, although not very often. And they're not very imaginative—they keep saying the same things over and over. Eventually I noticed a pattern to it, that there

were three specific voices. None of them resemble anyone I've known. There are two male voices and one female voice, and they've been the same for the whole seven years that I've been hearing them."

"Have you ever tried writing down what they say? That's what Carl Jung did when he felt possessed by spirits. He talks about it in his autobiography." I'm struggling to think of a way of linking Helen's experience to something I'm familiar with.

"No, I can't seem to manage that," she says, looking crestfallen, and immediately I regret having asked; she must think I'm criticizing her. "I've tried to do that but find it quite traumatic," she adds. "Besides, if I wanted to be accurate, it would take all day—they are incessant, filling up my mind so there's no space left."

I peer out the grimy window, distracted for a moment by a police siren on the street below. Has something happened in London on this tense morning, or is it just an ordinary emergency? A few moments pass in silence and then Helen interrupts my reverie.

"I do feel, thanks to my work in the hearing voices group, that my paranoia is a lot less intense than it once was. During the fighting in Kosovo, when I was at my worst, I was convinced that I had started the war." She shakes her head, frowning. "I was appalled when I turned on the radio this morning and heard about the attacks in Iraq. But it seems a major advance that it didn't even cross my mind that I was responsible for them."

A FEW WEEKS LATER, I'm on a 91 bus crawling toward Hackney in northeast London. It's 9:15 a.m. and the bus is still jammed with silent commuters when I get on at King's Cross. The man next to me, in black wingtips and the blue shirt and aubergine tie favored by the British businessman, is studiously stuffed inside the *Times*. Two women in halter tops chat rapidly in Italian and consult a brochure called *Hidden Gems of London's Ethnic Neighbourhoods*. The bus lurches into Islington. I gaze vacantly out at the people queued up for coffee at a café near a large shopping arcade. Most people get off. Then, suddenly, a woman behind me begins to yell in a language I can't recognize. I whirl around to see who could possibly be the target of this angry tirade. I see no one. The woman doesn't even have a mobile phone. She's talking to herself. Everyone else on the top deck moves away from her, shaking their heads in disgust. I wish I could ask her if she knows there are support groups for people who hear voices, right in this neighborhood.

HELEN CHADWICK AGREES TO MEET WITH ME AGAIN to talk in greater depth about her experiences. This time we're in my third-floor office

at the University of London's Senate House, a massive, intimidating building that was used as the Ministry of Information in the film version of George Orwell's *1984*. I'm in London for six months on a research fellowship, trying to figure out how to link the reports of historic figures like Margery Kempe to those of contemporary voice hearers like Helen.

We settle into our chairs and, for a few moments, look out the window, admiring the symmetry of the flower beds in Russell Square, just across the road. A warm breeze soothes us quietly into talk.

"Did the drugs the psychiatrist prescribed when you were in hospital help at all?" I ask, switching on the tape recorder. Helen has agreed to be quoted directly, as long as I give her a pseudonym.

"No," she says, clearly wishing that something had worked. "The medication never made the voices go away. It just dampened them a bit. Although they have gotten worse since I stopped taking the tablets, I still think it's worth it because I don't feel so drugged up and can see things clearly."

"What do you do at home when the voices get really bad? How do you cope?"

Helen takes a sip of tea from the cup I've given her and grimaces. She opens a packet of sugar, pours it into the tea, and stirs thoughtfully for several moments. "I've learned that sometimes just a simple change of activity is what's needed," she says hesitantly. "Sometimes, if we have people round to dinner, I have a lot of problems with cross-conversations and so on if the voice is clear as well. If things get really bad, I might just surreptitiously leave the room as though I am going to put on the coffee or check the dessert, and I just sit or even lie down for as little as five minutes. Sometimes this can switch off the voices temporarily."

"I've read about people whose voices are a kind of guide or inspiration," I say. "Have you ever felt that way?"

"No," she says wearily. "I want to be rid of them completely. They have never said anything remotely pleasant. I think I recognize that they are just projections of my own very fragile self-esteem and don't reflect my true nature, but this doesn't make them any easier to deal with. I know there are people who say they would miss their voices if they went away completely. I'd open a bottle of champagne and celebrate."

In our first talk, Helen had told me how little confidence she had felt when the voices started, despite having a good job and a loving partner. "Much of my adult life has been about this paradox between sort of 'knowing' that I am okay and yet not quite being able to believe it," she'd said then.

"Do you think the voices are communicating anything of importance?" I ask gingerly, not wanting to make her feel any worse about them.

"I've thought a lot about that," Helen says quietly, averting her gaze. A

telephone rings in the office next door. She waits until it stops. "It does seem to me that they are going at it with a sledgehammer. Sometimes I wonder if they are saying, 'Come on, stick up for yourself, are you really such a waste of space, are you really completely worthless?'"

"Has someone else in your life spoken that way? Could the voices be connected to an experience you'd had previously?" I know I'm not suggesting anything she hasn't already thought of. I'm just interested in learning more; Helen's been thinking about voice hearing a lot longer than I have, and I've read that HVN groups try to help people explore links between voices and personal history.

"Well, my mother never spoke in the obscene language the voices use, but the connection between what they say and her criticism is almost too obvious. I was never good enough for her. If I got a 98 percent on an exam, she asked, wasn't I concentrating? Nothing I ever did was good enough. But it just seems too obvious that they are repeating that pattern of how she felt about me. Besides, the voices don't sound anything like her."

I think back to Helen's experience on the way to Dr. Thomas's office. "You said earlier that you felt guilty about not being at work that day the voices started."

"It's true. I have this puritanical approach to work. At that point, I was carrying the work hitherto done by three people. And I do have a ridiculous tendency to set very high standards for myself. Even though I knew that it was quite wrong to think that I had to do the work of three people, I did my darnedest to try. I was having more and more difficulty in thinking clearly. I was frantically busy at work and unable to cope and yet working longer and longer hours to less and less purpose.

"I recognize that they are reflections of my bad feelings about myself, how I saw myself then. But I have never become accepting of them, even now, even though it looks as though they may never go away. . . ." Her voice trails off. She takes a small handkerchief out of her leather bag and wipes her eyes, struggling not to weep openly. I get up without speaking and pour a glass of water from the bottle on my desk, placing it next to her.

"They have been pretty consistently horrible for as long as they have been around," Helen says quietly. "As with my mother, who just says the same things over and over again. She tries to fill up every silence in case I should insist on saying something about myself."

Are the voices serving that same function, preventing Helen from thinking other thoughts? Do they absorb all the space, the way her mother does? What would Helen be thinking if the voices weren't there anymore?

She interrupts my thoughts. "If it weren't for the support group," Helen says, glancing at her watch and gathering up her things so she won't miss her

bus, "I don't think I could have gone on. Having other people to talk to breaks the terrible isolation one feels about voice hearing. I'm not nearly as bad off now as I was in hospital, before I found the group."

After she leaves, I sit for a long time, staring out the window and wondering how any of us know what's real and what's not. Are the people I see scurrying across Russell Square actually there or am I hallucinating them? Are the mumbled voices I'm hearing those of people in the next office or voices inside my head? I recall the line from Daniel Paul Schreber's famous narrative of paranoia, *Memoirs of My Nervous Illness:* "What can be more definite for a human being than what he has lived through and felt in his own body?" Or, as the Nobel Prize–winning mathematician John Nash replied when a colleague asked how he could possibly believe in voices and visions, "I believe them because they come from the same source as my mathematical ideas."

2.

BEYOND BELIEF

A MONTH LATER, dozens of voice hearers jam the University of London' elegant Chancellor's Hall, just downstairs from my office at Senate House The occasion is a formal one, and I'm lucky to have wangled an invitation t this special one-day conference titled Beyond Belief: How to Understand an Cope with Hearing Voices. There are 150 participants; another 70 peopl had to be turned away for lack of room. The event is historic: It is the firs time that people who hear voices—many, but not all of them, psychiatri patients—are presenting their own ideas at a mainstream mental healt meeting.

The National Health Service and various charitable foundations hav provided sufficient funding to offer free registration and an elaborate catered lunch for everyone. But no official from those bodies has dictate the content of the talks, which are based entirely on the approach of th Hearing Voices Network, an international organization run largely by cu rent and former psychiatric patients. Since its founding in 1989, HVN ha been developing a way of conceptualizing and treating "hallucinations" tha is radically different from the standard psychiatric approach. Now, in Apr 2003, mental health professionals are getting a chance to learn about thi new alternative.

The sessions are being held, somewhat incongruously, in a room hun with huge oil paintings of the Queen Mother and the Princess Royal, bot former chancellors of the university, for whom this hall is named. I step o the elevator into a crowd of people chatting over coffee and pastries. At th registration desk, a young man hands me a badge that simply has my nam no title or workplace information. He smiles broadly. "The conference org nizers don't want people to meet each other in stereotypic ways," he tells m "You can't tell who's who just by looking at people's name tags." The mor

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mistakes I make, the more I see the point of this—women in suits turn out to be mental patients, and scruffy-looking guys in sweatshirts introduce themselves as nursing supervisors.

I try to imagine a meeting like this being held in the United States, supported by the highest levels of government and key professional groups. It's inconceivable. The medical model is the sole viewpoint presented at American mental health conferences. There's never any discussion of alternative approaches, especially those developed by patients themselves. As I look around at the huge marble columns of the imposing room and watch the procession of HVN speakers taking their seats at a velvet-draped table, I struggle to imagine how I could ever convey this atmosphere to colleagues back home.

Hári Sewell, the senior NHS manager who's chairing the meeting, welcomes everyone. "This is a celebration as much as a learning event," he says with a big grin. "It isn't every day that we can forge such an important partnership between mental health staff and members of the Hearing Voices Network. This is an ideal opportunity for those of us in the NHS to learn about HVN's pioneering work." The man next to me takes off his silk scarf and fidgets nervously. I can just make out the ID tag dangling from his calfskin briefcase on the floor between us: "Richard Wilcox, Consulting Psychiatrist."

