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Hearing voices that others do not hear: adolescents' experiences in a large city in Midwest Brazil

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ABSTRACT

Objectives: to analyze the experience of adolescents hearing voices that others do not hear. **Methods:** a qualitative documentary analysis study involving a database of interviews with school-age adolescents in Cuiabá, Brazil. Data collection took place in July 2022 and involved 49 interviews. Content analysis was used for data analysis. **Results:** adolescents described experiences of hearing voices accompanied by sensory manifestations, voices calling out names, non-vocal sounds, sounds of known and unknown people, sometimes with negative content. In these experiences' contexts, feelings such as confusion, fear, threat, affection, and friendship are awakened, as well as coping strategies such as ignoring the voice and spirituality. **Conclusion:** hearing voices is an experience present in adolescence and requires nursing to reframe the understanding of the phenomenon to (re) construct new care practices, mitigating the medicalization and pathologization of the experience.

Descriptors: Hallucinations; Hearing; Adolescent; Mental Health; Education, Primary and Secondary.

INTRODUCTION

In mental healthcare in Brazil, two models of care coexist with opposing approaches: the psychiatric model and the psychosocial model. The psychiatric model is predominantly hospital-centric, focusing on the illness and its symptoms and ignoring the individuals' uniqueness in the context of distress, contributing to their segregation and exclusion from society. In turn, the psychosocial model is centered on individuals and their particularities, and is directed toward de-hospitalization, promoting social reintegration, and personal autonomy[1,2].

The psychosocial model began in Brazil through the anti-asylum struggle that culminated in the Psychiatric Reform instituted by the Law 10,216 of 2001, which deals with the protection and rights of people with mental distress, redirects the care model, and seeks to transform the mental health scenario, from a hospital-centric/asylum model to a model of psychosocial care in freedom[3].

The World Health Organization (WHO) recognizes the pressing need to implement assistance based on care in freedom and human rights and presents therapeutic strategies in this context, among which is the Hearing Voices Movement, created in the Netherlands in the 1980s by Dutch psychiatrist Marius Romme, his patient Patsy Hage, and social researcher Sandra Escher[4,5].

The Voice Hearing Movement seeks to deconstruct the view of voice hearing as something solely pathological, requiring diagnosis, and to create an understanding that it is a possibility, something natural, experienced by human beings. In this movement, voices are understood as part of the singularity and manifesta-

tion of each person's subjectivity, being real to those who experience them[6].

The experience of hearing voices can be characterized by noises, voices, or perceptions felt without external stimuli that other people cannot experience[7,8].

This is an event described since Antiquity[9] and which, with the advent of Modernity, began to be perceived as an alteration of the sensoriperceptive mental function, technically called auditory hallucination, which manifests itself mainly in schizophrenia[7]. However, studies have shown that hearing voices can occur in both clinical and non-clinical conditions[8]. In other words, the phenomenon of hearing voices is not limited to symptoms of mental disorders, and also occurs in children[10] and adults[11] without mental disorders. Hearing voices that others cannot hear is a phenomenon that has caused stigma and exclusion over time, but there is currently a movement towards its social acceptance[9].

The phenomenon of hearing voices presents peculiarities considering different age groups — children, adolescents, and adults[8]. Meta-analysis indicates that the mean lifetime prevalence of hearing voices is 12.7% for children aged 5 to 12 and 12.4% for adolescents aged 13 to 17[12].

Adolescence is marked by intense psychosocial development and several factors that can influence mental health, such as violence and socioeconomic problems, which can contribute to the emergence of the first voices[13]. In turn, hearing voices can be an experience that generates distress[8], anguish[14,15], shame and guilt[16].

Adolescence is an age group considered a priority for actions by the United Nations[17] and the WHO[18], which aim for this population not only to survive, but to prosper and transform the reality of their community, with this aim.

Therefore, understanding each adolescent's experiences with hearing voices demonstrates nursing professionals' and healthcare professionals' interest in the topic and can help direct care for this group. On the other hand, a lack of knowledge in this area can weaken the care provided by professionals working in healthcare services and schools, contributing to the prescription of treatment based on a pathological and medicalizing perspective, reinforcing the idea of the need for social exclusion, and contributing to the oppression suffered by people who hear voices[10,19].

