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THE GROUP OF VOICE HEARERS: MENTAL HEALTH CARE DEVICE

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ABSTRACT. Auditory hallucination is a phenomenon that is part of the lives of many people who are treated in the public mental health system of our country. In the daily life of a Psychosocial Care Center in a Brazilian capital, voice hearers frequently reported that they continued to suffer from hallucinatory experiences, even following the treatment prescribed by the health team. Considering this problem, a group was set up to deal with the phenomenon. This article aimed to analyze the experiences of this group. For this, the qualitative method was used, which involved the registration of sixty-two sessions in the form of a field diary, and the analysis of the corpus. The organization of the data occurred in three temporal spectra that structure group (psycho)therapies in general: "presentation", "exchanges of experiences", and "closure"; besides a dynamic aspect, called "therapeutic management". The presentation promoted the setting of the participants and allowed the emergence of important themes, which were worked on during the session. By exchanging experiences, the members were able to understand some dynamics related to voices, and there was the promotion of certain therapeutic factors. The management served to tie the spectra together and ensured the fluidity of the activity. It is recommended the adoption of groups with this focus and format in mental health services, considering that they increase the capacity of care.

Keywords: Group psychotherapy; hallucinatory confusion; mental health.

O GRUPO DE OUVIDORES DE VOZES: DISPOSITIVO DE CUIDADO EM SAÚDE MENTAL

RESUMO. A alucinação auditiva é um fenômeno que participa da vida de muitas pessoas que fazem tratamento no sistema público de saúde mental de nosso país. No cotidiano de um Centro de Atenção Psicossocial de uma capital brasileira, ouvidores de vozes relatavam com frequência que continuavam sofrendo em função de experiências alucinatórias, mesmo seguindo o tratamento prescrito pela equipe de saúde. Considerando esse problema, foi criado no local um grupo voltado para a lida com o fenômeno. Este artigo teve como objetivo analisar experiências desse grupo. Para isso, utilizou-se o método qualitativo, o qual envolveu o registro de 62 sessões sob a forma de diário de campo, e a análise do *corpus*. A organização dos dados se deu em três espectros temporais estruturantes de (psico)terapias de grupo em geral: "apresentação", "trocas de experiências", e "fechamento"; além de um aspecto dinâmico, denominado de "manejo terapêutico". A apresentação promoveu a ambientação dos participantes e possibilitou o surgimento de temas importantes, os quais foram trabalhados no decorrer da sessão. Ao trocarem experiências, os integrantes conseguiram compreender algumas dinâmicas relativas às vozes, e houve a promoção de determinados fatores terapêuticos. O manejo serviu para alinhavar os espectros temporais e garantir a fluidez da atividade. Recomenda-se a adoção de grupos com esse foco e formato nos serviços de saúde mental, considerando que eles ampliam a capacidade de cuidado.
Palavras-chave: Psicoterapia de grupo; confusão alucinatória; saúde mental.

EL GRUPO DE OYENTES DE VOCES: DISPOSITIVO DE CUIDADO DE LA SALUD MENTAL

RESUMEN. La alucinación auditiva es un fenómeno que forma parte de la vida de muchas personas que hacen tratamiento en el sistema público de salud mental de nuestro país. En el cotidiano de un Centro de Atención Psicosocial de una capital brasileña, oyentes de voces relataban con frecuencia que seguían sufriendo en función de experiencias alucinatorias, aun siguiendo el tratamiento prescrito por el equipo de salud. Considerando este problema, se creó un grupo orientado a la lectura del fenómeno. En este artículo se tuvo como objetivo analizar