The first speaker is an attractive young man whose delicate features and shy smile are accentuated by an elegant head of soft, downy hair that reminds me of a newborn bird. He introduces himself as Rufus May, a clinical psychologist and former schizophrenic. Who would have thought such a combination existed? It seems a perfect embodiment of the paradoxes of this meeting.

Rufus (as everyone seems to call him) talks about the confusing experiences he had as a teenager. "I thought the television and radio were sending messages, telling me I was part of the struggle between good and evil. I thought I saw the devil in my parents' eyes. I had special powers of communication and felt connected to larger forces in the universe.

"After weeks in a high state of vigilance," Rufus continues in a soft voice, "I began to have stabbing pains that kept me awake at night. I thought I had a gadget inside my chest that was being used to monitor and discipline me and could deliver shocks as punishment for my errors. When I went to my GP for help, she said I needed to see a specialist. I thought it would be a chest doctor, but it turned out to be a psychiatrist, who admitted me to hospital."

For the next two years, Rufus struggled to find his way out of the difficult situation into which he had been thrust. "I needed a safe space to explore my beliefs, sort out what they meant, and reconnect to other people," he says. "I needed to find a role for myself in the community and a career that would make good use of my talents. What I didn't need was to be given a diagnosis

of paranoid schizophrenia and put on medication that made it impossible for me to think clearly." The man sitting a row in front of me mutters, "No shit!"

Rufus says it took years for him to understand what he'd been through and to recover sufficiently to enter university. At no time during his studies, even when he went on to a doctoral program in clinical psychology, did he ever talk about his history as a mental patient. The risks were just too great—if anyone knew he'd been in a hospital for eight months with a diagnosis of schizophrenia, he never would have been admitted to postgraduate study.

Now, twenty years later, he's a successful clinician who talks openly about how his early experiences crucially shape his work with patients. Rufus is distressed by the narrow range of explanations psychologists allow themselves. "One of the main themes of our conference today," he says, looking intently around the crowded hall, "is the importance of respecting different belief systems. People are always making sense of their experiences, especially if they're unusual or can't be easily explained. We need to start appreciating this fact and opening our minds to different ways of thinking."

Then, flashing a brilliant smile, Rufus tells us all to enjoy ourselves. His relaxed intensity disarms everyone; it's impossible to dismiss him simply as a "former schizophrenic patient." I think of the standard claims in abnormal psychology textbooks—"mental patients lack insight," are "egocentric," and "cannot take a critical perspective on their own behavior." Mental health professionals may think they're the only ones capable of making sense of psychological experience, but Rufus May gives new meaning to the idea of patients taking over the asylum.

Next to speak is Julie Downs, the (non–voice hearing) administrator of HVN, a post funded by a grant from the British government. She describes the organization's work and the theory that's emerged from the groups they run. Epidemiological studies have shown that about 4 percent of the UK population hear voices—about the same percentage as have asthma—so HVN is under increasing pressure to expand the services it offers. People call the national office in Manchester from all over Britain to find one of the 160 support groups HVN now sponsors in the UK alone. Julie says that the NHS is beginning to refer its patients directly to the network's services. Staff at HVN's national office are themselves the facilitators of several support groups for voice hearers (including one in the Manchester prison and another conducted in Cantonese in the city's Chinatown), allowing them to stay personally attuned to the complexities of running successful groups.

"What we've found," says Julie, "in the fifteen years since HVN's founding, is that people who have strange or frightening experiences like voice hearing need to talk about their perceptions and feelings. This is what helps them learn to cope with what's happening to them. Psychiatrists tell people to

ignore the voices, but this just doesn't work. They're too compelling and too real to the person. Besides, voices often say important things about a person's emotional life. But it's hard to figure out what these messages are, and people are often too frightened by their voices to try to decipher them. Being in a group with other people who've had similar experiences, who accept each other's realities, no matter how strange they are, and who listen to one another in an interested, accepting way can be a lifesaver. The group can help the person understand why the voices are there, what they're trying to say, and how to respond to them.

"At HVN," Julie continues, "we respect whatever explanation a person offers for where their voices come from. People who have unusual experiences need to make sense of them somehow. So they say the voice is from God or a demon or the collective unconscious, or it's being sent through a satellite dish or telepathically. Some people think they're channeling their dead relatives. Others are sure they've got a brain disease. We don't argue with people's explanations. That creates barriers. And it's irrelevant to helping them. We just start where people are. If they want to change their views, we support them; if not, we don't pressure them to think the way we do."

I'm astonished by this approach. I think of all the professional groups that behave in exactly the opposite fashion. Whenever members differ on a key issue, the group splinters. People cut off their relationships with one another and end up in smaller, less effective groups. The history of psychology, psychiatry, and psychoanalysis is littered with bitter splits like these. If HVN has actually figured out how to keep differing belief systems about voices from dividing its membership, no wonder it's growing so rapidly.

The sociology here seems brilliant, but I can't imagine how this openness would work pragmatically. If one person says God is talking to him and another says she hears the voice of Satan, how can they avoid challenging one another? I flash to a famous study in social psychology called the Three Christs of Ypsilanti. Three patients in a Michigan psychiatric hospital, each of whom thought he was Jesus, were brought together to sort out their differences, and Milton Rokeach wrote a book about their confrontations.

But Rokeach's tone was ironic—"Look at these crazy people, trying to deal with the absurdity of their ideas about themselves." Julie Downs sounds nothing like this. She keeps talking about the courage of people in hearing voices groups, who risk speaking openly about intensely private experiences that humiliate or terrify them. The groups sound so obviously useful that I can hardly believe I'm just now learning about them.

The rest of the morning's session passes in a blur. Speaker after speaker—half professionals, half voice hearers—offer research data and personal testimony in support of HVN's philosophy. The person who affects me most deeply is Jacqui Dillon. An intense woman in her late thirties, Jacqui speaks

in the unmistakable accent of London's East End. Her tone is thoughtful and analytic, with the quiet authority that comes from direct experience. As soon as she starts speaking, Dr. Wilcox stops fidgeting in the seat next to me. He takes a gold fountain pen out of his suit pocket and starts taking careful notes on everything that Jacqui is saying.

"I grew up in an atmosphere of confusion and violence that left me with a profound sense of isolation, terror, and shame," she says wearily, clearly having told this story on other occasions. She goes on to describe the years of sexual abuse she endured, starting at the age of three. Her voices began soon after the abuse did. "My voices made me feel less alone and helped me cope with the dangerous situations in which I found myself. Having a voice that sounded like one of my abusers, for example, could prepare me for the next attack." She told no one about the voices even after the abuse stopped.

"The birth of my first child changed everything," Jacqui says. "Holding my tiny, vulnerable daughter brought the past flooding back. The secrets came pouring out of me. I ended up in a psychiatric hospital. When I admitted to the doctor that I heard voices, she told me I needed to take medication. I explained that my voices were parts of me, not something I wanted to be rid of. What I needed was support to be able to hear what they were saying. The doctor looked confused. For her, the fact that I listened to my voices was evidence of my mental illness, and wanting to keep them in order to understand more about myself was evidence of my resistance to treatment. She seemed to focus only on the negative aspects of my voices—for example, that they sometimes told me to do things to hurt myself—but she didn't stop to consider that this might be because of the desperation I felt. She didn't consider the ways that my voices helped to soothe me at three o'clock in the morning when everybody else was asleep, or how their insightful, often witty comments helped me to work out some of the problems I faced."

Jacqui looks around at the audience. She seems fragile, even though her tone is firm. "Just as people often have flashbacks following a traumatic event," she continues, "as they struggle to process overloading and distressing material, my voices kept trying to help me deal with the abuse. Instinctively, it felt wrong to try to medicate them away. What hope would there be for me then? They were messengers with disturbing messages, but why shoot the messenger?

"That first stay in hospital was my last," Jacqui says. "I knew that to be in such a desperate state in such an unsafe environment was potentially lethal. Ironically, the place that was meant to provide sanctuary became the place that nearly drove me over the edge. Fortunately, I had other people in my life who didn't blame me or deny what had happened. They were willing to listen to me and my voices and to provide the support I needed to make sense of what they were trying to communicate to me."

The psychiatrists in the hospital told Jacqui she'd never recover. But arduous work with a psychotherapist and her own painful self-analyses have allowed her to heal from the trauma she endured. "My therapist's support, and that of my closest friends, helped me in the long, difficult process of truth and reconciliation, of listening, bearing witness, and facing the horrors of the past," she says.

"Since that time, I have come to view hearing voices as an adaptive and creative strategy, an example of the persistence of the human spirit to survive in the most extreme circumstances. To pathologize the experiences of people like me," Jacqui says quietly at the end of her testimony, "only adds insult to injury and protects our abusers. People need to know about their cruelty and our resilience. I'm not sick; they are. My hearing voices was a perfectly natural response to the sadistic torment I experienced. Psychiatrists should stop asking, what's wrong with you? and start asking, what's happened to you? That's what we do in HVN support groups."

AFTER LUNCH, conference participants are asked to break up into smaller groups for workshops on specific topics. I'd signed up for How to Help If You're Not a Voice Hearer, which seemed like a safe choice given who I am. I take a seat next to a small man with a shaved head who's dressed in jeans and a light blue hooded sweatshirt. Thirty others crowd the circle, and I long for the security of name tags so I'd have some idea who these people are. Then suddenly the sweatshirt-clad man says in a loud voice, "I'm Andy Phee." His Scottish accent is so thick I can barely make out what he's saying. "I'm a community psychiatric nurse," he continues, "and am cofacilitating today's workshop with Tracy Millar, my psychologist colleague." He motions toward a stylishly dressed woman I'd taken for one of the catering staff.

"We're going to talk about how those of us who don't hear voices can help those who do," Andy says with a big smile, as if the topic is sure to be fun. I've never seen a nurse who looks as scruffy as he does. Why am I finding it so unsettling not to know who people are at this meeting?