To assist in this process, following the WHO recommendations, Brazil implements and maintains health risk factor surveillance systems aimed at the adolescent population, through the National School Health Survey (In Portuguese, *Pesquisa Nacional de Saúde do Escolar* — PeNSE)[20]. This research provides essential information for monitoring the factors that impact student health across the country and helps identify the main issues that require attention in the formulation of public policies aimed at promoting student health, with a special focus on the School Health Program (In Portuguese, *Programa Saúde na Escola* — PSE)[20].

Factors other than those considered in the PeNSE[20] need to be monitored. It is necessary to understand in detail the phenomenon of hearing voices in adolescence in order to differentiate auditory diversities and the processes of constructing meanings in relation to hearing voices and ways of coping[21].

Although the importance of implementing public policies aimed at promoting mental health in adolescents is well known, the number of studies related to the experience of hearing voices in various settings in Brazil is still limited.

There is a proposal, under analysis by the Education Committee of the Chamber of Deputies, to create the Brazilian National Policy for Psychosocial Care in School Communities[22]. This bill aims to guarantee psychosocial care actions in school environments, considering the demands of emotional distress in childhood and adolescence[22].

Among the professionals who work in the PSE, nurses stand out, as they are the professionals responsible for planning, executing, and assessing care plans in light of the demands that may affect adolescents[23,24]. In this context, nurses should consider monitoring and understanding voice-hearing as part of mental healthcare initiatives in school settings, coordinating actions between Primary Health Care and schools. Including these professionals contributes to strengthening intersectoral partnerships and promoting health in schools for adolescents who experience hearing voices.

Given the above, understanding adolescents' experiences in relation to hearing voices can help nurses be closer to this group, enable the creation of new approaches in nursing practice in Brazilian child and adolescent mental health, and contribute to the implementation of public policies for health promotion in schools.

Thus, the present study aimed to analyze the experience of adolescents hearing voices that others do not hear.

METHODS

This is a qualitative study, involving secondary data analysis from a main project entitled "Mental Health and the Use of Alcohol and Other Drugs in the Child and Adolescent Population of Cuiabá: Mental Health Assessment and Promotion", conducted in five state schools in the capital of the state of Mato Grosso, Brazil, from April 2021 to June 2022. The project met the requirements recommended by the COnsolidated criteria for REporting Qualitative Research (COREQ). This study was conducted in July 2022.

Data collection in the matrix project

In the main study, 136 adolescents aged 12 to 18 years, enrolled in the 7th, 8th, or 9th grades of elementary school and in the 1st, 2nd, or 3rd year of high school, were interviewed. The interviews were semi-structured, using the Youth Self-Report (YSR) data collection instrument[25]. They were conducted individually, in a private room provided by the school, lasting approximately one hour, and all interviews were recorded. The interviews were conducted by a professor, a doctoral student, and previously trained nursing students.

After responding positively to negative mental health symptoms and negatively to positive symptoms, the interviewer encouraged adolescents to discuss the topic further with the following

phrase: "Tell me more about that". The data saturation technique determined the study's participant count[26].

Document analysis *corpus*

By checking the database of the parent project, 51 interviews were identified, whose respondents declared a positive response to the "I hear sounds or voices that other people think aren't there" item of the YSR[25]. After reviewing all the interview audios, four more were included because adolescents responded negatively to the question about hearing voices. However, in subsequent reports, they mentioned hearing experiences and described them in detail. Of the 55 eligible interviews, six were excluded due to poor audio quality, which prevented transcription. Thus, 49 interviews with adolescents who reported hearing voices were included, and the audios were transcribed by the researchers.

In order to maintain anonymity, participants were randomly coded with "god names", following the order of participation in the research.

Data analysis

Thematic content analysis was used, which sought to interpret the meanings of the information behind the messages[26] reported by adolescents.

In the first stage, all speech fragments discussing hearing voices were read, grouping them according to similarities or repetitions of content into units of meaning, using color coding. Subsequently, the reading was repeated, confirming their aggregation by similarity of meaning.

In the second stage, a new, more in-depth reading was carried out, from which statements were reorganized, allowing the emergence of three thematic categories.

The data were discussed from the theoretical perspective of psychosocial care and the international Hearing Voices Movement (HVM)[5,27].

Ethical aspects

The main project was conducted in accordance with the ethical precepts mentioned in Resolution 466/2012 of the Brazilian National Health Council, registered on the *Plataforma Brasil*, and received a favorable opinion from the Research Ethics Committee, Certificate of Presentation of Ethical Consideration (In Portuguese, *Certificado de Apresentação para Apreciação Ética* — CAAE) number 38241420.4.0000.8124.

