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INVITED ARTICLE

Relating positively and openly with voices through dialogue: A talking with voices implementation guide for mental health practitioners

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Abstract

The Talking With Voices approach, influenced by the work of the survivor-led Hearing Voices Movement, is a non-pathologising way of relating to the experience of voice hearing which emphasises coping enhancement, formulation and direct dialogue as a way to promote control, co-operation and relationship-building while reducing distress. This article presents insights from specialised mental health practice regarding potential facilitators and obstacles to implementing this approach more widely within statutory settings. Consideration is given to transferable skills for practitioners, guiding principles and values, training requirements and the ongoing challenges of bridging the gap between research and practice in clinical services.

KEYWORDS

psychosis, schizophrenia, therapy process

BACKGROUND

The limitations in antipsychotic treatment (Aderhold & Stastny, 2007; Grunder, 2015; Leucht et al., 2009, 2012, 2013, 2017; Servonnet et al., 2021; Servonnet & Samaha, 2020; Weinmann et al., 2009), combined with widespread recognition of the role of trauma in the origins and maintenance of voice hearing, have galvanised discourse and practice to the development of alternative approaches to supporting voice hearers. In recent years, this has included social initiatives and peer-support groups, as well as a variety of therapeutic and creative strategies, many of which have been associated with the Hearing Voices Movement (HVM) in particular (see Parker et al., 2021) an international civil rights movement

of people with lived experience working in partnership with allied professionals to normalise hearing voices and similar experiences. Indeed, as outlined in this issue, there are now multiple different talking approaches showing promise and/or positive effects, including Compassion Focussed Therapy for Psychosis, AVATAR Therapy and Relating Therapy (see also Burr et al., 2022; Heriot-Maitland et al., 2023).

One such initiative is the Making Sense of Voices (MSV) approach (also known as the Maastricht Approach, Experience Focused Counselling, or Working with Voices), which seeks to depathologise voices and related unusual experiences (such as visions and tactile sensations) (Corstens, 2021), and to relate to them positively and trauma-sensitively (Schnackenberg, Fleming, & Martin, 2018), transdiagnostically (Schnackenberg, Fleming, Walker, & Martin, 2018) and in a recovery-focused manner (Schnackenberg et al., 2023). Correspondingly, it is also the only individual approach with a clear origin in voice hearers' perspectives, being closely aligned with the HVM. However, although the role of voice hearers as experts is subsequently emphasised, it is also accepted that mental health workers can be supportive when they allow themselves to be sufficiently led by voice hearers without imposing their own professional perspective (Longden et al., 2018). As part of the MSV framework, there is a possibility of engaging directly or indirectly with voices via dialogue (i.e., a therapist or other facilitator asks questions while the client repeats their responses out loud), known as Talking With Voices (TWV) (Longden et al., 2021).

The origins and impact of the MSV approach have been well documented (see Corstens et al., 2014), and a number of small studies with a TWV focus of varying degrees have shown some positive findings, including reduction of voice-related distress and the beneficial effects of its trauma-sensitive, sense-making, and recovery focus (e.g., Allison, 2022; Longden et al., 2023; Longden, Branitsky, et al., 2022; Longden, Corstens, et al., 2022; Schnackenberg & Burr, 2017; Schnackenberg, Fleming, & Martin, 2017; Steel et al., 2019, 2020). A definitive multisite RCT is also currently in progress (ISRCTN15897915). However, current clinical and self-help literature (e.g., Corstens et al., 2011; Longden et al., 2021; May & Svanholmer, 2019; Lafferty & Allison, 2021; Schnackenberg & Burr, 2017) contains little practical implementation guidance for routine mental health settings. This paper, therefore, aims to fill this gap for interested mental health professionals (MHP).

In this respect, the implementation of such novel ways of working is also taking place within the context of a wider conceptual shift around hearing voices. For example, one of the many insights to arise from MSV-derived research and practice has been confirmed by wider research findings: namely, that the mere presence of voices should not be considered symptoms of specific, or any, pathology (Linscott & van Os, 2013; McCarthy-Jones, 2017; Waters & Fernyhough, 2017), even if this is not yet reflected in current diagnostic guidelines. Correspondingly, it is a regular outcome within TWV practice to understand that the original purpose for the voices' appearance is for the psychological/emotional protection and personal growth of the voice hearer.

REFLEXIVITY STATEMENT

The authors of this article are experienced and active practitioners, trainers and/or supervisors in the MSV and TWV approaches and collectively represent psychiatric, psychological, social work, lived experience and nursing backgrounds. The insights presented in this paper have been derived from decades of listening to and engaging with people who hear voices, as well as voices themselves, about the implementation of this work. However, in an effort to reduce their inherent positive biases towards the MSV and TWV approaches, the authors remain aware of their need to constructively collaborate with colleagues and voice hearers who may prefer alternate perspectives to understand and work with voice hearing experiences (e.g., prioritising an illness model or scepticism for the benefits of dialogue).

THEORETICAL UNDERPINNING

The TWV approach in relation to MSV

The MSV approach, which originated in research by Romme and Escher (1989), was an early identifier of the significance of the relationship between hearer and voice; specifically, that the relative degree of avoidant vs. accepting and constructive relating is a decisive factor in why some voice hearers became users of mental health services while others do not (Romme & Escher, 2000). In this context, the MSV approach has long understood the value of voice hearers and professionals talking to voices indirectly or directly; for example, to improve the relationship with the voices but also to verify what their original intention might be for the voice hearer.