For the next hour, Andy and Tracy describe the groups they've helped to organize. Like all the morning speakers, they use no mental health labels: People are "group members," not "patients," who experience "voice hearing," not "hallucinations." Even though nurses, psychologists, social workers, and occupational therapists cofacilitate some groups, HVN meetings are not, Andy emphasizes, anything like group therapy. The mental health staff are not there to "treat symptoms" or encourage patients to take medication or "gain insight" into the fact that their voices don't exist. "We're just trying to create a space where people feel safe enough to talk to each other about their voice hearing experiences," Andy says. "Whenever possible, we try to recruit

voice hearers themselves as cofacilitators so we can keep our own role to a minimum. We're not trying to provide answers. We want to help create a context where we can join with the voice hearers in valuing a diversity of experiences." I can't believe I'm hearing a psychiatric nurse say this, but Andy is only two feet away from me and his message is vivid and clear.

Across the room, Tracy laughs and says, "We professionals often end up being the ones with the least amount of tolerance for diversity. The voice hearers have taught us a lot about being able to bear uncertainty and embrace new ways of thinking."

"But what about people who are dangerous?" a woman a few seats down from Andy asks in a loud, anxious tone. "What if a person in the group says his voices are telling him to hurt someone? You can't just act as if that's his experience and it shouldn't be challenged."

"Actually, something like that happened recently in our group," Tracy says. "A man said his voices were telling him to attack someone else in the group. The potential 'target' was asked how he felt about this threat. He said, 'Oh, I don't think he'll do it.' His reaction defused the whole situation. He was a lot less frightened than I was, and that really taught me something." Tracy's relaxed tone contrasts sharply with the startled faces around her.

"But isn't it your job to make sure that clients are safe?" the anxious woman interrupts again. "I'm a clinical social worker. If I were running a group for psychotic patients like the one you're describing, I'd feel it was up to me to keep people from threatening one another." She looks around, hoping for some reassurance that she isn't alone in having these concerns. Several people nod. "I feel the same way," says a tired-looking man in a rumpled suit. (A doctor who's been on call and slept in his clothes? A psychotic patient who dressed up for the conference? I've given up guessing who people are.)

"Well, first of all," says Tracy in a no-nonsense tone, "Andy and I are not running these groups. We're helping to facilitate them. The meetings belong to the voice hearers themselves. The ground rules are agreed to in advance by everyone involved."

"And remember, they're not group therapy," says Andy. "Thank God," he mutters under his breath. I'm leaning forward, straining to make out what he's saying through the thick accent. Good thing I took that vacation in Glasgow; otherwise, I'd be getting only every fifth word.

"The most important thing I've learned from my work with HVN," says Tracy, pausing and looking around the circle to make sure everybody gets this, "is that people can take care of themselves. It's not up to me to jump to conclusions about whether they're dangerous or not. Even patients with a long psychiatric history can rise to the occasion better than most staff think they can."

Andy interrupts. "As mental health workers, we often focus on the worst

possible scenarios," he says. "We spend so much time filling out 'risk assessment' forms that we can't help thinking of patients as dangerous. But it turns out that most voices aren't about homicide. They're often about mundane details of daily life, and it's helpful to people to understand them better."

TWO HOURS LATER, in the back of a smoky pub called the Rising Sun, I look with amazement around the table where I'm sitting with Andy and Tracy and many of the other conference speakers. After weeks of trying to find a way into the Hearing Voices Network, here I am, surrounded by people from every part of that world, who are taking turns buying me pints of Adnams ale and inviting me to visit their support groups. I know this is a turning point. But I had no idea how profoundly that conference would change my core assumptions. "Beyond Belief," they'd titled the meeting. Indeed it was.

How can people whom psychiatrists routinely dismiss as "egocentric" and "incapable of taking the role of the other" be organizing support groups to help one another cope with psychological problems? How can people diagnosed as schizophrenic, with very serious symptoms like hallucinations, be recovering without help from professionals? I walk slowly home to the flat in Bloomsbury where I am living, struggling to come to grips with the extraordinary ideas I've been hearing. How can there be 160 HVN groups in Britain and dozens more in countries around the globe without my ever having heard of them? Foundational ideas in my field are being challenged by the very people said to "lack insight." How can this be? They are hearing voices, but I am the one listening. I write down everything I can recall from my conversations at the pub and during breaks at the conference itself and resolve to journey as far as I can into this intriguing and disturbing new world.

3.

THE NETWORK

FROM MY OFFICE AT THE UNIVERSITY OF LONDON, it's only a short ride on the 168 bus north to Camden Town. The bus stops outside a cavernous pub called the World's End, and I follow the instructions I've been given to the day center down the block, hidden behind Sainsbury's supermarket. This week's meeting of the Camden group has already been in progress for almost an hour. I'm being allowed to sit in for just the last ten minutes.

The meeting is in a small conference room. A dozen people sit on beat-up brown plastic chairs, snacking on juice and chocolate biscuits. The muffled sound of the door buzzer seeps in from the lounge next door, where staff fight a losing battle to differentiate their "clients" from the hordes of others acting strangely in this famously eccentric neighborhood.

I slip quietly into an empty chair, nodding to Andy Phee, the psychiatric nurse who invited me to today's meeting. Andy smiles and says, "This is Gail, the professor I told you about. I met her at the Beyond Belief conference many of us went to last month. She wants to learn about voices and what we do here in the group." I thank everyone for letting me visit and then sit quietly, hoping I won't have to say much. I'm uncertain how to act and don't want to get off on the wrong foot with HVN.

Alan, the small man with jet black hair and a tapping foot who I happened to sit next to, is first to speak. Despite a somewhat disheveled appearance, his posh accent suggests a middle-class upbringing. "My voices like to play games with me," he confides in an urgent tone. "They tell me I shouldn't stay in my flat or that drinking Guinness is bad for my health. I shout at them, which keeps them quiet for a while. But I can't keep doing that, because the neighbors report me to the police. Last time that happened, I was locked up for weeks."

Polly, a heavyset woman in a torn, ill-fitting dress who'd kept her eyes closed even during my greeting, suddenly interrupts him. "My voices don't

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Polly, a heavyset woman in a torn, ill-fitting dress who'd kept her eyes closed even during my greeting, suddenly interrupts him. "My voices don't

talk directly to me," she says, shaking her head. "They converse with one another, usually about world events. I just listen. It frightens me to hear these people talking to each other inside my head. I don't even understand half of what they're saying."

Several people nod sympathetically. HVN meetings are the only place it's safe to talk about weird experiences like this. Everywhere else—with family, on the street, with their psychiatrists—people who hear voices can't risk revealing what's happening inside them. But here, they know they'll be treated with respect no matter what they say.

Polly shakes her head again. "I've never told anyone about this before today. When I was in hospital, I could barely move. I was practically comatose for a few weeks. I could hear the voices talking from a long way off. I never told the doctor any of this. He would just have given me more of those horrible tablets, the ones that did nothing but make me gain weight. Boy, they were something—you didn't have to eat at all with those pills. You just swallowed them and the pounds piled on."

Andy asks how many people have ever discussed their voices with the doctors, psychologists, or nurses who've treated them. "Are you kidding?" Alan laughs. "We may be crazy, but none of us is that dumb." His tone, like that of many of the patients in madness narratives I've read, is both ironic and sad.

A few weeks later, I attend the meeting of another hearing voices group. This one is in far southeast London, and it takes me more than an hour to reach the Tower Hamlets neighborhood. Tucked in back of a bedraggled church on the main shopping street, I find the blue door and tiny sign for Beside, the peer support organization sponsoring this group. I haven't even pressed the buzzer when a voice greets me through the intercom. It's a good thing I'm not paranoid, I think as the door swings open and yet another closed-circuit television camera registers my presence before I've even said a word. These days in Britain, no action goes unobserved.

A wall of smoke hits me as soon as I enter the small meeting room. Cigarettes are the only pleasure permitted on locked wards, so support groups for mental patients are among the few remaining havens for chain smokers. I take a seat next to a woman in her sixties who's dressed in a ripped skirt and sweater that look like something she rescued from a rubbish bin. Jacqui Dillon, the voice hearer whose testimony so moved me at the Beyond Belief conference, is the cofacilitator of this group. She smiles and says, "So, Gail, why don't you tell everyone why you've come?"

I hadn't expected to speak and fumble an answer about wanting to learn more about how HVN groups work. I'm not sure how to present myself. Jacqui says, "I mentioned your coming earlier in the meeting, and we agreed to take some time to talk with you." Clearly, I'm not going to be able just to sit in quietly, the way I did with Andy's group. "Uh, sure," I say, trying to think

of how best to explain my visit. "I'd be interested in people's ideas about where voices come from."

A man who says his name is John begins to speak, and I smile gratefully at him. "I hear five voices," he remarks. "Three of them are people I know; the others are strangers. I think God sends them to help me out." He's in his forties, wearing a T-shirt, jeans, and a smug look. "I've learned a lot from my voices." He winks lasciviously. "Maybe later I'll tell you more about what they say." I read the poster on the wall opposite—"You're just jealous because the voices are talking to me"—and say nothing.

"Oh come on, John," the woman beside me bursts in. "Don't fuck with her." She flashes me a smile. "He had a bad experience on a psychology course. Professors aren't his favorite people."

"Mine, either," I say, and John starts laughing.

"I'm Dorothy," the woman says. "My voices taunt me, like the bullies at school did. 'You smell, you smell, you smell,' one kept saying yesterday." She pauses and lights a cigarette. I slide back in my seat, trying not to inhale her smoke rings. "I think it's that I feel lonely," she says pensively. "When I go home all by myself, I have no one to talk to. That's when the voices appear."

I sit in stunned silence, wondering how it could be a standard assumption among mental health professionals that patients like Dorothy "lack insight" into their actions and feelings.

