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THE USE OF MASKS IN THE TREATMENT OF PATIENTS WITH CHRONIC AUDITORY HALLUCINATIONS

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Summary

Aim. The aim of this article is to describe a useful therapeutic approach in a patient with chronic auditory hallucinations resistant to a previous drug treatment and other forms of treatment available in the community therapeutic programme.

Person and method. The patient, a 28-year-old man, resident of a big city, treated psychiatrically from the age of 16, from the age of 20 diagnosed with psychotic disorders. A significant role in his illness history was played by severe, persistent auditory hallucinations associated with the illness for years, causing considerable suffering and acute problems in social functioning. Previous pharmacotherapy with antipsychotic drugs, full and part-time hospitalisation, individual outpatient treatment and participation in group therapy did not produce symptom remission.

Results. After a therapeutic intervention using a mask made by the patient which was a modification of the Avatar therapy described by Julian Leff, a significant improvement of the patient's condition was obtained: a dramatic reduction of auditory hallucinations and their severity and a marked improvement in social functioning.

Conclusions. Cognitive therapy with the use of a mask is a useful method in the treatment of patients with chronic auditory hallucinations, also for those who have experienced trauma. Low cost of this type of intervention compared with the Avatar therapy is an additional advantage.

Key words: schizophrenia, chronic auditory hallucinations, therapy with the use of masks and Avatar

Introduction

It is estimated that 20–30% of diagnosed schizophrenia sufferers do not respond to standard treatment [1]. Within this group, a significant number have chronic auditory hallucinations. Various kinds of innovative, non-standard therapies are being offered to such people. These include biological and pharmacological therapies [2, 3], as well as psycho-social interventions [4–7]. One of the latter is Avatar Therapy, designed and described by Julian Leff [8, 9] and described in Polish literature by Stefaniak and Leciak [10]. In short, this begins with creation of a virtual face/mask on a computer screen, which then represents and speaks the content of the patient's hallucinations. The patient starts a dialogue with the

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content. The role of the therapist is to accompany and support the patient and, as time passes, to modify the content of the voice's utterances in such a way that they become less traumatising for the patient. The final outcome is the disappearance of hallucinations or reduction of their severity. Despite its obvious advantages and the attainment of favourable therapeutic results, the method has some limitations. The most important is the significant degree of technological complexity, which may render it hard to implement in many low-income countries. In Poland, inspired and supported by Professor Leff, we attempted to modify the Avatar Therapy in such a way as to make it suitable for use within the Krakow system of community treatment [11]. In place of computer techniques requiring specialist hardware and software we decided to use papier-mâché masks made by the patients themselves.

Patient description

An invitation to participate in the study was extended to and accepted by Mr B. – a patient aged 28, resident in a city, both parents living, with older siblings, a brother and two sisters. A psychiatric patient since the age of 16, he was initially diagnosed with depressive disorders. Subsequently, from the age of 20, following his first psychiatric hospitalisation, this diagnosis was modified to schizoaffective disorders, and finally, after a second hospitalisation, to schizophrenia. The course of the illness was severe, necessitating a series of psychiatric hospitalisations, in both inpatient and outpatient settings. The majority of these hospitalisations occurred in the latter years of treatment, indicating his deteriorating state of health. His health between hospitalisations, especially in recent years, was poor, both in terms of protracted positive symptoms – chiefly auditory hallucinations of offensive content, intense disorders of thought processes with thought blocking, and negative symptoms – social withdrawal, apathy, abolition and anhedonia. These symptoms caused significant problems with social functioning – for the vast majority of this period he was not able to maintain social contacts beyond his immediate family, and was not able to study or work, with the exception of brief periods of employment in his sister's company as a kitchen helper. Pharmacological treatment involving a variety of anti-psychotic drugs (such as haloperidol, olanzapine, amisulpiride, aripiprazole) in suitable doses for long periods not only failed to produce the anticipated relief or diminishing of symptoms, but from a certain point started to have significant side effects in the form of intense dyskinesias.

