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RESEARCH ARTICLE

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Young people's narratives of hearing voices: Systemic influences and conceptual challenges

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Abstract

Despite the prevalence of voice hearing in childhood and adolescence, little qualitative research has been undertaken with young people directly to advance phenomenological and aetiological insights into their experiences and interpretations. Consequently, the researchers sought demographic, contextual, and qualitative data from 74 young people from eleven countries, aged 13–18 years (28% = male; 61% = female; 21% = Transgender and Gender Non-Binary [TGNB]), who self-identified as hearing voices. A Foucauldian-informed narrative analysis yielded four analytic chapters, offering novel perspectives into individual, relational, systemic, and cultural interpretative narratives surrounding multisensory and multi-self voice hearing. Overall, young people reported heterogeneous experiences of voice hearing and associated sensory experiences, and most participants reported voice hearing beginning between ages 8 and 11. Further, the emotions felt by the child, as well as reactions displayed by people around the child in relation to the voices, influenced voice-related distress and the nature of the voices in a triadic relationship. A continuum of multisensory features of voice content, nature, and relational significance is tentatively proposed to capture the breadth and depth of voice hearing for adolescents to offer a possible framework for future study and intervention design. Specifically, participants described that voice-related distress could be exacerbated by observed anxiety or internalized stigma about voice hearing, social isolation, and attribution to illness. These findings suggest that we may need to reconsider how the experience of hearing voices in childhood influences their relationships and how relationships influence the voice hearing experience. Further, young people seem to have a broad understanding of what the term “hearing voices” means, which could inform how researchers and practitioners work with this group of young people. Finally, participants described benefitting from multisensory coping strategies, such as imagery and meditation, which could offer important considerations for tailoring therapeutic interventions for adolescent voice hearers.

KEYWORDS

adolescence, hearing voices, multiplicity, multisensory hallucinations, narrative

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1 | INTRODUCTION

The experience of hearing voices that others cannot is relatively common and transient in childhood (Majjer et al., 2019), with incidence estimates ranging from 9% to 35% (Jardri et al., 2014; Majjer, Palmen, & Sommer, 2017). Young people might experience voice hearing due to a range of emotional, relational, socio-economic, and physiological factors. For example, the chronic stress of living in under-resourced communities (Hastings et al., 2019), bereavement, abuse and neglect (Corstens & Longden, 2013; Longden, Madill, & Waterman, 2012), medical conditions such as epilepsy (Bisulli et al., 2018), in response to certain medications (e.g., Capaldi & Carr, 2010), or disrupted sleep (Waters et al., 2016), are all possible causes. Further, negative voice content has been associated with negative self-schemas and insecure attachments with key caregivers (Scott, Rossell, Meyer, Toh, & Thomas, 2020). Accordingly, voice hearing is increasingly understood as a common developmental feature of childhood within clinical and non-clinical populations (Majjer et al., 2019).

Approximately three quarters of young people cease to hear voices within 5 years of onset (Bartels-Velthuis et al., 2011), although it is recognized that much more research with young people is needed to understand the frequency, prevalence, and nature of auditory hallucinations. Childhood experiences of voice hearing do not necessarily lead to mental health difficulties in adulthood (Edelsohn, 2006; Linscott & van Os, 2013; Poulton et al., 2000), although hearing voices in youth has been connected to later experiences of depression and anxiety (Kelleher & Cannon, 2011). Young people who experience even transient voice hearing tend to report reduced quality of life at later follow-ups compared with their peers (Calkins et al., 2017) and a higher rate of suicidal ideation (Fujita et al., 2015). There are likely to be a wide range of multisystemic factors connecting mental health difficulties and voice hearing, such as internalizing stigma, threats to self-perception, adverse childhood experiences (Varese et al., 2012), the appraisal of hallucinations (Fannon et al., 2009; Peters et al., 2017), and societal adversity (Veling, Counotte, Pot-Kolder, van Os, & van der Gaag, 2016). Therefore, voice hearing appears to be less detrimental to well-being than the voice-related distress caused through negative appraisals and adverse life experiences.

The auditorily diverse nature of hallucinations young people experience requires much greater understanding to inform further research and practice, especially among community samples (Luhmann et al., 2019). Within their review of adult voice hearing literature, Baumeister, Sedgwick, Howes, and Peters (2017) suggest that conceptualizing voice hearing along a continuum is more helpful than homogenous diagnostic categories. Developing an insightful understanding of a continuum of childhood voice hearing relevant to clinical and non-clinical groups is necessary in light of the relative frequency and increased divergence of these experiences throughout childhood compared with adult populations.