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experiencias de ese grupo. Para ello, se utilizó el método cualitativo, el cual involucró el registro de sesenta y dos sesiones en forma de diario de campo, y el análisis del corpus. La organización de los datos se dio en tres espectros temporales estructurantes de (psico)terapias de grupo en general: "presentación", "intercambios de experiencias", y "cierre"; además de un aspecto dinámico, denominado "manejo terapéutico". La presentación promovió la ambientación de los participantes y posibilitó el surgimiento de temas importantes, los cuales fueron trabajados en el transcurso de la sesión. Al intercambiar experiencias, los integrantes lograron comprender algunas dinámicas relativas a las voces, y hubo la promoción de determinados factores terapéuticos. El manejo sirvió para alinear los espectros y garantizar la fluidez de la actividad. Se recomienda la adopción de grupos con ese foco y formato en los servicios de salud mental, considerando que ellos amplían la capacidad de cuidado.
Palabras-clave: Psicoterapia de grupo; confusión alucinatoria; salud mental.

Introduction

This study had as a starting point the annoyance about the fact that patients from a Psychosocial Care Center II (CAPS II) complained about the inefficacy of medications for the treatment of the voices that only they heard - a symptom called “auditory hallucination” and that in modern western societies has been taken, albeit mistakenly, as a symptom of schizophrenia[2] (Bauer et al., 2011). Auditory hallucination is a sensory-perceptual manifested through vivid and intrusive thoughts, auditory mental images and/or listening to voices and sounds (Johns et al., 2014).

Many of these had been on treatment at this center for years, and participated in therapeutic groups and other activities offered by the service. But despite having a better clinical condition compared to when they were hospitalized and treated in psychiatric hospitals (asylums), they were unable to “get rid” of voices - which can cause isolation, limitations to work, and in some cases, are so unbearable that they lead to suicide (Kalhovde, Elstad, & Talseth, 2013).

Faced with this problem, it was decided to create a group to specifically work on the phenomenon of “voice hearing” (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014, p. S285). This type of device has advantages over composite groups with varying demands, since the participants feel comfortable talking about the voices, as well as increasing integration and exchanges towards more appropriate care (Ruddle, Mason, & Wykes, 2011).

The group was called “voice hearers” and its methodology was inspired by the assumptions of the “Hearing Voices Movement” (HVM) (Longden, Corstens & Dillon, 2013, p.1), which is currently coordinated by Intervoice. The HVM approach aims to provide a space for listening and sharing experiences. As a support group, it provides a sense of safety, facilitates the process of understanding, and deals with voices, as people are helped to see issues that may be triggering manifestations, and to find meaning for their narratives (Dillon & Hornstein, 2013).

According to Baker (2009), by understanding voice hearing as a non-pathological manifestation of existence - which must be welcomed and qualified - this approach has contributed to shaking the mastery of the biomedical model in dealing with the issue, and has provided benefits for voice hearers, friends, family, and professionals. In addition, it has encouraged research and the development of support networks that have helped large numbers of people to leave the system dependent on the asylum/health-care service - and even the stigma associated with psychiatric diagnoses (Corstens et al., 2014).

Considering these issues, this article aimed to analyze the experiences of a group of voice hearers from a CAPS in a Brazilian capital, in order to contribute to reflections on the importance of this device in mental health care. For this, meetings recorded in a field diary were analyzed according to the procedures described below.

[2] We emphasize that there is no pathognomonic sign in mental health (Martins, 2003). In other words, auditory hallucination may be present in other clinical settings such as epilepsy, substance abuse, dementia, and mood disorders, among others (Larøi et al., 2012). The literature points out that rates of non-clinical voice hearers in the general population of some countries vary from 0.8% to 31.4% (Nuevo et al., 2012) - which makes problematic the association of the phenomenon with a mental illness, postulated by traditional biomedical logic.

The history of the group and the method of analysis

This study was based on a qualitative methodology and was part of an empirical research that focused on the phenomenon of auditory hallucination. Its execution was possible from the creation of the group of voice hearers at CAPS, which had one of the researchers as coordinator. To begin the activity, the research project was presented to management, and then in a meeting with the technical staff of the service. This study was approved by the ethics committees of the institutions responsible for conducting research - the Higher Education Institution and the State Health Department - through CAAE codes: 52032315.6.0000.5540 and 52032315.6.3001.5553.