The interviews were conducted after the Informed Assent was obtained from all adolescents involved in the study, in writing and verbally at the time of the interview, as well as the Informed Consent of their guardians.

RESULTS

Of the 49 interviews included in the research, the majority referred to female participants (n = 34), predominantly aged 13 (n = 12) and 17 (n = 11).

The categories that emerged in the content analysis were:

1. Describing the experience of hearing voices;
2. Feelings awakened by the experience of hearing voices; and
3. Ways of coping when hearing voices.

Each of them and the respective excerpts from adolescents' statements that support them are presented below.

Describing the experience of hearing voices

This category encompasses sensations produced in the sense organs – hearing, sight, touch – accompanied by intangible sensations such as impressions of presence and intentionality.

In general, the experiences reported by adolescents in this category indicate the sensation of hearing voices calling the adolescents' name, similar to family members' (father and mother) or non-family members' voices, and even similar to the adolescents' own voice.

> *Always calling my name* [...] *the voice of my father, my mother, my sister and a friend of mine.* (Aphrodite)
> *I hear it, then I can't memorize the voice; sometimes it sounds like my voice and the voices of a person I've never heard in my life.* (Hestia)
> *I hear someone whispering in my ear.* (Athena)

In addition to voices articulating words, hearing screams, whispers, laughter, ringing in the ears, sounds of footsteps, and opening and closing doors and windows have been reported.

> *Steps through the house, opening doors and windows.* (Hades)
> *A laugh at home.* (Poseidon)
> *It's like a buzzing sound.* (Selene)

Added to these are the sensations of presence, of being watched, and body chills, accompanied by the sensation of seeing people, figures, as per the statements transcribed below.

> *I feel like someone is coming, but it turns out they aren't. I also feel people nearby. Someone is spying on me.* (Agamemnon)
> *A shiver, but it only got shivers on one side of my body.* (Medusa)

Feelings awakened by the experience of hearing voices

This category refers to the feelings aroused in adolescents when hearing voices, such as crying, confusion, guilt, fear, and feelings of threat, as described below.

> *I cried, woke my mother up, showed her, and heard a couple fighting.* (Achilles)
> *I get confused about this; I get scared.* (Persephone)
> *They put you down, and feel guilty.* [When asked how he felt about the voices] (Nidavellir)
> [...] *that I feel threatened by this, and it* [the voice] *was getting closer and closer.* (Medusa)

Sometimes, the voices had negative content, including commands that could influence adolescents to commit an unwanted action, such as bodily harm, destruction of material things, incisive instructions regarding where to go, where to come, and what to say, or and causing changes in mood status.

> *It's usually negative. It's never positive* [...] *that I won't achieve my goals.* (Isis)
> *It influences me to do things, like cutting myself or throwing myself...* (Apollo)
> *The voice told me not to say anything!* (Hercules)

Adolescents also report engaging in conversation with the voices, which play a supportive and positive role. Affection emerges as a consequence of interacting with the voices and is attributed to a friendship, as described below.

> *We talk about my day, about many things that hurt me or hurt other people. We talk.* (Ares)
> *...I have a friend named Gabriel; I always forget his original name* [...]. *The twins, they don't talk much, but Gabriel talks a lot* [...] (Apollo)

Ways of coping when hearing voices

In this category, the strategies adolescents use when hearing voices emerged, representing ways of living and coping with these phenomena. The narratives link hearing voices with spirituality as a form of communication with ancestors, a search for connections with the voices, and an understanding of voices as intuition, premonition, or even a gift, as the following statements demonstrate.

> *My grandmother is of a religion, spiritualism... and she has to choose another person to pass on a gift, so she chose me.* (Demeter)
> *I'm a spiritualist, so sometimes I have mentors...she speaks to me through intuition* [...] *something might happen.* (Themis)
> [...] *my ancestors trying to communicate with me by saying something* [...] *or someone from my future, also trying to communicate with me* [...] *the voice of someone I have never heard in my life; it is the voice of my soulmate.* (Hestia)

Strategies for coping with voices include engaging in attentive listening, dialogue, efforts to avoid responding, seeking to ignore the voices, or finding ways to block the voices from being heard, as can be seen in the following statements.