Voice Dialogue theory applied to TWV

While comparable methods exist for working with parts within non-psychosis populations (e.g., schema therapy (Young et al., 2003) and inner family systems therapy (Schwartz, 1995)), the experiential and explorative approach of Voice Dialogue (Stone & Stone, 1989) provides a useful theoretical framework for the ongoing development of dialoguing in the context of hearing voices. Specifically, Voice Dialogue is premised on working with inner parts (deemed 'subpersonalities' or 'Selves') in order to promote a more harmonious relationship both with one's Selves and between different Selves with each other. Its practice-based assumption is that all human beings experience multiple aspects of self, each with their own personalities and histories connected to the person, and with generally positive intentions towards the person. However, individuals will vary in their degree of consciousness and awareness of these different selves, some of which they will be more strongly identified with (primary selves) and some far less (disowned selves).

The practice of Voice Dialogue is a method in which an accompanying facilitator dialogues with any upcoming parts of the person in an ordered and safe manner. The aim is to provide an accepting space for the parts, become aware of them, and discover more about their underlying function for the person, thus ultimately promoting a greater freedom of choice. In applying these principles to supporting voice hearers, as is common in TWV practice, the method does not assume that voices are parts in the way conceptualised by Voice Dialogue (although the experience of dissociated personality states is acknowledged, as is the role of dissociation in voice hearing more generally (Longden et al., 2019)). It does, however, recognise that the dynamics with which voices and parts operate appear to be similar and may not substantially differ between diagnoses, or even for people who have no diagnosed mental health problems. Thus, it is hypothesised that one main difference between parts, which can be experienced by any person, and voices experienced by voice hearers may be that voices are generally experienced as audible and potentially as more disowned and ego-dystonic than parts (Moskowitz et al., 2012). In this regard, a key phrase coined by Voice Dialogue facilitation also fits well with the non-pathologising approach of TWV: "facilitate, don't fix." (Kent & Zimmerman, 2022, 2).

Basic assumptions of TWV

A more detailed discussion of the core assumptions of the TWV approach is provided elsewhere (see Longden et al., 2021). However, in brief, the conceptual basis proposes that the presence and function of voices commonly reflect the voice hearer's own needs and unresolved conflicts (often in a metaphorical way), ultimately trying to promote their psychological growth and restoration (see Moskowitz et al., 2017). Thus, voices may often come into a person's life when they have become trapped in a pattern of relating to themselves that may, for example, see them defined by fearfulness, avoidance and defeatism. Reaching this point often stems from traumatic experiences. However, voices – when

approached with an open mind – may eventually reveal their adaptive function for the individual, essentially conveying: "*Don't be defined by these negative experiences and views of yourself. It is understandable you feel oppressed because of what you have experienced. However, you are not defined by these events and you can rise above them. Whilst we sometimes use extreme language, this is not literal (for example, that a certain person will kill you). Rather, it is a way to get your attention so that you listen to us and establish some boundaries in the relationship with this particular person. So, start living your life and start asserting your needs, wishes, and preferences.*"

Who may the approach be suitable for?

As indicated above, TWV as part of the MSV approach has been used trans-diagnostically. However, whilst practice experience shows that it is possible to dialogue with many voices in principle, at least those which are sufficiently personified at the time of engagement, it is also true that it needs a conscious decision by the individual to be open to working within this approach. If sufficient openness does not yet exist, but the voice hearer still wishes to proceed, then this is something that can be addressed by, for example, finding a way to explore their inhibiting fears in a constructive way. It is also worth emphasising that not all voices appear to be capable of, or want to engage in, dialogue despite extensive attempts to engage them. This may be because some voices appear to be completely memory-based (e.g. occurring only in the context of a flashback) and may never make comments that were not said in the context of the trauma itself. Another reason for voices not to engage in dialogue at a particular time may be that the voices are hoping for a different kind of engagement by the voice hearer and/or the professional (for example, more empathic or with a greater provision of safety than had been possible so far) before they are willing to start dialoguing. As it is important to be guided by client preferences, it is good to accept the non-dialoguing at some point in the process and instead focus on what is possible, e.g. considering whether these unchanging voices could be seen as a warning that only appears in specific situations.

When to use TWV?

The TWV approach is offered within the context of a broader framework for working with voices, specifically a form of psychological formulation exploring their history and characteristics known as 'the construct' (Longden et al., 2012; Romme & Escher, 2000). In turn, dialoguing with voices should not be a goal in itself, but rather a means of improving the relationship between voices and the voice hearer. All or some elements of the TWV approach can be usable at any stage, and in any mental health or non-mental health settings, with adults and even children (Schnackenberg & Burr, 2017). Some individuals might also value social support around them while engaging in the TWV process. For example, in addition to more general benefits like solidarity and coping enhancement (Hornstein et al., 2025), attending a Hearing Voices Group could further serve as a space to practice gradual exposure to TWV ideas (Middleton et al., 2024). Family members or friends could likewise be part of a supportive social network; although, like professionals new to this approach, they may benefit from educational or training input in advance by experienced voice hearers or professionals. However, there are some advantages and disadvantages to the various settings and stages a voice hearer may find themselves in; for example, in an urgent situation of feeling strongly overwhelmed, such as on an acute ward, a person may naturally feel that they would like to share more about the voices if feeling sufficiently safe and supported to do so. Conversely, in a longer-term setting, engagement might be characterised by a greater level of avoidance from the voice hearer, although in turn there is likely more time to learn how to develop respectful boundaries and encourage positive relating to oneself as part of a genuinely trusting therapeutic relationship.