The following inclusion criteria were formulated for the participants: 1) hearing voices frequently or to have had at least one experience; 2) being a volunteer; 3) agreeing to participate in the project. The team was asked to limit the maximum number of members to eight, since a pilot study would initially be carried out to evaluate conditions more adequate for the operation of the activity - it was common in the CAPS that the groups had an average of fifteen people, and this could compromise the exchange of experiences and therapeutic management.

The professionals of the team gave the researcher names of people who were interested in the activity, and through telephone contact or conversations at CAPS, the project was presented. Over time, due to the demands that have arisen, there was a recomposition of the initial proposal (with eight participants), so that in some sessions we had the presence of a larger number of people - not only patients, but also of relatives and friends.

During the 18 months of operation, 31 voice hearers (12 men and 19 women), 10 family members and three friends - the latter in seven sessions, three of them previously combined, participated in the group. The ages ranged from 23 to 65 years, and aspects such as race, socioeconomic status, diagnoses, and schooling were heterogeneous. The average frequency per meeting was five people - quantitative that was already expected, given the characteristics of the group. In addition, participants reported that voices bothered them mainly on the group day, and this impaired frequency in the sessions.

After each meeting, the researcher narrated on a tape recorder what had happened in the session - some relevant stories, themes, and events. In all, there were 62 narratives, with a total time of 15 hours and 25 minutes, and an average of 15 minutes for each record. The audios were transcribed so that they could form the corpus and be analyzed.

From the analysis of the diaries, data were organized into three temporal spectra structuring group (psycho)therapies in general: “presentation”, “exchanges of experiences”, and “closure”; in addition to a dynamic aspect, called “therapeutic management”, which tied the temporal spectra together and ensure the fluidity of the group and the therapeutic factors. Spectra and dynamic aspect will be described below. In order to protect the confidentiality of the participants, fictitious names were used, and other personal data were omitted.

The operation of the group

Before entering the description of the spectra, it is necessary to contextualize the working set of the group. According to Zimmerman (2007), the setting (p. 144) is an essential element for group development, since it is constituted by elements that normalize and give possibility for the therapeutic process to occur. Each session had an average time of 1 hour and 30 minutes, with the frequency of once a week, over a period of 18 months. Most sessions were held at CAPS activity room in order to provide a reserved environment. Nevertheless, for some occasions, due to the lack of place to carry out the activity, or at the request of the participants, some meetings were held in open spaces (including outside the CAPS).

After the first 9 months, the group started to develop without a defined limit of people, and they were free to attend or not. The purpose of this decision was to give the voice hearer the opportunity to choose the activity according to its wishes, by implicating itself in the questions and assuming the main protagonist role in the treatment. In addition, some meetings were also open to family and friends.

With 15 months of operation, the group had not yet felt the need to establish "coexistence agreements", that is, rules to avoid conflicts. This occurred at the request of some participants, after a session in which three of them had an argument. The established rules had the objective of: to provide a time of speech equivalent to all; respect the experience and position of each member; avoid interrupting whoever is speaking; and avoid imposing religious beliefs. It should be emphasized that this type of strategy must be built collectively, once the group is formed, and remembered in situations of conflict or readjusted, if necessary.

In the presentation of the spectra, we will make other considerations about the operation of the group. In addition to stretches of the diaries, we will present the topics that were most present in the sessions, the way they were worked and the "therapeutic factors[3]" (Yalom and Leszcz, 2006, p. 23) promoted through the experiences of the group.