> [...] *all gossipy, they talk about everything, how they see everything! I love it, they talk about everyone* [...], *that's why I listen.* (Atlanta)
> *I already answered. My mother tells me not to answer.* (Hephaestus)
> *Better not answer.* (Theseus)
> *I try to listen to music to stop it.* (Ra-Atum)

DISCUSSION

This research adds to the body of scientific literature on voice-hearing in adolescents and can contribute to strengthening mental health nursing care centered on individuals, their uniqueness, and their needs. It can also inform training from undergraduate level onward, enabling nurses to develop work within the psychosocial care network with the necessary preparation to care for adolescents who hear voices. This is one of the first studies conducted in Midwest Brazil on this topic.

The experience of hearing voices is a multifaceted and complex phenomenon, involving diverse sounds beyond speech and more subtle sensations and impressions. It can have negative or positive content and be perceived as something frightening or a gift. In this variety of meanings produced, coping strategies reveal both acceptance and listening, as well as blocking and escape.

In the case of adolescents receiving mental healthcare services, distress related to hearing voices can be alleviated when these experiences are understood as related to past experiences, rather than being attributed to mental illness, especially when the personal meaning constructed around them reduces the perception that they are domineering, intrusive or persecutory[21].

Future longitudinal research should be developed to understand, in more depth, the personal meaning of hearing voices for different social groups and age groups of adolescents, the experiential mechanisms and their impact during this vulnerable period of adolescence and in the years to come in adulthood.

Several facets of voice hearing described in the present investigation have been reported in previous studies[7,28-35], which increases the volume of evidence.

Experiences of hearing voices calling adolescents by name, a significant finding in the narrative descriptions of the participants in this research, were also reported in another study[31]. In more than half of adolescents' reports, they reported hearing the voices of familiar people who were close to them, suggesting a dialogic relationship with the voice. It is worth noting that familiarity with voices causes less discomfort and anxiety, in addition to awakening feelings of tranquility[31-35]. In a population of adolescents without clinical alterations of psychoemotional disorders, the voices are generally loaded with positive content[36].

Hearing a voice is an experience that can be accompanied by sensory manifestations of feeling and seeing, such as those mentioned by the adolescents in this study, as well as associated with visions and smells, and can be described as "curious", "strange", and "mystical" experiences[28,29]. The hearing of non-vocal sounds, such as whispers, footsteps, laughter, and buzzing, found in the present investigation, was also described in another study in which buzzing, clicks, bangs, and horns were identified[30].

Other studies have also evidenced that Hearing voices with negative or derogatory content, i.e., voices that threaten, frighten, criticize, or abuse listeners[28]. It is noteworthy that users of mental healthcare services are more likely to hear frightening and negative voices compared to non-users[9]. The content of negative voices

plays an important role in generating distress and the need for care in those who hear them[7,28,31].

Studies suggest that the voice's content and the meanings attributed to them, may be related to listeners' life context[7,30,31], and to their religious and cultural beliefs[7,32]. Listeners' emotions can shape the voices and vice versa, i.e., negative voices can reproduce negative emotions[31].

In the dialogue between adolescents and voices, functional properties can be configured, such as attempts to control voices in relation to listeners, a phenomenon also identified in another study[30]. The commanding voices that attempted to control adolescents, such as not responding to questions, self-harm, destroying objects, and suicidal ideation, identified in this investigation, were also found in the results of a study in which the voices heard that verbalized commands presented a greater chance of self-harm[33].

Healthcare professionals can use strategies to: help adolescents face these situations, such as guiding them to record their experiences in diaries, which constitutes a device that encourages listeners' self-reflection[34]; carry out activities such as drawing, coloring, telling stories, listening to music, meditation, and breathing exercises[29]; practice physical activities and participate in religious services[35], which encourage the recovery of protagonism and control of individuals' own trajectory[32].

Spirituality is another strategy for coexistence between listeners and the voices referenced by adolescents in this study, which was perceived as a gift, a manifestation linked to the family's religion, in addition to providing a feeling of belonging to a group, which supports another study[35].

Several studies point to participation in groups of people who hear voices as a positive strategy that helps in understanding this experience, in addition to providing mutual help, constituting a space for acceptance, experience exchange, emotional support, and self-knowledge through sharing their experiences. These groups become places for the construction and active participation in decision-making in daily life, as they encourage, authorize, and value the narratives and meanings granted by people who hear voices, different and distant from psychiatric stigma[5,34], in addition to the construction of social meaning, which favors the sense of community, authenticity, and understanding[37].