Only a small percentage of children and young people seek help for voice-related distress, and most do not meet the diagnostic criteria for a psychosis-related disorder, although the majority of those who

Key Practitioner Message

- Voice hearing in adolescence is fluid and influenced by important others in young people's social milieu, suggesting family interventions could be beneficial.
- Communicating with voices and communication between voices can enhance well-being. Consequently, relational therapies could be advantageous.
- Adolescent's voices can become increasingly negative if the young person observes anxiety in others in relation to their voices.
- Adolescents have a broad conceptualization of "hearing voices," which includes multisensory experiences and emerging multiplicity (the experience of more than one "self" within the body), indicating therapeutic interventions need to recognize that voice hearing can exist on a diverse continuum of sensory experiences.
- Participants described beneficial creative and multisensory coping strategies, which could inform current talking-based therapeutic approaches.

do request specialist support, explicitly psychoeducation and coping strategies (Majjer et al., 2017). It is currently undocumented in academic literature whether young people who do not engage with mental health services wish to have similar support through informal or community initiatives.

In terms of treatment options, limited evidence exists regarding the efficacy and safety of antipsychotic medication for children and adolescents (Krause et al., 2018). Clinically recommended therapeutic interventions, such as cognitive behavioural therapy for psychosis, also show limited long-term effectiveness (McCarthy-Jones et al., 2014) and omit holistic tailoring often required for adolescents (Mueser, Glynn, & Meyer-Kalos, 2017). Deamer and Hayward (2018) propose that the limited effectiveness of such interventions may be due to these approaches not addressing the complexities and relational dynamics of voice hearing, supported by the comparatively promising outcomes of relational therapies. Encouraging results have recently emerged from virtual reality approaches to support social cognition therapy for early psychosis (Realpe et al., 2019): Avatar therapies (Craig et al., 2017; Dellazizzo et al., 2018) and Open Dialogue for adolescents aged 14–19 years (Buus et al., 2019). However, research around relational therapies for young voice hearers is scarce. Consequently, understanding relational aspects of voice hearing and therapeutic barriers across childhood is a crucial next step in developing effective therapeutic interventions for younger people. Further research around communication with voices and the communicative nature of voices has been posited as holding the most "explanatory power" (Deamer & Hayward, 2018, p. 4) of this enigmatic phenomenon.

Exploring phenomenologically and aetiologically meaningful features of voices could advance insights and therefore improve support available for adolescents as an under-represented group in the hallucination literature. A recent study of 10,346 16- to 19-year-old Norwegian adolescents drawing on a multinomial regression model of self-reported psychosocial and clinical variables highlighted important psychosocial risk factors in relation to voice-related distress (Løberg, Gjestad, Posserud, Kompus, & Lundervold, 2019). Distressing voices could be predicted by adverse experiences such as bullying and trauma and intrapersonal factors such as low self-esteem, self-harm, and anxiety, alongside a lack of family support. Undertaking qualitative research with young people from across the adolescent age range is essential to understand the personal meaning-making, experiential mechanisms, and impact of hallucinations during this developmentally vulnerable period. Therefore, the authors undertook an in-depth narrative study to explore the form and function of voices in adolescence to advance understanding through the unique perspectives of under-represented young people (Parry & Varese, 2020). However, when young people were asked to self-refer to the study if they identified as “hearing voices,” their narratives contained a broad range of sensory experiences alongside voice hearing, which we present through their narratives. Young people discussed a wide range of multisensory experiences and coping strategies, which could inform our understanding of their experiences and how we can develop services to support them, where suitable. Importantly, their narratives highlight that the term “hearing voices” has come to include a wide range of experiences, which should also inform how we conceptualize “voice hearing” as a construct for young people.

2 | METHOD

2.1 | Design

Following stakeholder consultations and a literature review, a self-report screening survey was developed to gather contextual data about the voice hearing experience and written narratives to explore personal reflections (Parry & Varese, 2020, S1). An online platform was selected as previous research indicated that this approach could be advantageous in gathering rich phenomenological data (e.g., Woods, Jones, Alderson-Day, Callard, & Fernyhough, 2015) and that participants appreciate the flexibility, anonymity, and privacy of this medium (Parry, Djabaeva, & Varese, 2018). A critically informed narrative analysis sensitive to personal sense-making (Iudici, Quarato, & Neri, 2018) and the sociocultural narratives that surround voice hearing was developed.

2.2 | Participants

Due to the exploratory nature of this study, age of participants and ongoing uncertainty around the validity and evidence base of diagnoses associated with voice hearing for young people, participants were

TABLE 1 Reported country of residency

Country	Number of participants		
	Female	Male	Non-binary gender
Australia	2	1	
Bahamas	1		
Canada	2	1	2
China		1	
Germany			1
Ireland	2		
New Zealand		1	
Saudi Arabia	1		
Spain		1	
United Kingdom	16	3	1
United States	15	11	4

Note: Not all participants gave all the details; therefore, numbers do not sum to 74.

not required to have received any formal diagnosis. Owing to the aforementioned findings that young people hearing voices do not usually seek help through mental health services, participants were not required to be connected to a specific service to take part through purposeful sampling. Participants were invited to take part if they self-identified as “hearing voices,” which was defined as “hearing a voice or voices that others cannot hear.” The study was available in the English language. Survey responses from 74 participants aged 13–18 years ($M = 15.06$; $SD = 2.83$) were collected, of which 28% identified as male, 61% female, and 21% non-binary. Participants' stated their country of residence (Table 1) and the number of voices they heard (Table 2). All participants reported hearing voices, with 55% reporting one to four voices.

