

Prevalence of auditory hallucinations in nurses in mental health

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Seventy-nine nurses and student nurses working in the mental health field were asked to complete a questionnaire that asked about the prevalence of their experience of events that might be considered as examples of auditory hallucinations. Eighty-four per cent of the 55 nurses who returned the questionnaire described having experiences that might be described as auditory hallucinations. This level of prevalence is broadly consistent with other studies, and the difference between voices considered to indicate 'schizophrenia' and voices perceived as normal or unimportant is discussed. The relevance of these findings for the process of diagnosis and for the attitudes of nurses working in the mental health field towards voices reported by clients is highlighted.

Keywords: diagnosis, hallucinations, nurses, schizophrenia, schizophrenic voices

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Introduction

Auditory hallucinations are often considered symptomatic of people diagnosed as suffering from 'schizophrenia'. However, according to new research something of this kind of experience appears to be prevalent in a group usually considered outside the diagnosis of mental illness – mental health nurses. The defining characteristics of 'schizophrenia' are its symptoms, yet definition of those symptoms is highly problematic, especially given some indications that one of the key symptoms, 'auditory hallucinations', are highly prevalent (Barrett & Etheridge 1992). In the current study 84 per cent of nurses described having an experience that can be seen as similar to examples of auditory hallucinations.

It can be argued that hearing voices is a more common experience than is usually accepted. It may be that the understanding of hearing voices varies according to

context, and high prevalence might be seen as challenging the very strong connection made between 'auditory hallucinations' and 'schizophrenia'.

A perception that hearing voices is necessarily a negative experience might be expected to be counterproductive if mental health professionals therefore see the treatment rather than exploration and understanding of these experiences as appropriate.

Given that professionals in mental health have the power to define experiences as a symptom of illness, the views and experiences of mental health nurses would appear to be particularly important. Boyle (1991) has argued that 'there is no evidence that hallucinations called symptoms of schizophrenia are different in some way from those not so called'. By moving away from the 'them and us' approach to auditory hallucinations fostered by diagnostic criteria used in psychiatry, it may be that nurses in mental health would have the opportunity of emphasizing

similarities in their experiences with clients and those in distress, rather than seeing 'psychiatric patients' as different from themselves.

As 'mental illness' can be described as a specific example of deviance or rule-breaking (Scheff 1984), the observation that 'psychiatric patients' and nurses in mental health may share experiences such as auditory hallucinations may challenge prevailing diagnostic models and offer scope for focusing on shared experience rather than endeavours at conformity. If differences between voices that become problematic and those that do not does not lie in the nature of the experience, they may lie in factors outside the individual. These external factors might include: where the experience took place, who was told and how others reacted. That the social context is important has been emphasized by many (Becker 1963), and Kroll & Bachrach (1982) have cited the difference in the perception of medieval religious experiences or visions, as compared with hearing voices in the 20th Century. In England, in the 1990s, it might be argued that the only appropriate place for God to speak to you would be in church on a Sunday – never on a Tuesday!

The continuum of experience will tend to challenge the psychiatric diagnosis of mental disorder. Sarbin & Juhasz (1967) state that 'since the 1920s textbooks of general psychology have differentiated hallucinations from errors of perception by the simple expedient of locating them in separate chapters'. Sarbin & Juhasz emphasize the negative evaluation of reports of certain individuals, rather than others, the distinction often being the social context. If a non-judgemental approach is taken to hearing voices, auditory hallucinations might be explored with clients, thus fostering the kind of relationships so frequently described as essential to any psychotherapeutic relationship in that it is based on non-judgemental acceptance. Jung (1963) has summarized the views of many other writers in this area: 'through my work with patients I realized that.... hallucinations contain a germ of meaning.... The fault is ours if we do not understand them'.

The diagnostic process within psychiatry appears to perceive the details of any single symptom as unimportant, a focus on patterns of symptoms being more consistent with non-specific interventions like psychotropic medication rather than approaches that are targeted at clearly identified behaviour. However, a wide range of concerns have been expressed regarding the term 'schizophrenia', with particular reference to poor reliability and validity, to the extent that the concept of 'schizophrenia' may be more unhelpful than helpful (Bentall 1990).

Boyle (1991) has argued that 'put simply, a person is deemed to be schizophrenic because of their oddity and they are deemed to be odd because they are suffering from

schizophrenia'. Schizophrenia might be no more than a catch-all or residual category of 'mental illness', thus explaining the difficulties of predicting whether or not psychotropic medication will be appropriate or useful and a wide range of outcomes for individuals diagnosed 'schizophrenic' (Ciompi 1980).