Presentation

The sessions started in two different ways, depending on who was present. In the case of the presence of new participants, the facilitator requested that everyone introduce themselves, speaking the name, and how they arrived at the group (if they felt comfortable). This request had the intention of bringing contents that could be thematized in the group and facilitated the process of identification among the members, as Monica reported:

> *I have felt free, with much desire to speak, for the first time in life I identify with people who are like me, who understand my problem, and here in this group nobody will judge me or ask me to stop talking* (Session 6)

When she realized that she was not the only one to have experiences with hearing voices - a therapeutic factor called "universality" (Yalom & Leszcz, 2006, p. 26) -, Mônica started to feel better. The feelings reported by Mônica can be awakened in people who prefer to remain silent in the sessions, interacting in silence, since there is a possibility of learning and changing through the mirroring of the other - the "imitative behavior" (Yalom & Leszcz, 2006, p. 35), which was reported by some members in dialogues with the researcher. Another aspect that she mentioned was the "freedom to speak", which was related to the characteristic of the group in welcoming and dialoguing on any topic.

An important notion transmitted to them arose in the following situation:

> *Mara reported that she had asked the psychiatrist about her diagnosis, but that she did not get a conclusive answer. And João interceded: "doctors do not know what we have. In one occasion, I went to consult, and I asked: Doctor, what do I have? You know what he said? I do not know, who knows best is you."* (Session 9)

The facilitator then posed to the group that we would act like this doctor, valuing their explanation in the task of assigning meaning to the voices. This is a fundamental point in working with the group, since it helps the voice hearer not to become dependent on the health professional in the therapeutic process and subverts the traditional hierarchy of treatment – the patient becomes a protagonist in the process (Dillon & Hornstein, 2013).

One of the main points involved in the presentation, with the presence of new participants, was the possibility of finding in the report of the reason that led them to seek treatment some elements that contributed to the emergence of voices:

> *Jobson introduced himself and said that he has been at CAPS for more than five years, takes medicine and does not understand why, since he does not get better - he continues hearing voices and seeing things. He reported that the symptoms began with the death of the bride (whom he loved very much) with a gunshot (stray bullet). Soon after, he began to hear voices, which ordered him to*

[3] They are part of a complex process that occurs when people interact with each other sharing their experiences, and thereby promote therapeutic changes (Yalom & Leszcz, 2006). It was tried to emphasize not only the factors common to any group, as well as the specific ones to groups of voice hearing.

> *cut his wrists. Because of the suicide attempt, he was hospitalized in the asylum, and remained there for a long time. He improved a little, but he never stopped hearing voices or seeing the bride* (Session 3)

Jobson saw the death of the bride as the etiology of the voices he hears to. In addition to the death of loved ones, several other life events can contribute to hearing voices, such as bullying, divorce and violence (Kråkvik et al., 2015). Like Jobson, other participants reported experiencing shocking experiences, and associated them with the emergence of voices. According to Romme (2009b), exploring the origin of voices is an essential step in working the manifestations and the emotions they generate, and the moment of presentation contributed not only to this but also to working the senses of voices and coping strategies in the group.

When all the participants knew each other - which required another way of performing this initial moment of the session - the facilitator started the activity asking if anyone would like to say something, how they had spent the week, how the voices were, or any other subject that encouraged the dialogue, as in the following scene:

> *Today we conducted the group on the porch. Who started talking was the sound car that passed in the street, announcing fruits. I asked if they used to eat fruit, and Luana said yes, but she is closing the mouth. This question opened the possibility for her to talk about the difficulty of following the nutritionist's recommendations, because the voices give her orders to eat, and threaten her when she does not obey them* (Session 36)

In this case, the sessions began with this tone of informality, which served as a "warm-up" (Yalom & Leszcz, 2006, p. 228) for people to talk about their pains, as in Luana's case. Thus, placing a seemingly common or simple situation in the group opened up the possibility of major complaints and demands coming to the surface. In this initial moment of the session, some topics were already beginning to be debated by the participants themselves, as we will see next.

Exchange of experiences

This spectrum was fundamental to the development of the group. The exchanges of experiences stimulate people to construct other narratives about the phenomenon (Muñoz, Serpa Jr., Leal, Dahl, & Oliveira, 2011) and thus reveal different ways of dealing with suffering. They occurred just after the presentation and took up a longer time compared to the other spectra.