Despite recruitment being supported through health and peer-support organizations, only 32% of participants reported that they had accessed mental health support for voices. As such, the participant sample appears to reflect population trends, supporting theoretical generalization. Proportionately, adolescent females are more likely to access mental health support than young males (Table 3). However, most female participants did not seek support for their voices overall. Although non-binary gender participants sought mental health support for voices proportionately more than the other

TABLE 2 Number of voices heard

Number of voices	Number of participants (%)
1–4	41 (55)
5–10	9 (12)
11+	5 (7)
20+	1 (1.4)

Note: Not all participants gave all the details; therefore, numbers do not sum to 74.

	Female	Male	Non-binary gender	Total
Sought mental health support	16	3	5	24 (32%)
Have not sought mental health support	22	14	1	37 (50%)
Prefer not to say	6	4	2	12 (16%)

TABLE 3 Reported help-seeking for voices

Note: Not all patients gave all the details; therefore, numbers do not sum to 74.

TABLE 4 Reported affect in relation to voices

	Female	Male	Non-binary gender	Total
Positive	4	7	2	13 (17.6%)
Negative	22	4	1	27 (36.5%)
Mixed emotions	9	1	3	13 (17.6%)

Note: Categorized from free-text responses. Not all participants answered; therefore, numbers do not sum to 74.

two groups, they also reported much greater positive or mixed emotions in relation to the voices (Table 4). With research so sparse around non-binary and genderqueer people (Scandurra et al., 2019), this appears an important area for further research before hypotheses can be developed around the context of these results.

2.3 | Procedure

Participant-facing documents were reviewed by experts by experience before undergoing review by an academic interdisciplinary research ethics committee (REC) and an English National Health Service (NHS) REC, specializing in research with young people. Following ethical approval, NHS trusts, peer-support groups, and social media supported recruitment by dissemination of the survey. The survey included a compulsory information and consent form, followed by the optional completion of the Manchester Voices Inventory for Children (Parry & Varese, 2020, S1) and 17 qualitative questions. Although optional, most participants completed the majority of the self-report survey. Follow-up support was available by email or telephone to all participants through Voice Collective, and participants chose their own pseudonym. The survey was open to participants between May 2017 and June 2019. The data reported in this paper encompass all data submitted by participants up until June 2019.

2.4 | Analytic approach

The Foucauldian-informed narrative analytic (FNA) framework (Bamberg, 2012; Foucault, 1989) aimed to explore narratives of individual experience alongside influences that diminish or enhance voice-related distress, sensitive to pervasive narratives, gender identities, perspectives, and trajectories. A growing number of qualitative methodological approaches offer a critical epistemological platform for analysis, such as interpretative phenomenological analysis

(Smith, Larkin, & Flowers, 2009), critical narrative analysis (Souto-Manning, 2012), and Foucauldian approaches to narratives (Tamboukou, 2008). On the basis of developments relating to Foucauldian discourse analysis (Willig, 2013), narrative approaches (Labov, 1972; Murray, 2000; Riessman & Quinney, 2005), and complementary aspects of narrative analysis and phenomenology (Patterson, 2018), a six-step analytic framework was developed and employed to (Parry & Varese, 2020, S2). We considered this approach important for this data set as so many of the participants reported anxiety around their experiences and internalized stigma due to powerful sociocultural and linguistic narratives. The FNA approach recognizes the impact of powerful external narratives upon the individual experience for the participant and researcher throughout the experience. To facilitate the analytic process, two postgraduate students also conducted preliminary analyses on parts of the emerging data in 2018 and 2019 to test the implementation of the FNA framework developed for this study. The analytic process was discussed within the team, with reflective discussions facilitated by E. L. to manage the implicit assumptions within our culture that influence all of us to a greater or lesser extent. From ideographic reflective narratives, the framework facilitated the emergence of emancipatory narratives, epistemologically accepting that biopsychosocial environments were likely to have influenced participants' meaning-making. The six steps we followed in relation to the framework were (1) origins at the individual level, (2) orientation in relationships and construction, (3) language and power in relationships, (4) individuality and commonality, (5) constructing a resolution, and (6) phenomenological and emancipatory narratives. Conducting the analysis was an iterative process over a 24-month period, which was supported by the ongoing presentation of our emerging findings at conferences, through the mainstream media and in small group discussions with stakeholders. This process supported steps three to five in particular, resulting in the phenomenological and emancipatory narratives presented in this paper. Quotes are presented verbatim as typed by the participants to preserve their original integrity.