A very dark-skinned man in the corner, who'd seemed to be sleeping, suddenly looks at me intently. In a soft Jamaican accent he says, "My voices are different." I ask what he means. As he reaches for the mug on the table next to me, I see that his entire arm is covered by a skull tattoo. "Well, I don't really think about my voices in terms of psychology," he says, smoothing his mustache and taking a sip of tea. "Philosophy seems more relevant. You know about Socrates' daemon, don't you?"

SOON AFTER THESE VISITS TO LONDON SUPPORT GROUPS, I take the train to Manchester to visit the national office of HVN. The organization is proud of its origins in the north of England, and it is still strongest in that region, not in London. I leave the gleaming glass and steel rail station—one of many self-conscious symbols of Manchester's modernist reinvention of its nineteenth-century industrial self—and walk a few blocks down Piccadilly, as I'd been instructed. Shoppers crowd the sales; businessmen rush toward the station, yelling into their mobile phones. Five minutes later, I reach Old Street, in the center of the busy commercial district. Next door to the T-shirt man ("Your message on any shirt!") is a storefront office emblazoned with a big sign, "Welcome to the Hearing Voices Network."

Julie Downs, the administrator I'd met at the Beyond Belief conference,

greets me with a big hug. "Great to see you here in our own space!" she says, leading me past desks and computers to a meeting area at the back of the office. "This is Gail, the American psychologist I was telling you about," she announces to the people scattered about.

"I'm Jon Williams," says a tall man whose thick black mustache and eyebrows accent a well-shaped head of curly gray hair. "We're just having a cuppa. Want some tea yourself?"

"Yes, thanks," I say. "It's great to be here. I appreciate your inviting me."

"No problem," says another man, dressed in a crumpled shirt and torn trousers that might once have been part of a suit. "Just be careful you don't catch something," he cackles, passing me a package of McVitie's, my favorite chocolate biscuits. "There are a lot of crazy ideas floating around this place."

"That's why I'm here," I laugh.

Jon sits me down for an orientation session, summarizing HVN's history and his involvement in its activities. "My first admission to a psychiatric hospital was on April 19, 1985, at 5:45 p.m.," he says. "Everything changed after that."

For the next half hour, Jon tells me about his years in the mental health system. Nothing he tried—stays in the hospital, medication, newer methods like CBT (cognitive behavior therapy)—reduced the intrusive voices he heard constantly. "The nurses on the ward organized Scrabble games to distract us," he laughs. "That helped about as much as the meds." Only when Jon discovered HVN did he start to get better. "The people in the group knew exactly how I felt. No doctor or nurse could match that, no matter how many degrees they've got hanging on their walls."

Five other people tell me stories like this. Mickey deValda, one of the founders of the Manchester support group, says, "Being called a schizophrenic made me feel that I wasn't a regular person, that I was expected to be violent and dangerous. So I became that person. Doctors see things too literally. They don't connect symptoms to a person's life experience. I felt much more in control and less dangerous when I started to understand how my mind worked instead of seeing it as a chemical machine whose operations were mysterious." Julie nods. "What I've learned over and over again here at HVN is that if people get a chance to explore their feelings and be less isolated, their experience doesn't have to become so distorted. One of the main benefits of being in a support group is that we break down this isolation and keep voices from turning into a more debilitating life problem."

Two hours later, laden with pamphlets and copies of HVN's newsletter and articles from the UK media hailing the group's accomplishments, I leave the office. I'm surprised to see twenty people standing on the sidewalk just outside the door. Some are reading the display in the large picture window. Are they members arriving for a meeting? Or are they there to protest the group's

work? I wonder if this happens a lot. Then I see the sign—it's a bus stop. How many people has HVN educated about voice hearing simply by virtue of having an office in the middle of one of Manchester's busiest shopping streets?

I DON'T WANT MY UNDERSTANDING OF HVN GROUPS to be based only on quick first impressions, so I ask Andy Phee if I can come to another meeting of his group. He says he'll ask the members. Every other facilitator I approach over the next four years says the same thing. The democratic character of HVN groups is crucial to their structure. Even when nurses like Andy are cofacilitators, they never have complete control, the way they would in a standard therapy group. At HVN, it's up to the members to decide who gets to attend meetings.

I'm invited back to Andy's group for a second visit. I slip confidently through the gate leading to the day center, recalling from last time how to negotiate the lock that keeps people who are looking for a place to shoot up from getting in. As soon as I enter the lounge, I see Polly, the woman whose voices discuss world events. "Hello, Professor," she says warmly, sliding over to make room for me on the battered couch she's sprawled out on. She takes a deep drag on her cigarette, and smoke curls through the thick air, mingling with rancid smells from the kitchen and the sweaty bodies slumped in nearby chairs. Polly brushes ashes off her shirt and asks, "How's your book goin'?"

"Okay," I say, surprised that she remembers what I said months earlier. "Writing is hard. I'm just trying to keep going." Could she sense how conflicted I felt at the moment? I'd spent the whole week struggling to figure out where to place myself in the narrative. Who am I exactly? An observer? A witness? A critic? An advocate?

I'm trying to take advantage of my unusual vantage point—a sympathetic outsider, neither practitioner nor patient. The last thing that people who've had their deepest feelings turned into symptoms need is someone else analyzing them. No matter how empathic I might be, every description is interpretive, and whatever I write imposes a frame on the event that wasn't there originally. In the politics of the mental health world, every framing is political; there's no neutral ground to stand on.

Polly takes a swig of tea and clears her throat. "Will I be in your book?" I can't tell why she's asking this.

"Maybe. Would you like to be?"

"Definitely," she says, winking slyly. "Those voices might as well be good for something."

Andy Phee sweeps in and announces the start of the meeting. Several people stub out their cigarettes and follow him next door to the conference room. Polly says, "See you later," and picks up the newspaper. I'm surprised

she's not joining us, but don't say anything. Whether people attend is their decision.

After reminding everyone of the ground rules of the meeting (confidentiality, no violence, respect for a diversity of viewpoints), Andy asks each person how his or her week has been. Barbara, a gaunt woman in her late fifties with long, scraggly gray hair, is wearing a dirty black knit dress covered by a red wool coat, both of which are too heavy for today's hot weather. She says, "I'm doing better, thanks to all of you," and smiles wanly at the group. "Until I came here last week, I hadn't been out of my flat for eighteen months. That voice just tormented me twenty-four hours a day. I felt powerless to escape it. But the stuff people said last week about telling the voice I'll only listen to it at certain times really helped."

"Wow. That's great," says Andy. "Did you feel less overwhelmed, like it was less present?"

"Yeah," says Barbara. "I just put that voice on ice. I stuck it in the fridge. Just put it on ice." We all laugh. Barbara smiles and shrugs off her coat. "I only took it out when I felt like it."

Andy starts talking about the importance of establishing a relationship with the voices. "They need to listen to you, not just order you around," he says. Barbara leans forward, her hair falling across her face, practically obscuring it. "People call me the Mad Witch of Kilburn," she'd said when we met in the lounge earlier, and she certainly looks the part.

"I think there are a lot of levels to this voice hearing business," Barbara says pensively. "I mean, think about somebody like Virginia Woolf." She straightens up, smoothing her hair. "She took the voices she heard and turned them into characters in her novels. They ended up being of use to her."

Suddenly Barbara sounds like the well-read middle-class woman she probably once was. "Have you ever read Jung's autobiography, *Memories, Dreams, Reflections*?" I ask. She shakes her head. "He talks a lot in that book about his own voices and visions and how they helped him develop some of the key concepts in his theory of personality." Barbara extracts a scrap of paper from the frayed cotton bag she'd slung over her chair and carefully writes down the title of the book. "I'd like to write a novel myself, drawing on my experiences," she says. "You come up with a lot of unusual ideas when you spend as much time alone as I have." Her demeanor has changed completely. She even looks different. Suddenly, I feel like we're at a seminar, not a mental patient support group meeting.

"I tried talking back to the voice, as you'd suggested last week," she says to Andy. "But that didn't work for me. It made me feel even more stuck there with it—like it was just him and me. Pushing it away for a while was better. I stuck it in the fridge and tried to forget it was there.

"Just coming to the group last week helped, too, I think." Barbara closes her eyes and sits silently. No one interrupts her reverie. "When you spend months alone, totally isolated, as I did," she says quietly, "you start to lose the ability to talk to people. It was just me and the voice, locked up together in my room." She looks intently at me. "Being here at these meetings is a lot better." I nod and write down what she just said. "Hope you're telling people in America about these groups," she says. "That's my goal," I say, tapping one of the small red notebooks I now carry everywhere.

Moazzem, a tiny man with coffee-colored skin and short, graying hair who Andy later tells me is a Kurdish refugee from Iraq, suddenly bursts in. His tone is insistent; he's sitting at the edge of his seat. I can barely understand what he's saying—his English is limited, and he's talking in a very soft monotone, repeating the same phrases over and over. "Is better me too. Voice not tell me walk front of car."

Andy says to him, "I'm so glad you came back to the group. You were feeling pretty desperate the last time you were here, weren't you? What was that, about a month ago?"

"Yeah, yeah," Moazzem says, nodding vigorously. "Very weak then. In bed, couldn't get up. Voices attack most when I weak. They, how you say, bullies."

"What helped you start to feel stronger, more in control, so you could stand up to the voices a little more?" Andy asks.

"Come here helps. Being in group like recharging mobile phone. I plug in and get stronger, more energy from others. Music also good. Makes me feel not so alone."

"What kind of music do you especially like?" Andy asks.

"Beethoven," says Moazzem.

4.

MAVERICKS IN MAASTRICHT

HVN OWES ITS EXISTENCE to the power of television. One day in 1986, viewers in the Netherlands who tuned in to a popular TV talk show found an unusual pair of guests—a soft-spoken psychiatrist named Marius Romme and his patient, Patsy Hage. Years later, I watch a clip from the show, dubbed into English for a British audience. Romme is warm and reassuring, with sparkling blue eyes and a lush shock of white hair, the perfect image of the good doctor. Patsy is articulate and focused, nothing like a stereotypic schizophrenic mumbling incoherently to herself. Romme talks about his frustrations as a psychotherapist. For weeks, Patsy has been in a deep depression, at times suicidal. Nothing he's tried has worked. Angry voices torment her, and she seems more convinced of their threats than his reassurances. They're appearing on the talk show in a last desperate effort to find something that might help her.