> *Samanta said she spent five days with severe headaches and that no medication helped her. The voices were ordering her to cut her hair, and after she cut it, the headaches ceased; but she was not happy about it. And then Luana reported that when she was married, she had the habit of changing the furniture, obeying commands from the voices. "After my husband left and separated from me, I stopped changing them. Then I understood that what really had to change was the relationship that I was not happy with." With that, we asked Samanta what she would like to cut out of life, which is bad* (Session 56)

The intervention of Luana was fundamental to draw attention to one of several possibilities of understanding voices: its symbolic meaning. When voices assume this form of communication, metaphorically, it is possible that they are referring to a problem in the voice-hearer's life. This was occurring with Samanta, who later reported that life was not good, because living with her husband was unbearable; she thought of living alone, but she would not do it yet because she did not have the emotional conditions to share the value of the house, and because she would lose a lot of money.

Important changes were made in order to help one to think of coping strategies:

> *Renato said that days ago he was hearing voices of sexual content that tormented him. He did not know what to do and started to hit the bed. He was getting nervous; his father came into the room and called his mother. They started to argue and he almost went into an outbreak. Daniel suggested that he leave the house to calm down. But Renato said it's no good, because the voices are with him. And Ana Beatriz said, "well, if the voices accompany you, you can try to relax, listening to music,*

> *something else, because the more you get into the voices, the more you become aggressive"* (Session 48)

The exchanges allowed for interpersonal learning (Yalom & Leszcz, 2006) about the voices, from the attentive listening of Ana Beatriz: that when reacting with aggression, the voices became worse, and thus Renato could have a crisis (mainly because the family did not accept well his clinical condition); and that he could perform an activity that moves in the opposite direction of aggressiveness. Renato was able to reflect on this and talk more about actions he had already taken to mitigate voices. Participants encouraged him not only to think about strategies, but also to try them out at a next opportunity.

One of the objectives of the group was to help people develop coping strategies, considering that dealing with voices is a crucial step to: a) empowerment (gaining control over them) and reducing emotional valence - which causes a lot of suffering (De Leede-Smith & Barkus, 2013); b) the recovery process (Escher, 2009); c) establishing some way of living with them. When this topic was debated in the group, people sought to talk about both strategies that worked well with them, as well as those they had already heard from other participants, and this served to give members a chance to increase their repertoires of strategies.

Other exchanges were given in order to provide emotional support to the pain of the other:

> *Manfredo entered the room very impatiently. A few days ago, the voices disturbed him, and this began when a friend told him he should sell his farm. They said, "Sell, you do not deserve to own the place". And then he told us the history of the farm, much suffering. He saw his father beating his mother, among other problems. He said he likes the place and does not want to get rid of it, but he is suffering, feeling very alone. Then the participants sought to help him. Heloisa spoke of things she does to not feel alone. Ana Beatriz advised him to stay more at the house of the friend who lives nearby. Mônica worried about his mother, asking how she was today; among other exchanges. At the end of the session, people gave him hugs, and he reported that he was feeling better* (Session 30)

In this stretch, therapeutic factors are present, according to Yalom and Lenszcz (2006): "altruism" (p. 32) - for the support and concern about Manfredo's pains - and "information sharing" (p. 29) - which was made through the suggestions he received. These resources were widely used among the participants, and they made them feel more comforted and strengthened to face the difficulties.

Talking about future goals was an issue in some sessions:

> *Alípio said his gift is to digitize documents, that the greatest blessing is when you find an old document available on the internet, and he wanted to make money from it. Daniel said that it is not something complicated, that if he has a scanner device, he could do. He said that once a farmer who had no internet at home asked him to digitize some laws and paid him a hundred reais (local currency). Alípio was very excited and said he would seek to learn more about it* (Session 50)

Two sessions later, Alípio resumed the subject: "*It took me so long to find out what I like to do, and now that I have discovered I have to seize this opportunity*". The group provided not only to Alípio, but also to some other members, the possibility of wishing, of getting excited with new plans, an issue that helped them in the process of empowerment in front of voices. These three aspects relate to some of the various benefits of voice-hearing groups and corroborate Romme (2009a).