3 | ANALYSIS AND DISCUSSION

3.1 | Chapter 1: Relational experiences of stigma

Participants of all ages were keenly aware of the stigma associated with voice hearing, even if their personal experience of voices was relatively positive: “I don't feel comfortable talking about it to my siblings or anyone else since I'm scared they'll be full of stigma and they'll leave me out. Or call me insane or crazy” (Rincad, 14); “there's a stigma that people who hear voices have psychosis and think of serial killers and psychopaths but that's incorrect” (Orange, 17). Such perceptions of voice hearing complicated participants' relationships with others and acted as a barrier to disclosing their experiences: “people don't want to be singled out as weird or different especially teenagers, we are very self-conscious” (Milly, 15); “Often, what makes people mentally ill is some other people's prejudice” (C, alter of M, 18). Further, some participants only worried about their health once relatives indicated that they should not hear voices, highlighting important systemic influences upon self-perception and interpretation of voice hearing: “Felt immediately that something was wrong with me because I was put into childhood therapy” (Veruca, 17).

Due to the developmental stage of the participants, peer relationships were important milieus to navigate. The perceived “normality” of others in contrast to the perceived “difference” of the self was a source of anxiety: “I feel bothered by people for not being ‘normal’, which makes interacting with others hard” (Fish, 18); “I feel embarrassed that I hear the voice and ‘normal’ people don't” (Madilyn, 16). Voices directly added to social anxieties, often leading to adjusted social interactions and could prompt self-doubt and social withdrawal. For instance, some participants described a paralleling of their critical thoughts or those of others in their voices: “Sometimes if I am doing something like making a gift for someone, it would say that I am a bad friend and they wouldn't like it in a mean angry voice” (Zee, 13). Further, misunderstandings and assumptions by others could invalidate participants' self-knowledge, which could add to their distress and make confiding in others more difficult. “It's rough. People don't understand it, and explaining it doesn't do much either because they don't expect you to have the mental capability to comprehend your own situation” (Veruca, 17).

Positive experiences of voice hearing and a perception of voices as helpful conflicted with participants' concerns that health services viewed voices as problematic, which could add to their anxiety around possible consequences of seeking help: “They bother me sometimes. A lot of times. But it's gotten to the point, where I'm not sure if I really want them gone anymore” (Alone, 15); “I also don't want people to tell on me to mental health professionals because I have heard that antipsychotic medicine sucks a lot” (Fish, 18). Likewise, Orange (17) described how she had come to accept even her troubling voice: “I don't like one of them but because I've had them so long I wouldn't want them to leave.”

Due to the silencing effect of stigma surrounding voice hearing and consequent isolation, many participants had developed their own ideographic conceptualization of their experience, either because they

could not discuss their voice(s) with others or because they did not accept the dominant narratives surrounding their experiences. Participants provided a broad range of accounts as to why they heard voices, explaining how their assumptions and conceptualizations changed over time, often due to the reactions of others or sociocultural narratives, which could be in contrast to their personal experience. The participants' explanations for their voices varied from commonly accepted doctrines, such as “Trauma/Mental Illness” (Milo, 17), to more socially constructed accounts, “I think they're here to protect me and my friends” (James, 14). Loss was also a key factor for many, as Katy (14) explained: “Because I lost my sister and lots of other relatives and I've been through a lot and I feel like this is my body reacting to it.” Others had not yet developed a resolved answer for their experience and drew on information provided to them: “I wish I knew the answer to this but the doctor has told me it is because I went through a really difficult time with other mental health problems that it probably came from stress” (Madilyn, 16).

In summary, participants' perceptions of voices and related well-being were often connected to the perceived perceptions of others, highlighting the significance of systemic influences upon the young person's overall well-being. Aligning with prior exploration of children's lived experiences of voice hearing (Escher, Romme, Buiks, Delespaul, & van Os, 2002), adolescents exposed to negative appraisals regarding their mental health were more likely to experience distress. Anxiety has also been previously connected to voice hearing for prepubertal children (e.g., Askenazy et al., 2007), and it has been recognized that there are many difficulties for young people and their parents when trying to access mental health services for voice hearing (Kapur et al., 2014). Overall, the impact of judgements from others was profound, leading to the internalization of stress and stigma, which influenced help-seeking, self-perception, relationships, and voice-related distress.

3.2 | Chapter 2: Emotional mirrors and ricochets across relationships

Emotional mirroring within voice-child and child-parent relationships was described across the majority of accounts. For some, this was a mirroring of mutual feelings in the voice-child relationship: “he hates me and I hate him” (Madilyn, 16). For others, the participant's emotions, influenced by the reactions of people around them, could be reflected in their voices: “I thought it [voice] was magic since I was so young and now I'm being told it's not normal the voices get angry” (Alone, 15). Further, distressing reactions from others towards the voices could be reflected: “No one would believe me and it would frighten them [the voices]” (James, 14). This emotional ricochet through parent-child-voice relationships and the participants' awareness of how the views and reactions of others might influence the voices was a recognized barrier to disclosing hearing voices.