When Patsy first entered treatment, Romme says he took the standard psychiatric view, seeing her hallucinations as the symptom of an underlying psychosis. But Patsy kept insisting her only problem was the voices. She told Romme, "Forget about whether or not I have schizophrenia. Help me with the voices. That's my problem." It had never occurred to Romme to think like this. "I was trained to understand voices as a symptom," he says, "so I was only interested in categorizing whether or not they were hallucinations." But Patsy, a thoughtful mother of two children, reported no other symptoms and talked only of the voices themselves.

Romme had read a book called *The Origin of Consciousness in the Breakdown of the Bicameral Mind,* in which Princeton psychologist Julian Jaynes made the provocative claim that in an earlier period of human history, everyone heard

voices. What we now consider thought, Jaynes argued, was once externalized so that it seemed to be coming from outside us. Romme loaned the book to Patsy, and it had a powerful effect on her. For the first time, her own mental life didn't seem so bizarre; at least at one time, voice hearing had been a common phenomenon.

But when Patsy's voices began forbidding her to leave the house and commanded her to kill herself, Romme knew he had to do something more active. During one of their sessions, Patsy yelled at him, "Why do you believe in a god you cannot see, but call the voices I hear every day unreal?" Romme began wondering the same thing. Then he had a strange thought. What if Patsy met someone else who heard voices? Might they understand her better than he did?

He brought her together with several other patients and sat quietly at the back of the room as they talked together. This was a highly unusual thing for a psychiatrist to do, but Marius Romme is no ordinary practitioner. And his experiment had an immediate benefit. The Patsy who had sat silently for so many weeks, who had insisted that no one could grasp how she felt, was now chatting animatedly with two women who also were struggling with voices. Romme decided that a larger meeting of voice hearers might foster even more useful exchange. Watching Patsy with his other patients, astonished by how openly they talked with one another, made him wonder whether voice hearers as a group could help each other to cope better. Romme's partner, science journalist Sandra Escher, got the host of the talk show interested, and Romme and Patsy agreed to appear as guests in the hope that a TV appeal might help to locate more such people.

They're like a Dutch version of Freud and his patient Anna O. being consulted as experts on the talking cure. Patsy talks movingly about being terrorized by an abuser trapped inside her own mind. Romme says that psychiatry has no answer to the problem of voice hearing and appeals to those who are watching to call in if they've had experiences that might help people like Patsy. The show's host announces that Romme and Escher are planning to organize a World Conference on Voice Hearing. She encourages anyone who's interested to contact the station for more information. The moment the show finishes, the phones start ringing. Over the next few days, 700 people call in, 450 of whom say they are voice hearers.

A special interviewing service has been hired to answer the phones. Each person is asked several questions: Have you yourself ever heard voices? If so, how do you cope with them? Would you like to attend the world conference? Anyone who says yes is asked for his or her name and address.

The callers who identify themselves as voice hearers are then sent a detailed questionnaire that Romme, Escher, and Patsy Hage have constructed

together. Some of those who say they cope well with their voices are intensively interviewed and invited to be speakers at the upcoming conference.

What immediately stuns Romme is that a third of the 450 voice hearers say they've never had any connection to the mental health system. They haven't seen psychiatrists or been diagnosed with schizophrenia. Yet they hear voices on a regular basis. How is this possible? Aren't auditory hallucinations a sure sign of mental illness? How can there be so many people living normal lives, yet hearing voices?

Romme starts posing research questions: Are these "nonpatients" having the same experience as people who've been institutionalized? Are they "hallucinating" as psychiatrists define it? Do they have ways of coping with their voices that can be taught to patients who feel overwhelmed?

In October 1987, the World Conference on Voice Hearing is held in Utrecht. For the first time in history, 250 people who hear voices meet together, along with about 50 family members, nurses, and mental health professionals. Romme wants to see if patients like Patsy can learn something from people who've figured out how to cope on their own. This was why he had agreed to appear on the TV show in the first place. Once he'd seen how helpful it was for Patsy to meet other voice hearers, Romme became convinced that as a group, voice hearers might be able to help one another in ways that psychiatrists couldn't.

At the conference, people share their experiences and their interpretations of voice hearing. Although some participants identify themselves as mentally ill and are very troubled by their voices, others present a picture of leading competent, healthy lives as voice hearers. No longer suicidal, Patsy is one of the main speakers and helps to found a follow-up group called Resonance. It becomes an organizing framework for Dutch voice hearers, sponsoring small groups in different locations to offer ongoing support and advice on ways to cope. Within a few years, these groups start meeting together, holding regular conferences and training sessions, and word spreads. After centuries of stigma and isolation, people who hear voices apparently have a lot to say to each other.

Still astonished by having discovered so many voice hearers who aren't mental patients, Romme starts looking at the literature to see if there are any studies of hallucinations in the general population. It turns out that several large-scale surveys have been published (none of which he'd ever seen cited by psychiatrists). As early as 1894, Henry Sidgwick and his colleagues had conducted a "census of hallucinations" based on interviews with seventeen thousand adults, primarily in England. Each person was asked, "Have you ever, when believing yourself to be completely awake, had a vivid impression of seeing or being touched by a living being or inanimate object, or of hearing a voice; which impression, so far as you could

discover, was not due to any external physical cause?" After carefully eliminating false positives from their final figures (for example, images occurring right before sleep or immediately after awakening), Sidgwick and his team reported that almost 10 percent of their sample had experienced hallucinations.

A century later, Johns Hopkins researcher Allen Tien used epidemiological data gathered between 1980 and 1984 on adults in New Haven, Connecticut; Durham, North Carolina; Baltimore; St. Louis; and Los Angeles to examine the prevalence of hallucinations in the US population. Initial interviews were conducted with 18,572 adults; a year later, 15,258 members of the original sample were reinterviewed. On both occasions, participants were asked, "Have you ever had the experience of seeing something or someone that others who were present could not see—that is, had a vision when you were completely awake?" As in the Sidgwick study, those who said yes were asked an additional set of questions to determine the nature of their experiences and whether they evidenced psychiatric symptoms. Tien found that "a substantial proportion of the population reports experiencing hallucinations, with prevalence at least 10–15%, and annual incidence 4–5%." Yet only a third of those who reported having hallucinations met the National Institute of Mental Health's criteria for a mental illness.

Two studies conducted with college students in the 1980s extended these findings, and a 1992 replication assessed participants for "tendencies toward psychopathology." The results were again striking: Hallucinators were no more likely than nonhallucinators to show evidence of psychiatric difficulties.

Romme can hardly believe what he's found—a whole body of research suggesting, as the TV show had, that voice hearing is a common human experience that cannot, in and of itself, be considered a symptom of mental illness.

He starts refining his research questions. If voice hearing isn't necessarily pathological, what makes it so intrusive and frightening for people like Patsy? Why do some people feel tortured by their voices while others welcome them as inspirations or guides to better living? Why do some people cope well with their voices, but others find them overwhelming?

At the world conference in 1987, voice hearers who'd been mental patients reported that psychiatrists never asked them what the voices were saying. "As soon as I answered yes to the question, do you hear voices," patient after patient had told Romme, "the doctor just started talking about which medication might get rid of them." Romme knew this was because psychiatrists wanted to avoid "colluding" with the patient's delusional system. But everything he'd witnessed since that day he sat listening to Patsy talk to his other voice hearing patients pointed to the opposite conclusion—encouraging patients to explore their voices seemed to help them.

As a first step in developing a new way of working, Romme and Escher collaborate with Patsy Hage to develop a systematic clinical interview that mental health professionals can use to learn more about their patients' voice hearing experiences. Research teams in Britain and the Netherlands conduct intensive studies of the two groups of voice hearers who'd called in after the TV show—those who coped well with their voices and didn't become psychiatric patients and those who experienced greater distress and ended up in the mental health system. This research is revolutionary: Never before has voice hearing been studied as an experience in its own right and not simply as a psychiatric symptom. Over the next fifteen years, Romme and Escher's empirical reports appear in prestigious publications like the *British Journal of Psychiatry* and *Schizophrenia Bulletin* and attract the attention of the popular media. Findings from all of their studies are remarkably consistent: Hearing voices per se is not pathological; it's only when a person doesn't know how to cope with the experience that it gets diagnosed as psychotic.

The "good copers," as Romme and Escher dubbed the nonpatient group, seem able to set limits to their voices, listen selectively to them, and talk with others about their unusual experiences. In contrast, those who cope poorly and become psychiatric patients feel too frightened or powerless to stand up to the voices. They keep their experiences secret and often desperately try to escape their voices by sleeping, playing loud music through headphones, or otherwise distracting themselves.

Since so many people—both patients and nonpatients—say that their voices appeared early in their lives, Escher and her colleagues conduct a specific study of voice hearing in children. Eighty children ranging in age from eight to eighteen are interviewed repeatedly over a four-year period. Half of the children are receiving mental health care when the study begins. Many, like Jacqui Dillon and Carol North (the author of *Welcome, Silence*), have been tormented by voices from a young age. These aren't the imaginary playmates of ordinary children; they're hallucinations, as psychiatrists define them. Like adult voice hearers, most of the children in Escher's study report that they first heard their voices after a trauma (sexual abuse, bereavement, illness, parental divorce).

In a striking challenge to the traditional view that voice hearing is a sign of long-term mental illness, 60 percent of Escher's participants are no longer hearing voices by the time the study ends (and more have stopped hearing them since then). "We found that children can learn to cope with their voices as long as they are not made to fear them," Escher says. "The key is to help them understand what first triggered the voices so they can learn to control them."