Being ambivalent or avoidant in engaging in the work is not a reason not to offer TWV. Instead, the reluctance may be validated as potentially protective in nature (e.g., if the individual fears being

overwhelmed by the process or the voices). An additional focus on subjective safety mechanisms or a reiteration of boundaries, such as the client deciding how long and about what they want to speak, and/or a reminder of the individual's abilities to cope with these experiences at their own pace, is usually sufficient to begin engaging.

Transferable life and professional skills

Successful delivery of TWV work does not depend on belonging to any particular professional group. It is, in contrast, the level of openness and preparedness to work differently and in a recovery-oriented way that is crucial, and it is expected that many MHP will already possess relevant transferable skills, including empathy, validation, warmth, building rapport and active listening (Longden, Branitsky, et al., 2022; Longden, Corstens, et al., 2022). For example, psychologists and psychotherapists might have experience of chair work, inner family work, schema therapy and working with trauma and/or psychosis. Social workers might make use of a human rights-based understanding, a strengths and resource focus and/or being guided by the respective "Lebenswelt" (biographically informed frame of reference) of the voice hearer. Likewise, the focus on improving basic coping strategies found in mental health nursing and similar 'on-the-ground' professions can readily be transferred to voices and related emotions and thoughts.

In some instances, training MHP to learn to engage with their own inner parts following the Voice Dialogue model can be used to promote personal growth and reflection, as well as promote empathic engagement with voices. However, successful implementation of such personal growth areas does not require specific techniques; rather, the requirement is for an active openness by MHP to engage both with their own emotional needs and connect authentically with the voice hearer and voices.

GUIDING PRINCIPLES AND VALUES

An overview of key principles and assumptions for delivering this work (Schnackenberg, Iusco & Debesay, 2021) is provided in Box 1, with specific considerations outlined below.

Openness

Openness includes an accepting, normalising, respectful and non-judgmental attitude, in which both the facilitator and the facilitated person are prepared to suspend any prior beliefs about what the voices are and what their function might be. The invitation for both the voice hearer and MHP is thus to trust the process and not try to rigidly determine or control the content of the dialogue themselves. Openness facilitates greater awareness of the needs, boundaries and challenges meeting both the accompanied person and the facilitator at the same time, and often naturally finds a way to respond respectfully to the boundaries of both the voices and the voice hearer.

Respecting boundaries

Many individuals who hear voices have learned to conform to others' expectations due to past and present traumatic relationships, including interactions with professionals in the mental health system. This adaptation can hinder the establishment and maintenance of personal boundaries, despite the fact that respecting personal limits and autonomy is essential for well-being. It is important to encourage clients to be aware of their boundaries, and for both voice hearers and professionals to avoid violating them, as this can help mitigate boundary transgressions experienced by voice hearers

BOX 1 Guiding principles and key assumptions for dialoguing with voices.

Guiding principles

- Improving the relationship with the voices is the goal
- Providing choice and control
- Asking if one is being helpful as a facilitating person, or if a change of style is needed?
- Creating safety: what does the client say they need?
- Validating any of the client's fears, but not being led by fear oneself
- An ability to sit with uncertainty
- Respecting the client's limits (e.g. regular reminders that they must/may observe their boundaries and need only speak about what they want to and at their own speed)
- Conducting conversations on equal terms
- Offering one's own views, never imposing them
- Adopting a positive, affirming attitude
- Imparting confidence and hope
- Functioning as a mediator between voices and voice hearers, as well as an empathic listener

Key assumptions

- The importance of acceptance, compassion and recognition
- Voice content is meaningful in a person's life context
- Voices often express emotions and thoughts that are unwanted or rejected by the voice hearer
- Avoidance may worsen levels of distress
- Practitioner mistakes are acceptable, should not be feared and can facilitate new learning opportunities
- The key to understanding voices can be found in a person's life history
- The voice hearer is strong and resilient; they have already overcome and survived significant adversity, even if they may not perceive it themselves

during previous trauma exposure. Likewise, it is equally important that the facilitator protects their own boundaries during engagement in the work. In this respect, exploring boundaries and catastrophic assumptions is also an important strategy to overcome avoidance when a person is convinced that talking about or with voices is detrimental (e.g., 'I will be punished', 'they will take revenge', or 'I will fall apart').

Client-Centredness

Being led by clients' views and preferences does not mean that one complies with them; rather, one seeks to be guided by them. Thus, whilst professionals may offer contrasting views, this should not extend to imposition and instead requires working with the voice hearer's respective wishes and perspectives. Importantly, the key to relating is not determined by whose explanatory framework for voices, or intended therapeutic goals, is the correct one. Rather, respectful, open and curious ways of relating to voices transcend respective views. All parties must feel safe with the process: voice hearer, voices and facilitator.

Approaching voices positively

In human relationships, approaching others with warmth, positivity, respect and an assumption of good intentions can ease tension as well as foster open, constructive communication (Rosenberg, 2015; Sawin et al., 2023). The same principle applies to relationships with voices. In turn, just as in human relationships, voices may ostensibly grow negative if they feel unappreciated and/or unacknowledged for their perspective, function and/or positive intentions.