3.2.1 | Emotional reflections in the voice hearing experience

It has previously been identified that voices can reflect past experiences as an emotional mirror (Connor & Birchwood, 2013) or “echo” of the past (Deamer & Hayward, 2018, p. 5), although the current study proposes that for adolescents specifically, the influence of people close to them in the present can also be reflected in the voices. Following earlier work (e.g., Honig et al., 1998), it has more recently been suggested that trauma exposure might lead to greater auditory diversity and voices that are more aggressive or frightening (e.g., Luhrmann et al., 2019), which aligns with many of the accounts in the current study from female participants in particular. Additionally, when participants experienced further relational or environmental stress or stigma, this could have an aggravating effect on the voices, perhaps signifying that these reactions to voices could also be, to a degree, traumatic.

3.2.2 | Agency and emotional influence of voices

An emerging theme within some narratives was that voices could have a soothing influence upon other voices and the young person: “the only other voice I heard said only the words ‘your safe now’ and I didn’t hear from the other one for the at-least the next few months” (John, 14). Considering the agency of voices (Wilkinson & Bell, 2016), rather than audio-centricity, particularly in relation to the intentions and characteristics of voices (Deamer & Hayward, 2018), appears important to interpretations such as John’s that indicate purpose. Similar evidence for such characterization and perception of intent and value was apparent in narratives of positive and pleasant voices in particular, even when they changed over time: “I feel like my current voices still have important things they are trying to communicate but they can’t express it right. I still like my current voices because they seem important” (Fish, 18). Participants also described relational benefits to their voices: “I was excited. It felt like I had a bunch of friends that I could talk to and get help” (Lily, 17). In this way, participants’ characterization and perceived relationships with their voices facilitated a sanguine interpretation, divergent of stigmatizing illness conceptualizations of voice hearing, which appeared to reduce internalized stigmatization and voice-related distress, leading to positive self-appraisals across such narratives.

3.2.3 | Meeting relational needs

Participants reflected that loneliness or bullying might have created a need for friendlier experiences: “It’s a kind of loneliness thing because I didn’t have a lot of friends being young and its kind of stayed” (Impavid, 13); “Because I don’t usually have anyone else to talk to about things” (Lola, 15). Other participants highlighted adverse social experiences in early life alongside imaginative abilities: “I blame it on the fact that when I was in infants I had imaginary friends as I was

bullied” (Gracie, 16); “because I’m a loner, and I believe in imaginary friends, or just... company” (TJ, 15); “Because I have a very vivid imagination which supports me through stressful times” (Milly, 15). Bullying between ages 8–10 has been connected to almost doubling young people’s likelihood of experiencing a range of symptoms associated with psychosis by age 12 (Schreier et al., 2009), including voice hearing. Further, bullying has been found to be a specific psychosocial risk factor for distressing voices (Løberg et al., 2019), alongside low self-esteem, lack of systemic support, self-injury, and anxiety. A critical age range of 8–12 years echoes the findings of the current study, with the majority of participants reporting voice hearing beginning between the ages of 8–11 years. The age of trauma exposure is crucial to document in relation to the onset and clinical trajectory of voice hearing (Baumeister et al., 2017), especially if a chronology of trauma exposure alongside risk and protective factors may forecast likely multisensory experiences.

Overall, across narratives for people with positive, negative, and auditorily diverse voices, the voices complicated social relationships. Many participants described how the voices would make conversation difficult to follow, which in turn led the participants to feel more isolated and increasingly dependent upon their voices: “It makes socializing harder as they are constantly talking to you and focusing on work is harder” (Tris, 14). The demands of the school environment could be particularly challenging, as Rincad (14) explains: “In school when I want to concentrate its hard. It makes it easier to be without friends.” However, despite these social difficulties, some found that there were still advantages to having the voices for their development in other areas: “Creatively, my voices help a lot. Socially, I am held back tremendously” (Veruca, 17). For most, voices ultimately enhanced feelings of isolation, especially for young people who did not feel they could talk to others about their experiences: “I felt as if I was completely alone in my experience” (Sophie, 15). Social isolation, driven by fear of disclosing their experiences, was also reported to exacerbate distress and the voices: “it makes you feel so alone and the voices get worse” (Milly, 15); again highlighting the power of systemic support for young people. In essence, although voice hearing appeared to increase feelings of social isolation, the voices could alleviate feelings of loneliness and were sometimes missed if they disappeared or changed: “I miss my old voices, they feel like my closest friends who I can’t talk to anymore” (Fish, 18).