Romme and Escher's studies show that the actual experience of voice hearing is surprisingly variable—for different people and even for the same person over time. But it's always qualitatively different from thinking aloud or talking to oneself. The voices are experienced as coming from other people, from birds or other animals, or from the TV, radio, or other objects. Many voice hearers say that the sounds come through their ears and are indistinguishable from the voices of people consensually agreed to be sitting in the same room. Others say the voices come from the space around their heads or from inside their skulls. For some people, the location of the voice or voices is quite clear; for others it's indeterminate. The voices may sound like they come from passing traffic or the rustle of leaves or like they are being generated by machines. But regardless of where they come from, they seem to come and go as if they have a life of their own.

These distinctive qualities of *voices*—as opposed to thoughts, inner dialogue, rumination, or dissociation—are present whether the voice or voices come occasionally or last for years. Voices give advice, threaten, swear, or inspire. They tell people to do things they may or may not want to do. Voices can be loud and articulate or barely audible, like a radio turned down to low volume. They can be accompanied by whispers, mutterings, or humming. They can incorporate strange noises—ticking or clicking, bits of melody, or the far-off whoosh of a seashell held up to the ear. Voices can be male, female, or a mixture of both; people often can't tell the gender of their voices, even after years of hearing them. They may sound as if they are coming from young children, or they may be robotic and machinelike. The voices may sound like someone the person knows now or in the past, or they can be totally unfamiliar.

Some people hear their voices only in certain contexts; for others, they are a constant presence. Some voices speak the person's thoughts out loud, or two or three voices argue or provide a running commentary on the voice hearer's behavior. Some voices issue commands. Some make threats or repeat a certain word or phrase. But whatever they sound like, voices compel attention—hearing them is too powerful an experience to be ignored.

People's responses to hearing voices are hugely variable, depending on what the voices say, how often they say it, what tone they use, and how intrusive they are. Most people are confused or frightened, at least at first. Others are angry at being singled out. Others feel special for having been chosen for such a mystical, otherworldly experience. Voice hearers may see themselves as mediums or clairvoyants. Or they may be convinced they're having a breakdown. If the voices are commanding or unrelenting, it may ultimately prove too exhausting to resist them.

Some neurobiological research suggests that the brain regions active when voice hearers "hear a voice" are similar to the ones responsible for the perception of direct speech. But the perceptual bases of voice hearing are complex

and difficult to pin down. It's easy to induce "pseudohallucinations" in normal people, manipulating laboratory conditions to get them to report hearing a sound, noise, music, word, brief phrase, or whole conversation that is "not there." There may even be a biologically adaptive reason for our capacity to be superalert to sounds with survival significance. Parents, for example, often hear the sound of a baby crying when water pipes expand or the wind whistles outside a window. Having our thresholds set so low, however, means that we can easily confuse background noises with the sounds we are listening for.

Regardless of whether voices are frequent or rare, vivid or faint, a threat or a comfort, people who hear them struggle to find an explanation for what's happening to them. The experience is just too unusual not to speculate on its cause. People use whatever frameworks are most familiar or comfortable for them. Some think voices are spirits—of dead people, demons, angels, or God. Others think the voices are telepathic communications from another dimension or that there's something wrong with how their brains function.

Once people latch on to a spiritual, mystical, or biological explanation for their voices, their response to them follows logically from that premise. They may become more religious or consult a doctor, priest, or healer. They may try to cultivate their capacity to hear voices if they see this as conferring special status (for example, by becoming a professional medium). Thinking that voices come from the collective unconscious or a spirit or a reincarnated being is likely to make a person feel connected to others. Taking a biological view, on the other hand, usually leaves people feeling isolated, pessimistic, and frightened. Believing that they have a brain defect or a chemical imbalance or a mental illness implies that they are powerless to do anything about their situation and must turn themselves over to the ministrations of physicians.

MARIUS ROMME doesn't see himself as a radical. And he's certainly no ideologue. His revolutionary approach to voice hearing emerged directly from the findings of the studies he's conducted. Research and teaching—he was one of the founders of the University of Limburg's medical school and taught there until his retirement a few years ago—have always been the main focus of Romme's work. Throughout his career, he's reserved at least a day a week to treat patients like Patsy Hage, but he thinks of himself more as a scientist than a doctor.

In the United States, the only psychiatrists who are considered scientists these days are those who define mental illness in neurobiological terms.

Since the 1970s, American psychiatry has increasingly narrowed its focus b first rejecting psychoanalytic ideas and then, in the past decade, any way c thinking about emotional distress that emphasizes family or cultural factor "Mental illnesses are biologically based brain disorders," says the Nationa Alliance for the Mentally Ill, the huge US organization that calls itself th nation's voice on mental illness. Today, it's rare to find an American psychia trist even willing to acknowledge another way of understanding psychologi cal problems.

But in places like Britain, Germany, and the Netherlands, social psychiatr remains a potent force. Emotional distress is assumed to result from famil crises, racism, poverty, sexual abuse, war, or terrorism. Unknown neurologi cal defects or "chemical imbalances" aren't given nearly as much prominenc as they are in the United States. Social psychiatrists don't minimize the rol of the brain in mental life; they just think it's silly to insist on hypothetica genetic or physiological causes for emotional problems (few of which have ever been found) when the effects of trauma are so readily apparent.

For Marius Romme, conceiving mental health in social terms comes naturally. His father was the Dutch government's Minister of Social Affairs in the 1930s and after World War II became leader of the Roman Catholic National Party, the largest political party in the Netherlands until the 1960s. Carl Romme saw poverty as a key cause of both physical and mental illnesses, and he considered it the government's duty to foster self-determination in its citizens. Dinnertime discussions throughout Marius's childhood were filled with animated talk of social policy. Could money solve social problems? Was it better to take care of people or give them the tools to help themselves? Marius's maternal grandfather owned a bank, and his mother took for granted that money created opportunity. But it was his father's public commitment to helping people emancipate themselves within a supportive social structure that most powerfully influenced him. Marius became a doctor less to treat sick people than to help redefine illness as misfortune.

IT'S SANDRA WHO MEETS ME at the train station. Maastricht isn't a tourist destination and few people are around on this Monday afternoon, so we spot one another just as I step outside the building. I'm touched that she and Marius have invited me to their home, but the June weather is sweltering, nothing in Holland is air-conditioned, and I've jammed this visit into a packed trip of archives and interviews. Spending two days with people I once met briefly at a conference suddenly seems like it might be far too long a visit.

Sandra's cheerful matter-of-factness during our short ride to their home in Fouron-le-Comte, just over the border in Belgium, soon puts me in a better mood. She and Marius are just back from a relaxing stay at their getaway in Cyprus, and the three of us spend most of the next forty-eight hours sitting outside on their patio, eating an assortment of cold meats and cheeses, and chatting about voice hearing. We barely know one another, and no natural affinities emerge to move our collegial discussions toward the personal. But their lack of pretense and our shared respect for the courage of patients like Patsy Hage create a sense of solidarity among us. We're allies, our professional backgrounds key to the skills we can offer.

Marius and Sandra—admirers in HVN always pronounce their names together in a rush, as if they were all one word—had each been married to someone else when they met twenty years ago. Now it's hard to imagine either one without the other. Their charm, willowy good looks, and obvious happiness together are so at odds with their unorthodox ideas that people often find themselves taken in by a viewpoint they would never otherwise have considered. Sandra epitomizes the frank open-mindedness for which the Dutch are famous. Marius has the elegance and charm of an elder statesman. When he twinkles his cobalt eyes and she smiles that broad grin, they're irresistible.

On the second day of my visit, Sandra and I drive into Maastricht's historic district. We have coffee at an outdoor café in the central square, chatting companionably about Dutch history and our mutual travels in England. The heat has eased enough to enjoy a stroll, so we wander through the nearby streets, footsteps echoing on the ancient cobblestones. People hurry into shops before they close. Suddenly, Sandra stops outside a small row of stone houses. She knocks on the door at the corner.

"One of the children in my voices study lives here," she says, backing up across the narrow street to see if anyone is visible through the apartment window. "Guess no one's home. I just wanted to say hello. This girl is one of those with a good outcome. My fellow researchers and I are very happy to see how much better she is feeling now as compared to two years ago. When we first met her, she couldn't leave the house. Now she's back in school and the voices are no longer a problem. Instead of ending up at a residence for disturbed children, she's here at home with her family, back in the class she'd been in before." I stare at the door, hoping she'll appear so I can talk to her myself.

I'm not surprised that Sandra knows the girl's house. Dutch psychiatry is far more deeply rooted in the community than we in the United States can even imagine. In the Netherlands, a collaborative team of doctors, nurses, and social workers works directly with patients and their families. The psychiatrist is not in charge; their structure is far less hierarchical than ours i The team meets regularly with patients, and often in their homes, not f ten-minute monthly medication monitoring appointments at an office like i the United States.

"It's not a diagnosis that gets you into a mental hospital," says Marius lat that evening, "it's your behavior in a conflictual situation. If the team ca help to solve the conflict, the person doesn't have to be sent away. When I wa in training as a psychiatrist in Amsterdam," he smiles, the memory still fond one, "I used to go to people's houses in the early evening. I'd ring th bell and say, 'I've heard there's a problem here. I'm a doctor. Can I help Since our whole approach focused on community mental health, and w actually had very few beds available to hospitalize someone, we'd try to ge the family to talk through the problem."

He pours me a cup of tea and sighs. "We'd tell people we understood th pressure to send someone off to hospital when the conflicts became to much for everyone. But we'd try to get them to see that this wouldn't actuall resolve anything. If the patient was very agitated, I might give them a shot t calm them down. Then I'd come back the next day. Psychosis is an emotio in a time span. The person who is psychotic is expressing themselves in a wa that nobody else understands. So then you get anxiety and aggression. You have to show that you can talk to someone even when they are very disturbed For instance, I might try to get them to promise not to do anything drastic before I returned with more help.