Learning from conflicts

Understanding effective strategies for resolving human conflicts can facilitate better relationships and coping mechanisms with voices. Practically, this may involve normalising the experience, documenting what the voices are saying, requesting explanations from the voices, listening with an open mind and being willing to reconsider one's perception of the intentions behind their comments. In this regard, there are numerous established coping strategies, which may help facilitate the listening process, reduce fear/avoidance and promote responding to the voices in calmer and less antagonistic ways. These can vary widely among individuals and include social initiatives, group activities, soothing and grounding strategies and various personal and artistic forms of expression (e.g., Romme & Escher, 2000; Parker et al., 2021; Schnackenberg & Burr, 2017).

FREQUENTLY ENCOUNTERED PRACTICE QUESTIONS

As mentioned previously, please note that the following insights are practice-based and have yet to undergo systematic evaluation.

How many voices should be worked with?

Usually, we would work with one voice at a time and consecutively with the others, although working with several voices simultaneously is also possible. In turn, if the voice hearer is amenable, it is often helpful to start with the more impactful/dominant ones, which cause the most distress, before asking their permission to engage with more vulnerable voices (Longden et al., 2021). The underlying understanding is that different voices generally have different functions they are trying to fulfil, although some may also appear to be very similar or speak as part of a group. In such a scenario, it might be possible to either organise disparate voices into groups, or else treat a group as if it were one voice.

Associations with trauma

Jointly reflecting on biographical information from a person's life often reveals a correlation between trauma and the onset of voices (Varese et al., 2012) as well as potential links with their content (van den Berg et al., 2023). Consistent with the concept of voices providing a psychologically protective function, they may therefore arise in situations when a person feels existentially threatened and normal coping has been unsuccessful. However, individuals in receipt of mental health services will frequently not recognise their voices as a protective mechanism, at least initially. Instead, they may perceive them as an added source of fear and threat during what Romme and Escher (2000) describe as the initial startling phase of the experience. However, this perception may change as they begin to engage with the voices (Middleton et al., 2024), transitioning through an organisational phase and ultimately reaching a stabilisation phase (Romme & Escher, 2000).

Here and now focus

Despite their frequent links with past trauma, it is our experience that voices often aim to help individuals cope with day-to-day challenges in their present lives; specifically, situations in which they may have learned to suppress their thoughts, emotions, or needs (typically as a way to survive traumatic situations in the first place) or to remain vigilant against the possibility of further victimisation. As such, voices' underlying functions will often reflect an encouragement for emotional expression, a desire to find alternative coping mechanisms, reducing avoidance, alleviating suffering and moving beyond negative self-concepts formed from traumatic experiences. Thus, in essence, as voice hearers learn to express their emotions, beliefs and boundaries, the voices are no longer needed in the same way and tend to reflect the change (e.g., an aggressive voice grows calmer as the person themselves becomes more assertive). However, even if a voice hearer disagrees with this positive interpretation, they might still benefit from using the voices constructively, e.g., as a form of sparring partner to improve boundary setting.

The necessity of voice work

Irrespective of a psychiatric diagnosis, the MSV/TWV approach suggests that voices, and subsequent reactions to them, can provide important insights and solutions into past and current distress (Schnackenberg, Fleming, Walker, & Martin, 2018). For example, some non-shared beliefs ('delusions') may be understood as a secondary response, such as an attempt to explain the voices, rather than a distinct experience (Moskowitz et al., 2009) and can therefore be alleviated in conjunction with the voice's work. Likewise, confused or disjointed thinking ('formal thought disorder'), extreme suspicion and mistrust ('paranoia') and social withdrawal ('negative symptoms') may in some cases be formulated as an intelligible and adaptive reaction to dealing with overwhelming voices. Improving one's relationship with the voices may therefore be crucial for assisting with adjunct difficulties and improving well-being more generally.

Incorporating multiple frameworks

Although trauma sensitivity is vital in the MSV and TWV approaches, unilaterally replacing one dominant model with another (such as a trauma model or a TWV approach) has not been found to be beneficial either within Hearing Voices Groups or individual professional practice, and should therefore be avoided. On the contrary, practice shows that whilst acknowledging trauma can help voice hearers feel understood, it is still essential to work within flexible models tailored to the individual client. Whilst understanding the origins of their beliefs and the roles these beliefs serve (e.g., protective functions) can be beneficial, it would be unnecessary – and potentially harmful – to coerce a client to adopt a particular perspective, as well as conflicting with the values of the HVM (Corstens et al., 2014).

Are there any adverse effects?

Available, albeit limited, research evidence, as well as our own practice, does not indicate an elevated risk of adverse effects associated with this work. Nonetheless, it is important to note that these may still occur, and an honest and open-minded exploration would be vital in such instances (e.g., voices might be experienced as stronger or more negative, or may disclose distressing information that the voice-hearer was previously unaware of). We believe the likelihood of exacerbating voices is greatly reduced when an appropriate focus is maintained on respecting both the person and voice's boundaries. However, as with any trauma-informed therapy, it is important that time is spent developing appropriate

coping and safety strategies, as well as constantly ensuring that both voices and voice hearers feel safe and comfortable with the pace and direction with which the work is proceeding.

RECOGNISING VOICE DYNAMICS

In our experience, voices tend to use the most suitable styles and explanations for ensuring their message will be maximally significant to the individual voice hearer. This will vary from person to person and will usually be influenced by biographical factors. However, there are some common patterns and dynamics that may frequently occur.

Different roles for different voices

Different voices can represent various conflicts, unmet needs and other vulnerabilities. This, in turn, can be interpreted as voices communicating important information about issues that need addressing to promote better functioning, and identifying the adaptive role of each voice can therefore be an important therapeutic goal (see Mosquera & Ross, 2017).