The identification of "triggers" (Longden, Corstens, Escher, & Romme, 2012, p. 4) was also another topic dealt with among participants:

> *Moema reported that from the age of 23 she listens to voices, and that as a child she went to an indigenous tribe, and she saw a demon entering the tent of an Indian. She has already attended spiritism, but no longer believes in this religion. And then Raiane started to feel sick; reported that the voices were coming to pick she up. Daniel got up and left the room with her for some water. And Renato pointed out: "Sigh, every time we talk about these things of spirit, she becomes ill"* (Session 46)

Renato made a fundamental contribution to the group work, since the triggers refer to factors that provoke or aggravate the voices nowadays, and that it is necessary to evaluate them so that we can understand the problems associated with them and their emotional dynamics (Corstens & Longden, 2013). During the time of the group, the most frequently reported triggers fit into the description of Corstens and Longden (2013): specific emotions (such as guilt and anger), specific people (family members and cohabitants), and specific circumstances (for example, situations in the social environment).

Once the topic was presented through speeches such as Renato's, the exchanges were to recognize the triggers of each participant and seek to explain them and were important to recognize that if they came into contact with them, there would be the possibility of voices to manifest. Moreover, the debate on this topic paved the way for dialogue on coping strategies, and was important because it helped not only members of the group, but also family members - since some strategies were focused on talking to a person of reference - , to give other resolutions to the matter.

Closure

This spectrum referred to the final moment of the session, which had a short duration, since it was sought to explore and preserve to the maximum the exchanges of experiences. However, considering that the closure was also an important moment of the activity, it is necessary to highlight some elements that were part of it.

One important aspect was the resumption of events (of positive or negative valence) that the members had reported during the session. This was done not only by the facilitator, but also by the other participants, and promoted the therapeutic factor "altruism" (Yalom & Leszcz, 2006, p. 32), as in Félix's speech: "*sigh, after these statements I see that my suffering is small. You must have great strength because this suffering is difficult* (Session 16)". Besides this element, when some important theme or demand was finalized by the end of the session, without having been sufficiently explored, the facilitator briefly summarized the question, and then asked the participants if they would like to resume it at the next meeting.

The closure was also a time for the transmission of some warnings and recommendations from CAPS, or from the group itself. In addition, it was checked if any member was having to resolve any issues or clarify doubts about a particular subject. It was common for the members to ask the facilitator to help with the verification of the appointment date of the psychiatric service with the manager, as well as the interest in enrolling in professional courses or income-generating activities - which required dialogue with professionals with whom had not had contact at CAPS.

Next, we will discuss the therapeutic management, which served to tie together the three temporal spectra analyzed.

Therapeutic management

In this topic, the most frequent interventions performed by the facilitator will be presented. A basic intervention was called "circularization":

> *Ana Beatriz had said that the voices were appearing and ordering her to kill herself. And then Luma said, "Oh the voices always tell us to mess up, bad thing, then it's not to believe them". I opened the question to the group, asking what they thought could be done with these voices* (Session 20)

The circulation of the speeches opened the possibility for people to formulate ideas and integrate themselves, as well as to horizontalize the knowledge - an important aspect for the egalitarian decision-making process among the people of the group (Vasconcelos, 2013). In addition, this type of intervention provided the discussion of other issues (such as Luma's statement, which triggered dialogue on coping strategies).

Another intervention was the reiteration (Rogers & Kinget, 1977), which consisted in punctuating an important element in speech, summarizing the narrative or repeating words spoken at the end of a story:

> *Samanta reported that after her daughter died, everything collapsed. The husband quit his job and abandoned everything; they live on the benefit she receives, and they have three children. She feels good going to the cemetery, and she does not understand why.*
>
> *- Facilitator: You feel good going to the cemetery* (Session 35)

As she talked more about the cemetery, Samanta could understand why she felt good at this place - she was close to her daughter and away from home (the family thought her suffering was fussiness). Reiteration is a preparation for awareness and broadens the field of perception about what is being called into question (Rogers & Kinget, 1977). Further, the participant has the feeling that someone is accompanying him/her and that he/she is making him/herself understood - which serves as a stimulus to the free expression of content (Holanda, 2009).