3.3 | Chapter 3: A relational triad with voices

Due to the young age at which many participants started hearing voices, they did not know that other people could not also hear them, as Katy (18) explained: “I didn’t realize it wasn’t real until other people/their reactions told me.” For many, their voices changed over time as their awareness grew and they established more relationships, which often altered the participants’ perceptions of their voices. For Orange (17), her voices changed in nature, which influenced her conceptualization of the experience: “before the voices became sinister I thought they were normal.” Experiences and ideas changed over time,

as Alone explained how, even though she valued her voices and had originally thought of them as “magic,” the disaffirming reactions of others influenced how she felt: “Before I was glad now I have mixed emotions about them” (Alone, 15). These developmental changes in voices and perceptions may be particularly common for young people, whose experiences of voice hearing appear fluid and changeable and influenced by important others in their social milieu, usually parents. Combined with the emotional ricochet effect discussed in Chapter 2, these relationship-dependent perceptual changes appear to indicate a triadic relationship (Figure 1), with voices connected through the child to relationships with family and friends.

Within these triadic relationships, participants described a perceived responsibility to the well-being of parents, friends, and voices. Consequently, a relational barrier to disclosing voice hearing was that young people were concerned about protecting others, a finding reflected in qualitative research with young adults experiencing distressing voices (Bogen-Johnston, Visser, Strauss, Berry, & Hayward, 2019). Milly explained: “I wouldn't want my parents and friends worrying about it because it doesn't really hurt me and isn't negative.” Other barriers involved being disbelieved or misunderstood, which could deter the young person from seeking further help: “parents said I was lying and have never helped me with any mental/emotional problems I've had, so I don't trust them or anyone else they are related to” (A, 14). Research around adolescent health more broadly connects the functioning of young people to the coping styles displayed by, and attributions of, their parents (e.g., D'Angelo et al., 2019). Within the data, participants described an awareness that parental stress may exacerbate their own stress and that of the voice(s), which formed another barrier to discussing their experiences.

For participants who did feel they could share their experiences, outcomes were varied. Some participants felt as though they were

not believed or as though their experiences were dismissed. However, some explained the positive impact of talking to others, including family members, carefully selected friends, and educators:

I used to be able to talk to my old year manager in high school (...) and it breaks my heart that I am no longer able to share my thoughts and feelings with her. She knew everything about me (even about hearing a voice) and she never judged me once. Aria, 16

Participants also discussed having siblings or friends who experienced mental health difficulties who they felt comfortable talking to as they were seen to have a level of insight: “Best friend. He is weird in a good way” (Zee, 13). For reasons of empathy and common ground, sharing experiences through “voices groups” to normalize the experience could reduce anxiety overall (Newton, Larkin, Melhuish, & Wykes, 2007), although the findings of the current study suggest that reassuring peers may not need to have heard voices to be able to offer conciliatory support. Within adult voice hearing population, friendship has also been found to be an important protective factor for coping (e.g., Mawson, Berry, Murray, & Hayward, 2011).

3.4 | Chapter 4: Stretching the voice hearing continuum

For male and non-binary gender participants in particular, who generally reported more positive experiences of voices, voices could be accompanied by visions and other sensory experiences, which seemed to lead these young people to conceptualize their experiences as “curious,” “weird,” and generally more mystical in description than in accounts of only auditory experiences. Of the relatively small number of female participants who described multisensory experiences (Table 5), Rincad (14) explained how her initial acceptance and curiosity led her to explore these sensory experiences further, with generally positive results: “I would see the world they would reside in. She would warn me if the enemy was near ... Sometimes I'll see a face or a full blown person that quickly disappears.”

Similarly, other participants discussed associating “smells with the voices” (Tris, 14), such as “I will be able to smell my dad's aftershave” (SAT3, 15). Auditory characteristics such as pitch and volume could alter too, “They get really loud when I see something that reminds me of my experiences such as growing out my hair, my scared self voice starts telling me he is gonna come back” (Pierce, 15); “It sounds like the room in my head is getting gradually louder” (Lulu, 15).

Milly (15) explained she could use imagery to communicate closely with her voices: “I can take myself to imaginary locations and talk to them ‘in person’”. Participants described other ways in which they “felt” their voices, even if they could not see them: “I have only ever seen the voice in my dreams and I do feel it's presence in the room” (Madilyn, 16). For some, these additional sensory experiences were frightening and made the overall experience more anxiety provoking, as Veruca (17) explains: “If I feel happy, they bring up

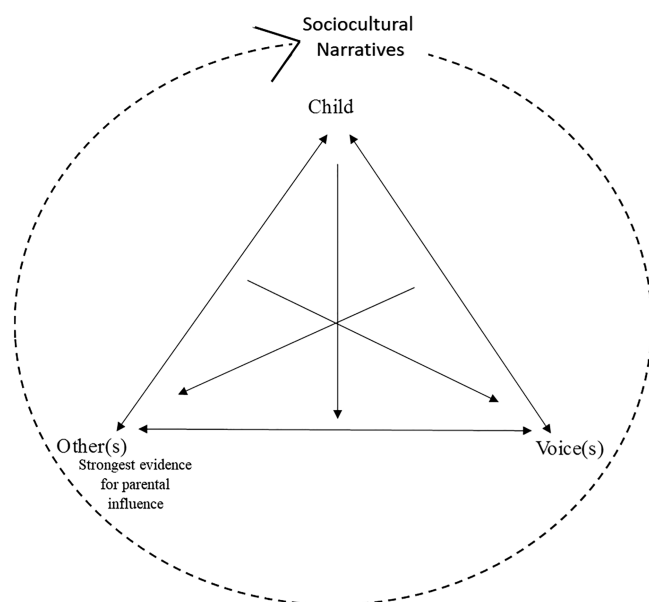


FIGURE 1 Influential triadic relationships between child, voice, and other

Presence of multisensory experiences	Female	Male	Non-binary gender	Total
Present	9	7	4	20
Absent	22	1	1	24