Another important strategy to be developed with adolescents, within the reach of nursing, is dramatization. It is characterized as an intervention that helps in coping with situations of oppression, through sharing experiences among participants, who use bodily and verbal expressions of emotions to vent their feelings. It can be applied in the school environment to prevent negative emotional impacts on adolescents through problematization[38].

The formation of groups of individuals with mutual interests is an important social movement, built on the horizontality of knowledge between caregivers (often healthcare professionals) and the individuals who experience hearing voices[39]. This type of space provides a leading role, autonomy in actions, positions in the search for political and civil rights, and reflections on psychiatric knowledge, transforming itself into an important pathologizing counter-discourse[7,39].

In this context, it is worth highlighting that, in early 2024, advances were made in policies related to school health, with the establishment of the Brazilian National Policy for Psychosocial Care in School Communities, which seeks to promote: the school community's mental health; the intersectoral approach of educational, health, and social assistance services to guarantee psychosocial care for this population; the guarantee of access to psychosocial care for the school community; the intersectoral action between educational, health, and social assistance services to guarantee psychosocial care; the raising of awareness in society about the importance of psychosocial care in the school community; in addition to the dissemination of scientifically verified information and clarification of information related to mental health[40]. This policy converges with the PSE, in which nurses gain a new field of activity.

The implementation of the Brazilian National Policy for Psychosocial Care in School Communities may contribute to the early identification of the experience of hearing voices and the use of strategies to promote mental health and the monitoring of students by healthcare professionals, especially nurses.

Nurses can contribute with early actions and interventions to minimize adolescents' and their families' distress through humanized care, based on Psychiatric Reform and Human Rights guidelines, working with a close eye on the most vulnerable to identify children and adolescents experiencing psychological distress and triggering events that may contribute to its onset, such as the positive association with being a woman, self-identifying as black, having a boyfriend/girlfriend, and smoking. The stressful event was the rupture of affective, sexual, emotional, and material ties.

Furthermore, other strategies can be implemented by nurses, such as reflecting with adolescents on the risk of suicide induced by the voices and the possibility of deciding to refuse to act in the face of harmful commands[32].

Nurses lead health promotion actions at school, in the context of the PSE, through clinical evaluations and health promotion and disease prevention actions, effectively collaborating in the early detection of changes and encouraging care. In addition, nurses develop educational moments that address important topics for adolescents' health, through participatory and active learning methodologies that encourage learning and the making of positive health choices, thus favoring the leading role of students in self-care[22,39].

Although this research contributes to improving understanding and expanding discussions about the phenomenon of hearing voices, to prevent and/or reduce medicalization and pathologization of this experience, it must be acknowledged that it has some limitations, such as poor audio recording quality, which resulted in the loss of some data. This weakness was only noticed after the interviews were concluded, making it impossible to reconstruct the statements under the same spontaneous conditions as the others.

CONCLUSION

Adolescents perceive the experience of hearing voices as encompassed by not only vocal sounds but also noises and sensations that evoke feelings such as guilt and fear. Voices can present themselves as commands, with negative content, resemble the voices of familiar people, or be interpreted as forms of connection with the transcendental dimension, with protective purposes. Strategies used by adolescents to cope with voices include ignoring the voice, listening to the voice, and blocking the reception of the voice.

The experience of hearing voices that other people do not hear demands that nursing professionals reframe their understanding of this phenomenon and (re)construct new mental healthcare practices that help people who hear voices cope this phenomenon, such as the approach proposed by the international Hearing Voices Movement.

Professional support for adolescents who report hearing voices is crucial within the Psychosocial Care Network. In this context, nurses are prominent and proactive in implementing new mental health approaches that support individuals.

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RUHB: conceptualization; data curation; formal analysis; investigation; methodology; writing – original draft and writing – review & editing.
BSA: conceptualization; data curation; formal analysis; investigation; methodology; writing – original draft and writing – review & editing.
CGW: supervision; validation; visualization; writing – original draft and writing – review & editing.
MNB: data curation; methodology; validation; visualization; writing – original draft and writing – review & editing.
DFSJ: data curation; methodology; resources; validation; visualization; writing – original draft and writing – review & editing.

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Conflict of interest

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