Use of exaggerations, symbols and metaphors

Voices often use exaggerated, symbolic, or metaphorical expressions, which can grow more pronounced when they feel unheard. However, once acknowledged, their language tends to become more transparent. In turn, strong expressions should not always be taken literally as opposed to embodying underlying conflicts and needs (see Moskowitz et al., 2017); for example, a demand to harm oneself or others may indicate a desire for significant change in relationships that are harming the voice hearer.

Stopping talking or becoming abusive

When voices feel ignored, attacked, or otherwise disrespected by the voice hearer and/or the MHP, they may choose to either cease communication entirely or else retaliate and become abusive. However, a clear and sincere re-emphasis on respecting everyone's boundaries will usually suffice for the voice to resume constructive engagement.

When voices leave

Voices may disappear, or become significantly quieter, once they perceive that their objectives have been met. However, it is important to note that for this to occur the voice hearer does not necessarily have to follow the voice's exact advice, nor do they need to have perfected a particular skill. Rather, it may be the case that voices are generally satisfied with merely observing an effort being made by the voice hearer to address the issue.

Are voices ever just meaningless?

Some voices require substantial engagement to understand their role and purpose, particularly those that speak in terse, obscure and/or metaphorical ways. However, in our experience, voices may often reveal themselves to aim to help, protect, and foster positive development in the hearer, despite this

goal manifesting in ways that initially cause the person great distress. Nevertheless, an impression of meaninglessness, hostility, or untrustworthiness can still arise if there is insufficient openness to recognising what the voices intend to achieve with their comments and influence, including how certain contexts emotionally impact the voice hearer, and the ways in which the voices are attempting to resolve and draw attention to these issues (see Moskowitz et al., 2017).

Commanding voices

The concept of 'command hallucinations' is often linked with increased risk, yet commanding voices are not inevitably intending to cause harm as opposed to simply being heard (often as a result of frustration after previous attempts to gain the person's attention have failed, thus leading them to escalate). In turn, for someone overwhelmed with anxiety and indecisiveness, clear instructions might be of help when one lacks a sense of control and confidence in managing a challenging situation.

Voices that appear to represent a perpetrator

Whilst it is not uncommon for voices to resemble a real-life aggressor, either in tone or content, such voices may still perform a protective function by drawing attention to the unresolved aftermath of abuse and thus the need to process and heal from it (see Longden et al., 2021). In turn, our experience has been that voices will not always identify themselves as the perpetrator. Instead, further exploration may reveal quite a different dynamic: i.e., "*I am not the abuser. You might think I seem that way, but I'm using past examples of abuse to warn you of what could happen. The abuse wasn't your fault, but you can learn to protect yourself better now as an adult. It's important to confront the abuse so you can move past its harmful effects.*"

However, as a voice hearer may experience the voice as the 'actual perpetrator' prior to dialogue, it is important to have created some distance for the voice hearer before engaging with such a voice. This may be facilitated by considering the perpetrator voice as a 'copy' or a 'screenshot' of the trauma, with the voice embodying beliefs and emotions about what happened to them, as opposed to hearing the actual abuser. This can often feel like an acceptable and emotionally safer explanation for the voice hearer before embarking on dialogue with a 'perpetrator voice'.

TRAINING IN THE TWV APPROACH

While experience and some informal evidence within the HVM show both voice hearers and MHP can constructively engage with voices with little to no training, it is also clear that the necessary paradigm shift in mental health settings is more easily supported by a formal training process. The HVM has not standardised training methods for the MSV or TWV approach, though many countries' training initiatives share similarities. The schedule outlined in Box 2 provides examples of training components included in existing studies that used TWV as either an element or a major focus of the intervention.

FREQUENTLY ENCOUNTERED CHALLENGES IN PRACTICE

Conflating trauma-sensitivity with trauma-focused therapy

Many mental health services operate with the belief that only specialised experts should handle trauma cases. As such, a perceived lack of confidence and competence may cause a reluctance on the part of staff to enquire about adversity without previous training, which in turn can result in service users

BOX 2 Training considerations for the TWV approach.

- The ethos of the HVM: theoretical and practical foundation for a de-pathologising approach to voices and similar experiences
- Dissociation and a trauma framework for voice hearing
- Survivor-informed strategies for coping and engaging with voices
- Theory and practice of the Maastricht Interview, Report and Construct (Romme & Escher, 2000)
- Theory and practice of Voice Dialogue, including self-experience for MHP
- Role-play and case examples of dialoguing with voices
- Therapeutic barriers and challenges

feeling dismissed and reluctant to share their experiences. In contrast, the MSV framework advocates for a trauma-sensitive approach, in which it becomes the responsibility of the accompanying MHP (who does not have to be a trauma specialist) to create a sufficiently safe environment for the client to share traumatic experiences if they wish and to receive an appropriate response. Importantly, clients may also feel a sense of relief simply in disclosing trauma without wanting, or feeling ready for, structured trauma-focused therapy. In this regard, it should also be noted that many MHPs (including specialised professions such as psychiatrists, psychologists, trauma therapists and psychotherapists) have little experience of, or training in, working with the voices of people diagnosed with psychosis in a non-pathologising, trauma-sensitive manner.