Note: Categorized from free-text responses. Not all patients answered; therefore, numbers do not sum to 74.

horrible thoughts and imagery.” James (14) also described a vision, related to one of his voices, as a physical personification: “There was actually one of the voices bodies standing in front of me but no one else could see them. I couldn’t see his face though.” In another account, Fish (18) explained: “There’s weird shadow people that watch me and my reflection in the mirror changes a lot,” reinforcing the existence of associations between depersonalization and voice hearing (Pilton, Varese, Berry, & Bucci, 2016). Throughout all such accounts, the language used to explain their experiences was more tentative and less descriptive in terms of the emotional impact it had upon them in contrast to accounts about only auditory experiences. However, multisensory experiences were not described as being more powerful or overwhelming than only auditory experiences.

The coping strategies participants described were equally multi-sensory, with many of the participants discussing creative means such as writing, drawing, storying, listening to music, meditation, and colour breathing. Imagery was a powerful medium, especially for participants who experienced visions as well as voices: “Turn it into an imaginary setting and talk to them if they’re bothering you” (Milly, 15). For participants who did not feel comfortable talking about their experiences, they found other means of communication: “I’ve never been a ‘talker’ I find it very difficult to express my feelings and talk about them ... when I wrote I can be me” (Aria, 16).

Finally, for a small number of participants, elements of multiplicity emerged, which is the experience of more than oneself in the mind and body. Multiplicity was not always explicitly named or identified as multiplicity within individual accounts, perhaps because participants

did not have the language. Rather, the experience was reflexively narrated, as M (18) explains:

We are all ordinary people, although sharing a body. We should all have the right to pursue our own dreams and aspirations. To get closer to or to decide what we want to do, we use the body to try to explore and impact the world outside.

During the survey, an alter of M’s also contributed, discussing her experience of collaboration:

We work together well, and if we have our individual freedom we would have no amnesia. But now we cannot have common friends for fear of being imprisoned by psychiatry, and it is really hard to separate social relationships ... I will let Michel submit this survey.

Such accounts highlight the phenomenological, relational, and experiential diversity across a population who self-identify as “hearing voices” (Figure 2), although the nature of those voices and accompanying multisensory or multi-self experiences ranges enormously: “I believe them each to be their own person with feelings and thoughts independent of mine. I consider them to be friends.” (Justin, 18).

Similarly, A (14) described how he first became aware of multiplicity and how the alter states’ voices could change when reassured, reflecting further emotional mirroring within the child-voice/alters

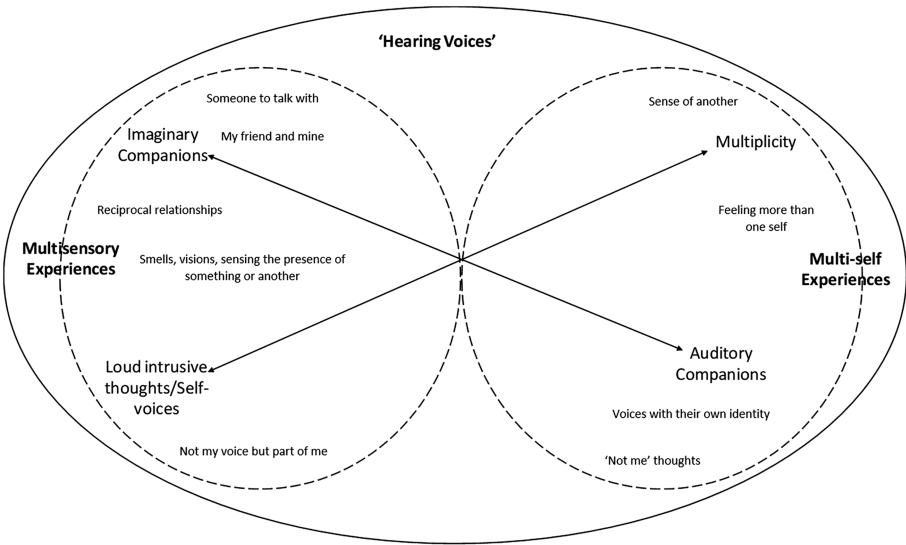


FIGURE 2 Proposed content and relational continuum of “hearing voices” for adolescents, with multisensory and multi-self experiences

relationship: "I found out that they were people and that they only said violent things because they were afraid and thought they needed to defend themselves. When I let them know that they were safe, they started helping me instead." Accessing support was more difficult for participants describing multiplicity, as A (14) explains:

I had a counselor that didn't treat my headmates like people even when I tried to tell her that they weren't just voices ... External people treating my headmates like problems is very distressing for all of us (...) They are my family. I love them all very much.