The conclusion of Bentall (1990) that 'schizophrenia appears to be a disorder with no particular symptoms, no particular course, no particular outcome and which responds to no particular treatment' leads to a suggestion that the term schizophrenia be dropped and that individuals might be understood better when their own personal experiences are used as the basis for that understanding. By moving away from the stigmatization of labelling, nurses in mental health might be better freed from the constricts of biological psychiatry so that they can use their own personal experience as a basis for working with clients in distress.

Studies have demonstrated the existence of hallucinations in the general population, but we found no study that had examined the prevalence of auditory hallucinations in the workers who most often have contact with people who experience difficulties coping with voices, mental health nurses.

Whereas previous studies have focused on psychology students (Posey & Losch 1983, Barrett & Etheridge 1992), this study focuses on mental health nurses, whose understanding and experience of auditory hallucinations may be of particular relevance to their working with clients in distress. It may be that greater self-awareness would be of assistance to mental health nurses, and it may be that awareness of prevalence of auditory hallucinations may reduce some anxiety towards voice hearers in mental health nurses. In a very early and primitive survey of over 15 000 subjects in 1894, Sidgewick recorded that 7.8% of men and 12% of women reported at least one hallucinatory experience. More recently McKellar (1968) questioned 500 students, a quarter of whom reported having had at least one experience that may be described as hallucinatory. McKellar, unfortunately, does not provide details of his research method.

In this study, a questionnaire used by Posey & Losch (1983), was used to measure the prevalence of hearing voices in nurses in mental health.

Subjects

The questionnaire was distributed to 79 nurses and student nurses working in the mental health field. Fifty-five questionnaires were returned fully completed. The completion of the questionnaire was confidential, and subjects were given the opportunity to complete the questionnaire alone,

returning the questionnaire in an envelope to ensure confidentiality.

Method

Subjects in this research were asked to respond to 13 statements taken from Posey & Losch's (1983) questionnaire that might be considered to be an example of an auditory hallucination.

The questions were prefaced with the statement 'the voice heard must have been as if someone had spoken aloud rather than a thought or feeling'. Full details of questionnaires are given in the appendix but took the form illustrated by Question 2 as below:

2 'Sometimes when I am just about to fall asleep, I hear my name as if spoken aloud'.

Has this happened to you? (Yes) (No)

Results

The number of subjects responding positively to each statement is shown in Table 1 as a percentage of those answering.

Table 1 also includes comparative results from two previous studies using this or a similar questionnaire.

Discussion

The results confirm that auditory hallucinations are a fairly common experience for a group who are likely to be without a diagnosis of 'mental illness', that is mental health nurses. The results obtained from this sample are largely

consistent with those in previous studies, indicating that hearing voices does appear to be common outside a diagnosis of 'mental illness' and cannot therefore always be considered a symptom of mental illness. The assumption is made throughout this study that the majority of mental health nurses are not 'mentally ill'.

Barrett & Etheridge (1992) tested the assumption that their subjects were not subject to a high rate of undiagnosed 'mental illness'. They interviewed subjects with high and low scores, but concluded that psychopathology in subjects could not account for high prevalence. Given an overall return rate of 70 per cent and prevalence rates indicating 84 per cent of subjects answering 'Yes' to at least one question, auditory hallucinations in this study are unlikely to be a reflection of widespread 'mental illness' in the sample group.

It can be argued that all the statements in the questionnaire are not 'schizophrenic voices', so no connection between the current findings and 'mental illness' may necessarily be inferred.

However, a distinction between 'schizophrenic' and 'non-schizophrenic' voices is not clearly made in medical and psychological definitions of hallucination. Content, context and persistence of auditory hallucinations are not emphasized or even included in many definitions. The popular psychiatric definition of a hallucination is a 'sensory perception without external stimulus of the relevant sensory organ' (DSM III-R 1987, American Psychiatric Association). Statements in this study therefore fulfil some of the main criteria broadly used for definitions of hallucination in 'mental illness'; the particular difference being the absence in this study of any focus on the recent experience of the respondent, as opposed to 'have you ever experienced...?'.

Many therapeutic approaches to auditory hallucinations aim to block out or stop voices, yet this appears to be at odds with this research that indicates that voices are not necessarily negative or distressing. Psychiatry does not tend to consider the existence of non-problematic voices.