Transdiagnostic vs. diagnostic focus

Although the transdiagnostic nature of hearing voices has been recognised for some time (see Waters & Fernyhough, 2017), many services continue to rely on diagnostic categories when determining care. Additionally, addressing clinical needs within a biographical context through methods like psychological formulation (Johnstone et al., 2018) is still relatively uncommon. Correspondingly, the importance of voices in understanding past trauma and current distress in a transdiagnostic way, as well as the need to focus on such experiences as part of recovery, still awaits widespread recognition (Schnackenberg et al., 2023; Schnackenberg, Fleming, & Martin, 2018; Schnackenberg, Fleming, Walker, & Martin, 2018).

Limited access to recovery services

Crucially, the structures, content and legal frameworks that govern many mental health services, especially those focused on psychosis, may often not align with the principles of recovery-focused care (World Health Organisation and the United Nations, 2023). As a result, implementing recovery-orientated practices within a system that lacks a clear conceptual awareness of recovery practice can pose a significant challenge.

Barriers for trusting relationships within hierarchical systems

Many mental health services operate hierarchically, with professionals often following their managers' guidance in favour of team-based evaluation and critical thinking. This, in turn, can lead to a prevalence of fear-based, risk-averse interactions among both staff and clients. Nurses and

allied professions, given their more frequent and interpersonal contact, would also be better placed to develop trusting relationships and thus engage in an MSV/TWV framework than is currently widespread practice.

The research – practice gap

Although the extent may vary by location and country, it is not uncommon for MHP to lack knowledge of current research and practice developments in the specific field of hearing voices. This may naturally lead to resistance or anxiety from practitioners at the prospect of actively and constructively working with voices, as well as a lack of interest from decision-makers regarding training and supervision investments. Furthermore, some services may adopt a strict evidence-based framework when supporting voice hearers, leading them to primarily advocate for cognitive behavioural therapy for psychosis (CBTp) at the exclusion of other approaches. It is important to note that CBTp has a robust evidence base and proven efficacy for individuals, yet this singular focus can also inadvertently limit access to emerging or alternative models. The cognitive model also appears to be quite limited in its ability to address the dialogical, content and purpose elements of voices. Correspondingly, a prioritisation of established approaches may lead services to overlook more novel interventions that could provide meaningful support for voice hearers who do not benefit from CBTp, ultimately narrowing both client choice and the scope of available support.

CONCLUSIONS

The ongoing demand for MSV/TWV training in the workplace, coupled with the willingness of some mental health services to embrace new methods of supporting voice hearers, indicates that recovery-orientated change is possible within existing service structures. However, it is also clear that more extensive innovation requires sustained national and international investment for paradigmatic change towards truly recovery-focused, trauma-sensitive and personal growth-promoting services. Importantly, and consistent with several other novel talking therapies aimed at supporting voice hearers (Burr et al., 2022), the evidence base for the MSV/TWV approach also awaits the results of definitive randomised controlled trials. Nevertheless, the clinical discourse surrounding psychosis and voice hearing has still advanced significantly (Burr et al., 2022; Hardy et al., 2024), with the potential for additional innovations still to come. In turn, the scope for the HVM to influence research and practice (Corstens et al., 2014), in addition to a variety of social initiatives beyond conventional mental health systems (Parker et al., 2021), continues to reiterate the value of incorporating lived experience perspectives within health and social care systems.

AUTHOR CONTRIBUTIONS

Joachim Schnackenberg: Conceptualisation; writing – review and editing; writing – original draft. **Dirk Corstens:** Conceptualisation; writing – review and editing. **Samantha Bowe:** Conceptualisation; writing – review and editing. **Craig Steel:** Conceptualisation; writing – review and editing. **Eleanor Longden:** Writing – original draft; writing – review and editing; conceptualisation.

CONFLICT OF INTEREST STATEMENT

Joachim Schnackenberg is a practitioner, supervisor, trainer, researcher and author of the Making Sense of Voices and the Talking With Voices approach. Dirk Corstens, independent, supervisor in the Making Sense of Voices and the Talking With Voices approach. Samantha Bowe, no conflicts of interest. Craig Steel, no conflicts of interest. Eleanor Longden has received payment for delivering presentations and workshops on the Making Sense of Voices and the Talking With Voices approach and is the joint Chief Investigator of the TWV-II trial (ISRCTN15897915).

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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REFERENCES

Aderhold, V., & Stastny, P. (2007). Full disclosure: Toward a participatory and risk-limiting approach to neruoleptic drugs. *Ethical Human Psychology and Psychiatry*, *9*, 35–61.

Allison, R. (2022). A tripartite relationship theory of voice hearing: A grounded theory study. *Psychosis*, *16*(1), 65–77.

Burr, C., Schnackenberg, J., & Weidner, F. (2022). Talk-based approaches to support people who are distressed by their experience of hearing voices: A scoping review. *Frontiers in Psychiatry*, *13*, 983999.

Corstens, D. (2021). Chapter I. The Maastricht approach: Social and personal perspectives on hearing voices. In I. Parker, J. Schnackenberg, & M. Hopfenbeck (Eds.), *The practical handbook of hearing voices. Therapeutic and creative approaches*. PCCS Books.

Corstens, D., Longden, E., & May, R. (2011). Talking with voices: Exploring what is expressed by the voices people hear. *Psychosis*, *4*(2), 95–104.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: Implications for research and practice. *Schizophrenia Bulletin*, *40*(Suppl_4), S285–S294.