Such accounts not only advance our understanding of voice hearing for young people but also offer insights into what young people consider to be encompassed by the term "hearing voices." As illustrated in Figure 2, the narratives of young people's multi-type and multi-self voice hearing experiences indicate that the continuum should perhaps be broader and deeper to represent young people's own conceptualizations of their experiences.

4 | CONCLUDING DISCUSSION

The fear of judgement and stigma at an intrapersonal, interpersonal, and societal level were consistent barriers that prevented young people from seeking help and support, also directly influencing their coping and masking strategies around their peers in particular. A recent study into the use of the Maastricht approach (Steel et al., 2020) highlighted the importance of non-judgement and core therapeutic skills within the therapeutic relationship, perhaps as these features can address and reduce internalized judgement and stigma. Further, voice hearing could reduce feelings of loneliness but made social relationships more complex. Voices often mirrored participants' emotions, especially in relation to how other people could make them feel about hearing voices. In this way, young people were in triadic relationships with their voices and others, emotionally influenced by one another, which could alter the content, auditory, and relational nature of the voices (Figure 1).

Participants described a range of multisensory coping strategies, which is particularly interesting, considering previous research has suggested that parents request holistic approaches, whereas young people identify normalization and destigmatization most helpful (Kapur et al., 2014; Newton et al., 2007). Perhaps as the majority of the participant sample of the current study had not sought professional help for their voices, they had already turned to alternative methods, highlighting the need for widely available holistic interventions that do not necessarily recognize voice hearing as problematic. Further, personal meaning-making appeared helpful, connecting past and present experiences with voice tone and content reduced participants' voice-related distress. These features, alongside curiosity and recognized benefits of reassurance and relational soothing, suggest that imagery and self-acceptance could be beneficial. Such features are present within compassionate mind training approaches

(e.g., Gilbert & Irons, 2008; Roeser & Pinela, 2014). Particularly relevant to the systemic findings of the current study, self-compassion may even address family factors associated to distress, such as negative appraisals, self-perception, and well-being for adolescents (Neff & McGehee, 2010). Consequently, compassion-based approaches that can operate with the child-voice-other relational triad may be particularly advantageous, as a compassionate self-to-voices and voices-to-self thread is likely to be an important relational factor to include (Dudley, Eames, Mulligan, & Fisher, 2018).

In conclusion, further research reflecting triadic child-voice-other relationships and the exacerbating or mitigating role of family and peer appraisal and support seems advantageous. Critical explorations of gender differences with sociocultural power structures across larger populations could further refine our understanding of helpful interventions, particularly for girls who, in this study, seemed most adversely affected by adversarial voice content and relational oppression. Finally, developing our understanding of the auditory and multi-sensory diversity within experiences for adolescents who identify as voice hearing in this study and elsewhere in the literature (Garraida, 2016; Upthegrove et al., 2016) is crucial due to the variety of experiences shared. Within this novel study that captured previously unheard accounts from participants with and without clinical histories, descriptions of emerging multiplicity and the multi-self nature of some of the voice hearing experiences illustrate important phenomenological and relational differences that require further critical consideration among this under-represented participant group to inform community and clinical interventions. As recently noted (e.g., Choi et al., 2019), research into dissociation in adolescence is emerging, although it is important to further explore dissociation and dissociative coping for young people, so the intersections between unusual sensory experiences and multi-self experiences, whether theorized as dissociative identity disorder or developmental multiplicity, are not overlooked.

Due to the online nature of this study and use of survey questions and data, it was not possible to engage in dynamic enquiries with participants about their unique accounts or the conceptualizations they narrated around their lived experiences. However, participants offered original reflections upon the life experiences that they considered had led to these diverse sensory experiences and what the hallucinatory experiences had come to mean for them. Within this study, we were extremely fortunate to benefit from diverse data from young people around a range of sensory experiences and multiplicity, in answer to questions about hearing voices. There is clearly a great deal more to learn from engaging young people in this field of research, working with them to develop suitable questions to explore the answers to questions not yet asked. As primary research, we asked broad questions to a self-selecting sample. Future research could focus on exploring some of the phenomenological, linguistic, and gender-based differences found within this study. Personal meaning-making and direct consultation with young people should further inform this under-researched area of child and adolescent mental health.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Aspects of the data that support the findings of this study are available on request from the corresponding author (S. P.). The data are not publicly available due to their personal and sensitive nature, containing information that could potentially compromise the privacy and anonymity of research participants.

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