"The next morning, I'd get up early and meet with my colleagues. We would discuss what to do, how to solve the problem, ask whether it was really necessary to hospitalize the person. Then we'd decide whether I should be the one to return to the family or might it be better if some of the nurses went instead. We weren't afraid of people who were psychotic. If you're afraid, you consider too few options. Hospitalization isn't a solution; it's just a way of getting rid of the problem." As I sit listening to Marius speak so matter-of-factly about ideas most psychiatrists would consider heretical, I fantasize about his addressing the American Psychiatric Association or some similar body. Would his US colleagues boo him off the stage? Or would they simply see him as a crackpot who'd spent too much time listening to mental patients?

At the end of my visit, Marius drives me to the airport in his BMW convertible. We can't talk much as the wind roars across the flat landscape, but I don't mind. My head already feels too crammed with ideas from our hours of conversation. Suddenly, the sky darkens and we're pelted with raindrops. Marius speeds up. "If we go fast enough," he yells, laughing, "we won't get wet." I spend the short flight back to London reading through the pages

and pages of notes I've taken, trying to nudge my thoughts onto unaccustomed paths.

WHEN ROMME FIRST BEGAN HIS RESEARCH, he thought about hallucinations much as other psychiatrists did, as evidence of a disease process, a symptom to be removed. But the more he listened to Patsy and other voice hearers, the more he realized how destructive it was for patients to be told that their voices were alien intrusions whose messages were gibberish. That just made people feel estranged from their own minds. And trying to block out the voices made it impossible for them to notice variations in intensity or intrusiveness in different situations. They weren't able to identify the triggers that made the voices worse and try to gain more control over them. And ignoring the voices prevented people from exploring whether some important symbolic message was being communicated.

Romme began to wonder how biological psychiatrists could be so certain that voices were meaningless when they didn't even ask patients to describe what their voices were saying. Could something be learned if patients were encouraged to try to make sense of what they heard? Patsy's original suggestion to focus on the voices themselves, rather than on some hypothesized disease process underlying them, was, after all, what had stimulated his thinking in such productive directions in the first place.

He went back to some of the core things he'd learned from the interviews he and Escher had been conducting. First, people typically remember exactly when their voices started. Second, if they're asked about the specific circumstances of that first episode, they often identify a traumatic antecedent, like violence or sexual abuse. Medicating people in an attempt to rid them of their voices pushes the memory of this abuse away and denies its importance. No wonder patients were so angry with their doctors. Maybe it was time to do what Jacqui Dillon had urged at the Beyond Belief conference—start asking patients what had happened to them instead of focusing on the symptoms that were the consequence of the trauma.

Now, after fifteen years of systematic research, Romme and Escher have clear empirical evidence that 80 to 90 percent of people who hear voices—whether psychiatric patients or not—link traumatic events to the origin of their voice hearing. In other words, it makes no sense to claim that hallucinations are meaningless neural activity unrelated to a person's life experiences. More broadly, their research demonstrates that it isn't trauma itself that makes someone a psychiatric patient; it's the nature of the trauma, when it occurs, how long it lasts, whether it's denied by others, and whether the person gets help. (This makes intuitive sense. We can all think of examples of

people who've experienced violence, war, abuse, etc., and not become ment patients.) When the reality of trauma is acknowledged and symptoms a seen as its consequence, a person doesn't have to mistrust his own perce tions, thoughts, memories, and feelings.

Romme and Escher found that those voice hearers who do end up as me tal patients are likely to have had multiple traumas that started early in chil hood or took place over a long period. They are less likely to have h someone to help them cope with the trauma or its aftereffects. They oft report being threatened with further violence if they tell anyone what ha pened. Not surprisingly, their voices are typically more violent, intrusive, ar frightening than those of people who get more support.

Sexual abuse is, by far, the trauma most frequently found to precede voi hearing. In a 1992 study, Romme's colleague B. J. Ensink found that 27 pe cent of sexual abuse victims later heard voices. Voice hearing occurred mo often when the trauma took place before the age of seven.

Romme and Escher's findings have since been confirmed by a large-sca study conducted by Charles L. Whitfield and his colleagues and published i 2005. A survey of 17,337 adults in California found, for both women an men, that physical, sexual, or emotional abuse in childhood significant increased the likelihood of experiencing hallucinations in later life. Tho with the most severe trauma histories were almost five times more likely t have hallucinations later.

"Voices are messengers that sometimes bring awful messages," Romm says. "Hearing them can be a survival strategy rather than a symptom of il ness. When people hear voices and have no context to talk about them, the develop a series of secondary reactions like concentration disturbances, emo tional outbursts, social isolation, and other behaviors that are incompreher sible to those around them, for instance, rituals that prevent the person fro doing what the voices are ordering them to do. What are seen as the symp toms of mental illness are really the consequences of covering up the voice or lacking effective strategies to cope with them. Since the content of th voices often includes a metaphoric expression of the trouble the person i having, paying attention to what the voices say is the crucial first step in bein able to solve that problem."

After years of listening to the stories of the people in their studies, Esche recently wrote, "Unfortunately, voice hearers all too often find their famil and friends too embarrassed or afraid to listen to their experiences, and i can prove impossible to find anyone genuinely interested in what the voice have to say. Even when someone is prepared to listen, the phenomenon is s extraordinary that it can be very difficult to convey to anyone entirely unfa miliar with such experiences. Mutual communication among voice hearer themselves is a practical solution to these problems. The sharing of simila

experiences, using a common language, provides real opportunities for all concerned to share and learn."

Such sharing can often transform a person's experience. Escher cites the example of a woman repeatedly admitted with little effect to psychiatric hospitals. After joining a hearing voices group, this woman said, "People's questions made me reflect on the voices I heard, which I had never really thought about. I was surprised to discover a pattern—whenever I think negatively, I find myself hearing a negative voice." Another woman, who had made many suicide attempts and spent long periods completely dominated by voices that forbade her to eat, drink, or sleep, started talking back to her voices as the members of her support group had suggested. "Now I regard them as a warning sign," she says. "Whenever they materialize, I know things are going badly for me and I must take notice."

Romme and Escher stress that context is crucial. Most people don't hear their voices at every moment, and they vary in intensity across different situations. Until voices are contextualized, they do seem to come out of nowhere. But when the person learns to identify the conditions most likely to trigger his or her voices and to interpret the significance of hearing them in the first place, they start to make sense within the framework of prior life experience.

For example, a woman who had endured years of threats and humiliation from her father and boyfriend began hearing tormenting voices. "They call me a loser, a scrounger, a bitch, a prostitute," she reported. "They say I'm ugly, weird, lazy, and pathetic. They comment on my clothes, saying I look a mess and am too fat. These words are spoken in different voices, but they are the words of my father and my ex-boyfriend and they show how my mind has been distorted by their twisted thinking."

As Romme says, "When a person feels that they are in a hopeless situation where the self is not strong enough, an outside agent—religious or otherwise—intervenes to help the person. Voices are a sign of the mind's creative capacity to cope. If you automatically link voice hearing to schizophrenia, you're blind to the fact that many people who hear voices never become psychiatric patients."

SOME MONTHS AFTER MY VISIT WITH ROMME AND ESCHER, I happen to take the train from Boston to New York. It's just before Easter, a particularly busy travel season. The train is too crowded to sit alone, so I take a seat next to a nervous-looking woman, to the dismay of both of us. For the next four hours, she chastises herself in a low murmur. "I'm so stupid. Can't believe I did that. What am I going to do? Stupid idiot! What's wrong with you?" And so on. She doesn't seem psychotic; when the conductor comes around to ask for our tickets, she has a perfectly ordinary interaction with him.

As she continues to berate herself, I'm forced to put in earplugs to get some work done. But I can't totally ignore her. I start wondering if she's recently been widowed. Bereavement is the most frequent cause of voice hearing; researchers estimate that up to 10 percent of widows hear the voice of their dead husband. Whatever the cause, she seems to appreciate my not commenting on her behavior. At times I'm tempted to ask if she wants to talk, but hesitate to get too involved on a trip where I have a lot of work to finish up. I've stopped doubting Romme and Escher's claims about the prevalence of voice hearing in the general population. But is spending so much time thinking about voices somehow making me a magnet for people like this?

5.

Who's Crazy Now?

June 2004

After two terms of plunging back into teaching, department politics, and the myriad tensions of life as an academic, I return to Britain for the annual meeting of the Hearing Voices Network. My colleagues are busy planning trips to the American Psychological Association's annual convention; they'd be astounded if I told them I was heading off to a conference of voice hearers. I haven't yet figured out how to bring together the two worlds I've been living in. During the semester, I'm a psychology professor; as soon as school ends, I'm back in the world of HVN. They're so radically different—in style, assumptions, and structure—that I feel as if I'm traveling a lot farther away than just to England.

Like every registered charity in the United Kingdom, HVN is required to have an annual general meeting (AGM) of its members to elect officers and vote on policy changes. So the AGM is basically a business meeting. If you walked into the room and didn't know what was happening, you'd think it was pretty much like the yearly meeting of any other organization—highly structured, a bit boring, with a lot of people there mainly to see their friends and go out for a drink later.

At 10:00 a.m. on a rainy morning, after an overnight flight and a rushed trip from London, I grab a cup of tea and take my seat in a small auditorium in downtown Manchester. The faded parquet floor and shabby curtains of the Central Methodist Hall remind me of an old primary school. About fifty people are present, mostly facilitators of HVN groups who've come to report on activities in their region. John Robinson, a community nurse from Deptford, South London, whom I'd first met at the Beyond Belief conference, chairs the meeting from the wooden stage.

The tone is upbeat. They are now 160 HVN groups all over Britain, 26 in the southwest of England alone. Membership continues to grow at a rapid

rate. The national office, across the street from where we're meeting, now has a grant to run a telephone help line. "We've gotten such a positive response from the people who've called in," says Peter Bullimore, a voice hearer who volunteers there. "A woman rang the other day and said we were the first people who'd ever talked to her about her voices. She said she'd first contacted SANE [a patient advocacy group closely tied to the medical establishment] and they kept asking, 'What's your diagnosis?' She said she hung up and called us."