Grunder, G. (2015). Are antipsychotics neurotoxic or neuroprotective? A long-term comparison of two treatment strategies: Study design of the multicenter APIC trial. https://doi.org/10.1002/central/CN-01198311/full

Hardy, A., Keen, N., van den Berg, D., Varese, F., Longden, E., Ward, T., & Brand, R. M. (2024). Trauma therapies for psychosis: A state-of-the-art review. *Psychology and Psychotherapy: Theory, Research and Practice*, *97*(1), 74–90.

Heriot-Maitland, C., Gumley, A., Wykes, T., Longden, E., Irons, C., Gilbert, P., & Peters, E. (2023). A case series study of compassion-focussed therapy for distressing experiences in psychosis. *British Journal of Clinical Psychology*, *62*(4), 762–781.

Hornstein, G. A., Branitsky, A., & Robinson Putnam, E. (2025). The benefits of hearing voices groups: More findings from a US national study. *Psychosis*, *17*(1), 1–11.

Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society.

Kent, J., & Zimmerman, M. (2022). *Handout: Facilitator training*. Voice Dialogue UK.

Lafferty, R., & Allison, R. (2021). Chapter 19. Voice dialogue. In I. Parker, J. Schnackenberg, & M. Hopfenbeck (Eds.), *The practical handbook of hearing voices. Therapeutic and creative approaches*. PCCS Books.

Leucht, S., Arbter, D., Engel, R. R., Kissling, W., & Davis, J. M. (2009). How effective are second-generation antipsychotic drugs? A meta-analysis of placebo-controlled trials. *Molecular Psychiatry*, *14*, 429–447.

Leucht, S., Cipriani, A., Spineli, L., Mavridis, D., Örey, D., Richter, F., Samara, M., Barbui, C., Engel, R. R., Geddes, J. R., Kissling, W., Stapf, M. P., Lässig, B., Salanti, G., & Davis, J. M. (2013). Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: A multiple-treatments meta-analysis. *The Lancet*, *382*, 951–962.

Leucht, S., Leucht, C., Huhn, M., Chaimani, A., Mavridis, D., Helfer, B., Samara, M., Rabaioli, M., Bächer, S., Cipriani, A., Geddes, J. R., Salanti, G., & Davis, J. M. (2017). Sixty years of placebo-controlled antipsychotic drug trials in acute schizophrenia: A systematic review, Bayesian meta-analysis, and meta-regression of efficacy predictors. *American Journal of Psychiatry*, *174*(10), 927–942.

Leucht, S., Tardy, M., Komossa, K., Heres, S., Kissling, W., Salanti, G., & Davis, J. M. (2012). Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: A systematic review and meta-analysis. *Lancet*, *379*(9831), 2063–2071.

Linscott, R. J., & van Os, J. (2013). An updated and conservative systematic review and meta-analysis of epidemiological evidence on psychotic experiences in children and adults: On the pathway from proneness to persistence to dimensional expression across mental disorders. *Psychological Medicine*, *43*, 1133–1149.

Longden, E., Branitsky, A., Jones, W., & Peters, S. (2022). 'It's like having a core belief that's able to speak back to you': Therapist accounts of dialoguing with auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice*, *95*(1), 295–312.

Longden, E., Branitsky, A., Jones, W., & Peters, S. (2023). When therapists talk to voices: Perspectives from service-users who experience auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice*, *96*(4), 967–981.

Longden, E., Corstens, D., Bowe, S., Pyle, M., Emsley, R., Peters, S., Branitsky, A., Chauhan, N., Dehmahdi, N., Jones, W., Holden, N., Larkin, A., Miners, A., Murphy, E., Steele, A., & Morrison, A. P. (2022). A psychological intervention for engaging dialogically with auditory hallucinations (talking with voices): A single-site, randomised controlled feasibility trial. *Schizophrenia Research*, *250*, 172–179.

Longden, E., Corstens, D., Escher, A., & Romme, M. (2012). Hearing voices in biographical context: A framework to give meaning to voice hearing experiences. *Psychosis: Psychological, Social and Integrative Approaches*, *4*(3), 224–234.

Longden, E., Corstens, D., Morrison, A. P., Larkin, A., Murphy, E., Holden, N., Steele, A., Branitsky, A., & Bowe, S. (2021). A treatment protocol to guide the delivery of dialogical engagement with auditory hallucinations: Experience from the talking with voices pilot trial. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*(3), 558–572.

Longden, E., Moskowitz, A., Dorahy, M., & Perona-Garcelán, S. (2019). Auditory verbal hallucinations: Prevalence, phenomenology, and the dissociation hypothesis. In A. Moskowitz, M. J. Dorahy, & I. Schäfer (Eds.), *Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology* (2nd ed., pp. 207–222). Wiley-Blackwell.

Longden, E., Read, J., & Dillon, J. (2018). Assessing the impact and effectiveness of hearing voices network self-help groups. *Community Mental Health Journal*, *54*(2), 184–188.

May, R., & Svanholmer, E. (2019). Self help guide to talking with voices. Ideas for people who hear voices and want to try engaging in dialogue with them, 14.02.2025.

McCarthy-Jones, S. (2017). *Can't you hear them? The science and significance of hearing voices*. Jessica Kingsley Publishers.

Middleton, K., Cooke, A., & May, R. (2024). "It allowed us to let our pain out": Perspectives from voice-hearers and their voices on the 'talking with voices' approach. *Psychosis*, *16*(2), 131–143.

Moskowitz, A., Corstens, D., & Kent, J. (2012). Chapter 2. What can auditory hallucinations tell us about the dissociative nature of personality? In V. Sinason (Ed.), *Trauma, dissociation and multiplicity: Working on identity and selves*. Routledge.