High prevalence rates in the current study could indicate misunderstood directions or ambiguities in the questions. Firstly, however, instructions made it clear that voices meant 'as if someone had spoken aloud' in order to clearly distinguish voices from powerful thoughts or feelings. Secondly, misunderstandings as to what constitutes a voice in this study appear unlikely in the light of clarity of the small number of supporting descriptions of voice hearing experiences. Thirdly, it may always be difficult to differentiate between voices and strong feelings or thoughts. What one individual experiences as 'hearing voices' may be very different from another. Any possible ambiguities in responding to the statements may be a strength of the survey in that they represent ambiguities in labelling or

Table 1
A comparison of current research with similar prevalence studies

	Current study	Posey & Losch	Barrett & Etheridge
Subjects:	Mental Health Nurses	College Students	College Students
	<i>N</i> = 55	<i>N</i> = 375	<i>N</i> = 586
1 Own name in shop	42%	57%	64%
2 Own name falling asleep	27%	30%	25%
3 Phrase when waking	4%	14%	15%
4a Garbled voice falling asleep	13%	21%	–
4b Any voice falling asleep or waking up	20%	41%	–
5a Imaginary playmate	20%	25%	14%
5b Voice of playmate	7%	6%	–
6 Voice on radio	2%	6%	–
7 Own name in house alone	9%	36%	32%
8 Own name called outside	25%	39%	38%
9 Doorbell or phone	69%	71%	–
10 Own thoughts aloud	22%	39%	37%
11 Driving car, voice from back	13%	11%	13%
12 Voices in rear of car	2%	6%	6%
13 Conversation with dead relative	0%	5%	6%

diagnostic process. The questions asked by a psychiatrist or mental health nurse may themselves be ambiguous. There are likely to always be problems between the observer and the person being observed. For example, an observer may use language in a different way from the person being observed: in particular it is possible for professionals to understate the metaphorical nature of some descriptions or experiences. The term 'voices' itself may be limiting and in effect be a convenient way of categorizing experiences rather than exploring what exactly occurred. High prevalence of voices in the current study cannot therefore be accounted for through misunderstandings or ambiguities.

High prevalence of voice hearing from the research may be accounted for by attempting to find explanations as to why individuals may have heard voices. Believing that you heard a doorbell or your name in a shop may, for example, be accounted for through there being lots of other noises hence making it difficult to distinguish one sound from another (statements 1 and 9). The other statements concerned with waking up, falling asleep or driving may be accounted for through extreme tiredness (statements 2, 3, 4, 11 and 12). Finally, hearing the voice of someone the subject knows well or knew well may occur because the subject would desperately like to hear from them due to the closeness of the relationship (statement 3, 8 and 13). These explanations, and others similar to them, could also, however, be used to account for the prevalence of hearing voices in individuals who are diagnosed as 'mentally ill' or are in the process of being diagnosed.

Analysis of the research therefore suggests that it may often be possible to account for experiences that could be described as auditory hallucinations. If the difference between voice hearing experiences in individuals who are not diagnosed 'mentally ill' and those who are lies in the ability to account for your experience, this is itself a significant departure from psychiatric orthodoxy. The focus may therefore move towards accounting for auditory hallucinations in people called 'schizophrenic', with the explicit assumption that hearing voices is itself a common experience and not always a symptom of so-called 'mental illness'.

It is also possible that the research understates the prevalence of voices in nurses in mental health. Subjects were asked to respond to statements made by others. This may have helped to clarify what experiences constitute hearing voices – or the absence of more open questions could have led to the exclusion of some experiences. It may be, similarly, that nurses are actually more aware of such experiences because of their training.

The 13 statements were not comprehensive of all voice hearing experiences and some were not relevant to all subjects. For example, two statements concern the driver of a car and not all subjects are likely to be drivers.

Some subjects in the current study offered descriptions of their experiences that support the validity of their responses. These included a description of hearing the voice of a child following the loss of the subject's baby. Barrett & Etheridge (1992) gave their subjects an additional questionnaire concerned with social conformity to explore the possibility that the subjects could be tailoring their responses to what they perceived the researchers wanted. They concluded that no clear relationship existed between social conformity and the reported occurrences of auditory hallucinations. Barrett & Etheridge (1992) also measured frequency of the experiences. Almost half of the individuals who reported audible hallucinations in their study experienced them at least once a month.