Another strategy was the reflection (Vasconcelos, 2013), which has the same objectives of reiteration, but is done through questions:

> *And on the voices, João said that "the only solution to this suffering is to die".*
>
> *- Facilitator: And why dying is the only solution to this suffering?*
>
> *- I have several problems, and it is only getting worse, I cannot see with one eye, I hear voices, I do not sleep, I cannot read or write, my family does not like me because I hear voices, I do not receive any benefits, I cannot get medicine. So, it's all very bad, and if I die, I'm done with all this, so I can rest* (Session 10)

After João's speech, the facilitator opened the question to the group. Participants were able to reflect on death and suicide, and we talked about other ways of dealing with problems that caused great suffering. This session was important for the following ones, because when one participant spoke about dying, it was supported in order to seek another way of thinking - which means that there was an increase in the capacity to deal with this question. In another session:

> *Marieta reported a problem with her mother and sister, which has brought her a lot of irritation, and she does not know how to behave with her mother; feels that it will "burst" (sic). She asked the group for some advice. And then Luana said: "My great-grandmother said that we have to keep silent, that the greatest wisdom is to do nothing, to be silent and to be calm, that this avoids much fighting."*
>
> *-Facilitator: But is it best to keep quiet?* (Session 61)

Luana has a biographical trajectory full of violence and learned to remain silent since when she was raped in childhood (nothing was done by the person who knew the fact). This behavior contributed to her not being able to deal well with the voices and harmed her in marriage - she was silent in the face of her ex-husband's violence.

Considering the situation of Luana and other participants who had also suffered from the most diverse violence, and who had difficulty dealing with voices because they could not talk about them, the intervention of the facilitator was to suspend prejudices and expand possibilities in dealing with what causes suffering. Reflection was also used in other sessions, more often when a participant had an event related to voices, and it is a form of management that should be done with care and through open questions (to avoid suggestions).

Another form of intervention was the normalization, which consisted of presenting the phenomenon from different perspectives, through: stories of clinical voice hearers or international famous personalities who established a good coexistence with voices; data from HVM surveys; and information from cultures that treat the phenomenon differently, among others. Such an intervention had the objective of promoting the feeling of belonging to a common, "normal" place, and identification with a phenomenon that is part of the human condition - issues that attenuate self-stigma and isolation (Ruddle et al., 2011). In addition, it favors the "instillation of hope" (Yalom & Leszcz, 2006, p. 25) - the belief that suffering can be overcome (as occurred with some participants). Normalization is

characterized as a non-specific therapeutic factor - that is, common to all group approaches - called psychoeducation (Cordioli & Giglio, 2008).

One of the most specific interventions in the treatment of the phenomenon and in the management of this type of group is the dialogue with the voices, which combines techniques of Transactional Analysis, Gestalt and Psychodrama, and was developed by professionals of psychiatry, psychology and voice hearers who are part of HVM/*Intervoice* (Baker, 2009). It consisted of talking to the voices directly or with mediation of the participant, as in the following stretch:

> *Heloísa said the voices were unbearable. She had something to tell, but she was not ready, and the voices would not speak to me. So, I proposed an agreement:*
>
> *- Excuse me, I want to talk to Heloísa, and I know you're very upset because we talked things in the group that you did not like. But she is suffering, and I wanted to request an agreement. Would you just let me talk to her without talking? I'll set a minute on the clock, and when that time is up, I'll let you know if you want to talk again. Is that ok?*
>
> *She agreed. I started the clock, and I told the time had begun* (Session 31)

And then Heloísa seemed to have woken up. She reported that she was abused by her father at the age of five, and that the voices were disturbing her with that content a few weeks ago, since there were family conflicts related to that subject. With the end of the agreed time, the facilitator warned Heloísa, but she said she did not want the voices to come back, because it seemed that she has gotten rid of the burden and was feeling relief. In this intervention, we used one of the focusing techniques created by the Hearing Voices Network Australia (2006).