Moskowitz, A., Mosquera, D., & Longden, E. (2017). Auditory verbal hallucinations and the differential diagnosis of psychotic and dissociative disorders: Historical, empirical and clinical perspectives. *European Journal of Trauma & Dissociation*, *1*(1), 37–46.

Moskowitz, A., Read, J., Farrelly, S., Rudegeair, T., & Williams, O. (2009). Are psychotic symptoms traumatic in origin and dissociative in kind? In P. F. Dell & J. A. O'Neill (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 521–533). Routledge.

Mosquera, D., & Ross, C. (2017). A psychotherapy approach to treating hostile voices. *Psychosis*, *9*(2), 167–175.

Parker, I., Schnackenberg, J., & Hopfenbeck, M. (2021). *The practical handbook of hearing voices. Therapeutic and creative approaches*. PCCS Books.

Romme, M. A. J., & Escher, A. D. M. A. C. (1989). Hearing voices. *Schizophrenia Bulletin*, *15*(2), 209–216.

Romme, M., & Escher, S. (2000). *Making sense of voices*. Mind Publications.

Rosenberg, M. B. (2015). *Nonviolent communication: A language of life*. Puddle Dancer Press.

Sawin, G., Klasson, C. L., Kaplan, S., Sawin, J. L., Brown, A., Israni, S. T., Schonberg, J., & Gregory, A. (2023). Scoping review of restorative justice in academics and medicine: A powerful tool for justice equity diversity and inclusion. *Health Equity*, *7*(1), 663–675.

Schnackenberg, J., Burr, C., with Furrer, M., Iusco, O.-M., & Debesay, S. (2017). *Stimmenhören und Recovery. Erfahrungsfokussierte Beratung in der Praxis*. Psychiatrieverlag.

Schnackenberg, J. K., Fleming, M., & Martin, C. (2017). A randomised controlled pilot study of experience focussed counselling with voice-hearers. *Psychosis*, *9*(1), 12–24.

Schnackenberg, J., Burr, C., Debesay, S., Furrer, M., & Iusco, O.-M. (2017). *Stimmenhören und Recovery. Erfahrungsfokussierte Beratung in der Praxis*. Psychiatrieverlag.

Schnackenberg, J., Fleming, M., & Martin, C. (2023). Experience Focussed counselling with voice hearers as a recovery-Focussed approach: A qualitative thematic inquiry. *Community Mental Health Journal*, *22*(3–4), 125–146.

Schnackenberg, J., Fleming, M., & Martin, C. R. (2018). Experience focussed counselling with voice-hearers as a trauma-sensitive approach: Results of a qualitative enquiry. *Community Mental Health Journal*, *54*(7), 997–1007.

Schnackenberg, J., Fleming, M., Walker, H., & Martin, C. R. (2018). Experience focussed counselling with voice-hearers: Towards a trans-diagnostic key to understanding past and current distress – A thematic enquiry. *Community Mental Health Journal*, *54*(7), 1071–1081.

Schnackenberg, J., Iusco, O.-M., & Debesay, S. (2021). Experience focused counselling with voice hearers (180–193). In I. Parker, J. Schnackenberg, & M. Hopfenbeck (Eds.), *The practical handbook of hearing voices. Therapeutic and creative approaches*. PCCS Books.

Schwartz, R. C. (1995). *Internal family systems therapy*. The Guilford Press.

Servonnet, A., & Samaha, A.-N. (2020). Antipsychotic-evoked dopamine supersensitivity. *Neuropharmacology*, *163*, 107630. https://doi.org/10.1016/j.neuropharm.2019.05.007

Servonnet, A., Uchida, H., & Samaha, A.-N. (2021). Continuous versus extended antipsychotic dosing in schizophrenia: Less is more. *Behavioural Brain Research*, *5*(401), 1–12. https://doi.org/10.1016/j.bbr.2020.113076

Steel, C., Schnackenberg, J., Perry, H., Longden, E., Greenfield, E., & Corstens, D. (2019). Making sense of voices: A case series. *Psychosis*, *11*(1), 3–15.

Steel, C., Schnackenberg, J., Travers, Z., Longden, E., Greenfield, E., Meredith, L., Perry, H., & Corstens, D. (2020). Voice hearers' experiences of the making sense of voices approach in an NHS setting. *Psychosis*, *12*(2), 106–114.

Stone, H., & Stone, S. (1989). *Embracing our selves: The voice dialogue training manual*. Nataraj Publishing.

van den Berg, D., Tolmeijer, E., Jongeneel, A., Staring, A. B. P., Palstra, E., van der Gaag, M., & Hardy, A. (2023). Voice phenomenology as a mirror of the past. *Psychological Medicine*, *53*(7), 2954–2962.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin*, *38*(4), 666–671.

Waters, F., & Fernyhough, C. (2017). Hallucinations: A systematic review of points of similarity and difference across diagnostic classes. *Schizophrenia Bulletin*, *43*(1), 32–43.

Weinmann, S., Read, J., & Aderhold, V. (2009). Influence of antipsychotics on mortality in schizophrenia: Systematic review. *Schizophrenia Research*, *113*, 1–11.

World Health Organization (WHO) and United Nations (UN). (2023). Mental health, human rights and legislation: guidance and practice Geneva World Health Organization and the United Nations (represented by the Office of the United Nations High Commissioner for Human Rights).

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy. A Practitioner's guide*. The Guilford Press.

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