High prevalence of 'auditory hallucinations' in nurses in mental health could lead nurses toward acceptance of the voices reported by clients. Nurses may listen to these experiences and seek to understand them through perceiving them as similar to their own, rather than fundamentally different, incomprehensible or even 'schizophrenic'. This research could lead nurses to explore where, when and how the experience took place. As nurses hear voices too, professionals can begin to understand the experience as not inherently bad and in need of elimination - instead it is a common experience that we can accept and begin to make sense of.

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Appendix

Questionnaire: 'hearing voices'

Please read the following statements and answer whether or not you have had a similar experience. The voice heard must have been *as if someone had spoken aloud* rather than a thought or feeling.

1 'Sometimes I have thought I heard people say my name. . . . like in a shop when you walk past someone you don't know. . . . but I know they didn't really say my name so I go on'.

Has something like this ever happened to you?

Yes 23 (42%)
No 32 (58%)

2 'Sometimes when I am just about to fall asleep, I hear my name as if spoken aloud'.

Has this happened to you?

Yes 15 (27%)
No 40 (73%)

3 'When I wake up in the morning. . . . but stay in bed for a few minutes, sometimes I hear my Mother's voice. . . . when she's not there. Like now when I'm living in the dorm. What I hear is her voice saying stuff like, 'Now come on and get up' or 'Don't be late for school'. I'm used to it and it doesn't bother me'.

Has a similar experience happened to you?

Yes 2 (4%)
No 53 (96%)

4 'I hear a voice that is kind of garbled. . . . can't really tell what it says. . . . sometimes just as I go to sleep'.

(a) Has this happened to you?

Yes 7 (13%)
No 48 (87%)

(b) Have you any experience with hearing voices just when falling asleep or waking up?

Yes 16 (29%)
No 39 (71%)

5 'When I was little, I had an imaginary playmate. I remember that I really thought I heard its voice when we talked. That went away. . . . hearing its voice. . . . but for a while it was just like a real voice'.

(a) Did you have an imaginary playmate?

Yes 11 (20%)
No 44 (80%)

(b) Did you hear his/her voice aloud?

Yes 4 (7%)
No 51 (93%)

6 'Every now and then – not often – I think I hear my name on the radio'.

Has a similar experience happened to you?

Yes 1 (2%)
No 54 (98%)

7 'Sometimes when I'm in the house all alone, I hear a voice call my name. . . . No, it really isn't scary. It was at first, but not now. . . . its just once. . . . like "Sally" like kind of quick and like somebody's calling me. I guess I kind of know that it really isn't somebody and it's really me. . . . but it does sound like a real voice'.

Has this happened to you?

Yes 5 (9%)
No 50 (91%)

8 'Last summer I was hanging up clothes in the garden. Suddenly I heard my husband call my name from inside the house. He sounded like something was wrong and was loud and clear. . . . but he was out in the garage and hadn't called at all. Obviously I guess I made it up. . . . but it sounded like a real voice and it was my husband's'.

Has this or something similar happened to you?

Yes 14 (25%)
No 41 (75%)

9 'I've heard the doorbell or phone ring when it didn't'.

Has this happened to you?

Yes 38 (69%)
No 17 (31%)

10 'I hear my thoughts aloud'.

Has this happened to you?

Yes 12 (22%)
No 43 (78%)

11 'When I am driving in my car. . . . particularly when I'm tired or worried. . . . I hear my own voice from the backseat. It's behind me over my right shoulder I know that it's really coming from my head, but it sounds like its little short statements. . . . usually soothing. . . . like "It'll be all right" or "now just calm down" '.

Have similar things happened to you?

Yes 7 (13%)
No 48 (87%)

12 'I drive a lot during my job as there is a lot of travel involved. Sometimes late at night, when I'm tired, I hear sounds in the backseat like people talking. . . . but I can't tell what they say. . . . just a word here and there. When this first started happening. . . . when I first started driving at night so much. . . . four or five years ago. . . . it scared the hell out of me. But now I'm used to it. I think I do it because I'm tired and by myself'.

Has anything similar happened to you?

Yes 1 (2%)
No 54 (98%)

13 'Almost every morning while I do my housework, I have a pleasant conversation with my dead grandmother. I talk to her and quite regularly hear her voice actually aloud'.

Has anything similar happened to you?

Yes 0 (0%)
No 55 (100%)