At the break, I wander up to Geoff, a burly guy in jeans and a torn Manchester United football jersey who's got a startled look. He's slouched down in a folding chair with two grim young women glued to his either side. "Hi, where are you from?" I ask, passing him the ubiquitous plate of chocolate biscuits. Geoff stuffs two in his mouth and flashes me a wicked look. "I'm from Northumberland Hospital," he says, "and these are my nurses. They've let me off the psych ward for the day to come to the AGM." For a second I think he's joking, but when I see how embarrassed the women look, I realize he's not.

Geoff and I chat about the speakers. "Boy, I'm tired today," I say, yawning, despite having just drunk three cups of tea. Geoff nods sympathetically. "Are you on clozapine? That drug used to zone me right out." I burst out laughing. "No, it's jet lag. I just flew over from the USA." The two nurses glare at me. "Really," I smile. "I'm a psychologist." Geoff winks. "Right. You've heard that one before, haven't you, girls?"

In one of the meeting's most powerful presentations, Peter Bullimore talks about a key obstacle facing HVN—patients' own reluctance to seek support from their peers. After years in the mental health system, people take on negative attitudes. "By the time I went to my first hearing voices meeting," Peter tells the group, "I'd become the person I'd learned to be in hospital, a 'typical schizophrenic.' I didn't wash. I wore clothes I found on the street. I looked terrible. I smelled worse. People avoided me wherever I went. So when I walked into the hearing voices group that first time and saw these ten people wearing nice clothes and sipping tea, I thought, these can't be schizophrenics, they're too clean!"

Now, six years later, Peter is a paid consultant on the staff of Asylum Associates, a survivor-run company that earns thousands of pounds each year training mental health workers to understand voice hearing from the perspective of those who experience it. Once written off as a chronic mental patient and so heavily medicated he had to wear a towel around his mouth to soak up the uncontrollably dripping saliva that was a side effect of the drugs he was given, Peter's account of recovery through mutual support and self-help profoundly affects everyone who hears him speak.

There's a bit of the traditional conference at this particular AGM, with some formal papers presented on topics of interest to members. Philip Thomas reports on a research project funded by Mind, the United Kingdom's largest mental health charity, which surveyed people who'd weaned themselves off psychiatric medication. This study is the first systematic attempt to find out what the "coming off" process is actually like for people who choose to go through it. Thomas is a psychiatrist, one of the few to risk openly criticizing his field while also working on the senior staff of the National Health Service. He wants psychiatry to admit its limitations, help those it can, and listen more carefully to patients. In 1999, he helped to found the Critical Psychiatry Network to give dissident doctors their own form of peer support. He's one of HVN's strongest allies and a close friend of Marius Romme.

Thomas doesn't need a microphone. He's got the authoritative tone of the experienced lecturer, and bristly gray hair and a pair of reading glasses perched on his nose give him the air of a professor. For the first few minutes, he sounds like the standard speaker giving a scientific paper. He's got slides and a pointer; he paces as he talks. But this audience isn't behaving the way a group of doctors would. Every time Thomas glides over some conceptual detail or statistical subtlety in the results of the Mind study, people start yelling out comments from the floor. It sounds more like a public hearing on a controversial issue than a scientific lecture, as indeed it is. HVN is full of people who've spent years being silenced by doctors. There's no way they're going to let anyone, even a staunch ally like Phil Thomas, keep them from raising challenges or questions.

IT TOOK THREE MORE YEARS of attending these kinds of meetings, visiting support groups across England, and reading hundreds of pages of materials produced by HVN before I felt confident that I understood how hearing voices groups work. Now that I do, I want to share the optimism of this approach with everyone.

The structure of local HVN groups varies a great deal: Some have fixed membership, while others operate as drop-ins. Some are facilitated by nurses, social workers, or occupational therapists; others are run entirely by voice hearers themselves. HVN meetings are never as tightly structured as those of twelve-step groups like Alcoholics Anonymous, where there's a fixed order and everyone knows exactly what will happen. But all HVN meetings do share certain general themes. Members give detailed descriptions of their individual experiences. They ask one another probing questions like these: What do the voices say? What tone do they use? How many different voices are there? Are they male or female? Have they changed over time? Are there certain situations when they're most likely to appear? How do you feel when

they come? By encouraging this kind of detailed contextual analysis, hearin voices groups help people make sense of experiences that have often baffle or terrified them.

Most people who end up at HVN have spent years struggling on their owr Any experience that continues for so long and is as confusing, isolating, an heavily stigmatizing as voice hearing can eventually become overwhelmin If no doctor or nurse or priest has ever created a space for you to talk abou what's happening inside your head, suddenly finding yourself in a supportiv group, with other people who are struggling as you are, who seem genuinel interested in helping you understand your experience, can be an enormou relief. As a nurse who cofacilitates one HVN group wrote recently, "Th group is a safe space for people to feel desolate. Non–voice hearers cannc appreciate the impact of voice hearing on a person's life. During the life c the group, members have used the space to describe the sheer awfulness o voice hearing and the impact that it has on their ability to cope with thei day-to-day existence."

But HVN is not just a place for sufferers to commiserate. By reframing th problem itself—not voice hearing per se, but the anxiety, guilt, or fear tha often accompanies it—support groups help people analyze the symbolic sig nificance of the voices. For example, someone who has difficulty makin decisions might have a voice that tells her what to do. A person who's beer abused may have a voice prohibiting him from talking about it, thereby keep ing the threats of the abuser alive in his mind. Someone who comes from a family that forbids talking about emotions might have a voice instructing he not to trust others. By taking a curious, interested, and accepting attitud toward the whole experience, hearing voices groups help people realize wha functions the voices might be serving so they can consider other ways of han dling these problems.

A particular benefit of HVN groups is that they help people identify th circumstances most likely to trigger the voices so they can have more contro over the experience. Many people don't realize until they're in these group that there *are* specific triggers or that the voices vary in frequency or intensit in different contexts or over time. As one member of a London group wrote "Being in the group encouraged me to develop a vocabulary to describe m own experiences and also gave me a sense of understanding and coherenc about the way I'd been and the way I had needed to be to survive. By chal lenging the critical content of the voices, the group helped me to feel mor able to take control of my own fate."

Another member of the same group said, "Talking with the other mem bers has increased my self-awareness of what's happening to me, my state o mind, and why I need to do certain things to help myself. I've become mor responsible for myself and feel less helpless. I realize now I do have som

power over my situation." Since the most difficult part of the experience for many people is feeling completely at the mercy of the voices, unable to affect or control them in any way, trying out some of these strategies can be a tremendous help. And as people start to cope more effectively, they feel less distracted or preoccupied by the voices and more in control of their own minds.

Denying that the voices exist or trying to block them out—with psychiatric medications or heroin or loud music or earplugs—paradoxically seems to intensify them. People often end up totally isolated, terrified that if they visit friends, go to work, or even just go into a shop, their voices will be discovered and they will be punished or locked up.

In Romme and Escher's research and in HVN's fifteen years of experience running support groups, the people with the best outcomes are usually those who make a pragmatic deal with their voices. They come to terms with being voice hearers the way people adapt to other powerful life events or challenges. They pay attention to the positive voices and ignore the threatening ones, or they listen selectively at certain times. (This isn't so different from people with asthma, for example, deciding to take up yoga or eliminate certain foods from their diets to limit the intensity of their symptoms.)

At HVN groups, people hear about a range of techniques that have proven helpful. Some voice hearers, for example, carry mobile phones (even ones that don't work) on buses or trains or while walking down the street. That way, they can talk back to their voices without attracting attention. Others keep diaries that help them identify the kinds of situations that trigger the voices or make them worse. Some voice hearers practice deep relaxation, yoga, or meditation to reduce anxiety. HVN facilitators stress that no one strategy will be effective for everyone. People are encouraged to take an active, exploratory attitude toward figuring out what works best for them personally.

After talking with hundreds of voice hearers and intensively studying the phenomenon for two decades, Marius Romme wrote, "Hearing voices is not primarily an incomprehensible symptom of an illness but more a way of coping with personal problems. When the self is not strong enough, an outside power can enable the person to take some distance. In a hopeless situation with no way out, a spiritual solution often arises. We see this in religious inspiration and in voice hearing."

The optimism and energy of HVN's approach have paid off. By 2006, there were hearing voices groups in Austria, Australia, Denmark, Finland, the Gaza Strip, Germany, Ireland, Italy, Japan, Malaysia, the Netherlands, New Zealand, Norway, Portugal, South Africa, Sweden, Switzerland, and the United Kingdom. From the beginning, Britain has been the world center of the network. You can live in a remote village in Dorset or in the Scottish

Highlands and still find a group near enough to meet with regularly. In 2000, the Division of Clinical Psychology of the British Psychological Society issued a revised set of guidelines for understanding and treating psychosis that incorporated HVN's assumptions, and in 2003, the NHS started paying for its doctors, psychologists, nurses, and social workers to be trained by voice hearers and adopted parts of HVN's model as the framework for many of its own services.

Without ever downplaying the anguish of voice hearing, Hearing Voices Network members have a refreshing sense of humor about certain aspects of the experience. Here's a story—perhaps apocryphal—that has circulated for years at support group meetings.

A voice hearer is traveling by train from Sheffield to London. He's taken the advice of people in his support group and pinned a small microphone to the lapel of his jacket. This way, he can talk back to his voices and appear to be speaking into a mobile phone. Soon after the train leaves the station, he, like other passengers, begins an animated conversation. Nearing London, the train goes through a series of tunnels. Everyone else loses telephone contact, but he keeps chatting. When the journey ends at St. Pancras station, a man comes up to him and says, "I'm sorry to intrude, but I couldn't help noticing that your phone kept working when none of ours did. Could I just ask, what network are you on?"