Baker (2009) stated that with the application of this form of management it is possible to verify that, when the voice hearer manages to develop a stronger and positive attitude in relation to the voices, it is possible that they change. Thus, the dialogue with the voices aims to: encourage the person to communicate with them; explore reasons why they are manifesting; help them to see different perspectives on what they are talking about; give support to the person to have greater control over the experience (as was clear in the stretch) and to find coping strategies.

Its application is not limited to the individual clinics, but also in a group. However, in the sessions where all participants remained in the room, the dialogues were more difficult, and the facilitator sought other speech intervention strategies. They should be alert to this type of intervention: it should not be intentionally induced unless it is conducted by persons trained or experienced in the subject, otherwise other problems may arise (such as hospital admission or loss of bond with the family). In any case, the collaboration of the participants is the differential factor in crisis support.

Other strategies were the provision of a space to attend the participant and/or its family at different times to the group and the possibility of them seeking support from the network. As for the first, it occurred when someone did not feel comfortable in the group to expose a particular situation, and when the relatives had difficulties or doubts in understanding and dealing with what was happening with the participant.

Regarding the dialogues about the possibility of seeking the support of the care network - CAPS professionals, institutions in charge of guaranteeing rights, as well as family and friends - they took place based on the guidelines established by the Psychosocial Care Network (Ordinance 3088, 2011), in order to: diversify care strategies; meet more specific needs of the participant; and stimulate social control.

This intervention served not only to increase the capacity for care, but also generated positive effects in relation to voices. As an example, we have the case of Moema, who was feeling anguished by the debts that the previous owner of her residence had left. The facilitator guided her to seek the Public Defender's Office, and with the help of this body she was able to begin solving the problem. From there, she became less worried, and this contributed to reduce the manifestations of the voices.

Final considerations

This study sought to present experiences from a group formed in a public health service, and had some limitations: bureaucratic service issues - the participation of people who were not patients or family/caregivers of patients was not allowed; because it was an open group, there was variability in the frequency of participants; and the impossibility of recording sessions - an issue that could have provided a greater volume and precision of data to be analyzed.

We emphasize exceptions to generalizations about auditory hallucination from the results of this work, considering that it portrays an experience based on a specific current of thought (HVM/*Intervoice*) - and that there are other ways of dealing with the phenomenon. Even so, it has been found that this current provides essential elements for the care of people who listen to voices. The data of the group indicate that it is possible to affirm that this is a device that promotes important therapeutic factors for the process of dealing with the phenomenon of hearing voices and recovery in mental health.

Thinking about these aspects, the group of voice hearers can be carried out in other spaces belonging to the community. This could contribute to a decrease in the demand for health services, as a strategy for prevention and promotion in mental health, as in countries that have HVM nuclei (Corstens et al., 2014), and to promote changes regarding the stigma of madness. In addition to these groups, family and territorial interventions - essential elements to demystify and transform social representations about auditory hallucination - assisted and articulated employment with services (including CAPS) and skill training are psychosocial strategies highly recommended, since they have a proven level of efficacy (Green et al., 2014).

With these actions, it would be possible to transform traditional treatment logic, which insists on trying to reduce, silence and suppress the phenomenon of hearing voices (Englisch & Zink, 2012; Sommer et al., 2012). It is important to point out that, in favor of the biomedical model for the treatment, which consists of diagnosis and medicalization, the health service opposes the idea of CAPS as a place for the creation and implementation of ways to care for and treat mental health (Merhy, 2007). And in addition, in the attempt to silence the voices, the person is who become silent, and with it the most genuine possibilities of coming to be.

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