Mr B. was unable to take advantage of the psychosocial forms of therapy offered to him owing to his considerable difficulties with activeness, which caused him to be late to therapy sessions or not to attend them at all. Several times, for the same reason, he was unable to complete treatment begun on day wards. Inpatient hospitalisations either failed to improve his mental condition, or produced temporary improvements lasting only a few weeks. Outpatient treatment was also difficult. On many occasions the patient did not attend previously arranged doctor's and psychotherapist's appointments. His wherewithal to take advantage of outpatient forms of psychotherapy, whether in individual or group settings, was limited.

The patient's family circumstances had been very hard for many years, particularly in his childhood, with acute conflicts erupting between his parents, and loud arguments accompanied by swearing. There was also an alcohol problem at home, affecting both parents. His adolescence had likewise been difficult. During this period Mr B. had been a victim of

chronic persecution by his peers, lasting several years, which only ceased following the intervention of a friend of the patient's brother. Most of the patient's care was provided by his older siblings, above all his brother. Even once an adult, when he was in treatment, the person who brought him to outpatient appointments when he was incapable of coming alone was his brother. One of the factors in the decision to invite Mr B. to use the mask therapy was the context: the chronic, sustained nature of his positive and negative symptoms, and the limited efficacy of previous forms of treatment, whether pharmacotherapy or psychosocial interventions. Another significant factor in the selection of the patient for participation in the mask therapy was the fact that he hears one voice. Julian Leff's research [9] indicated that the greatest benefits from the Avatar Therapy are derived by patients who hear single voices. Patients with multiple voices find it harder to concentrate on dialogue with the voice and to choose one single one with which to polemicise.

Preparation of therapeutic intervention

In view of our previous contacts with Prof. Julian Leff, we resolved to use a modified form of the Avatar Therapy, with the personal participation of Leff himself in the first therapy meeting. The initial session was preceded by several weeks of preparations, including correspondence with Prof. Leff on the subject of our selected case, allowing him to study the patient's case history in advance, and creation, in cooperation with an art therapist, of a mask that was to personify the voice heard by the patient.

Over 5 days Mr B. made a face in clay, which subsequently, impressed in papier-mâché, painted, and adorned with hair, took on the form of a mask. As well as the patient, the other participant in this stage was an art therapist with both an art education and many years' experience of working with psychotic patients. The stage involving creation of the avatar – the mask – is the first, but also a very important element of the therapy process, because the mask is a reflection of what the patient feels, sees and hears, and what is often material inaccessible to the therapist. The mask made by the patient is a self-portrait of his inner experiences; already at the stage of creating the mask the patient is revealing something that was hitherto deeply, often unconsciously concealed. Moreover, creating a mask that is to personify the voice he hears is a way of confronting it, even at this stage. What had previously been invisible can now be seen by Mr B. in reality and it is possible to become familiar with something that had previously elicited fear. Over the course of the week-long workshop, he sculpted a mask of a woman with long hair, slightly terrifying, or perhaps terrified, as suggested by her large, wide-open, somewhat exaggerated eyes that attract attention and provoke a range of emotions, as we found out in our discussion after the first session as we attempted to answer the question "What do we see in this face?". Fear, sadness, a smile that is not a smile, terror and shame, as intimated by the red cheeks. A whole gamut of emotions, perhaps a reflection of the feelings harboured by the patient for his mother. (Figure 1)

Figure 1**. – The mask**

When the mask was ready, the patient was invited for his first session. In addition to Mr B., the (female) therapist acting as the voice for the mask, and the therapist supporting the patient, this session was also attended by Julian Leff. (This was similar to the first successful session with a female patient which has not been described yet). Leff was advising the therapist on how to work with an externalised voice. His remarks, reflections and comments were an integral part to prepare for the meeting with the mask. Also present was a team of a few of our system therapists who had earlier been involved in therapeutic work with patients and who observed and then offered their reflections on the course of the meeting [11]. The observers had dynamic, systemic/family and psychodramatic background. Although Mr B had been prepared by his therapist and the art therapist for the meeting at first he was very tense and agitated. He had difficulty with having to be present in a social situation, with the necessity of revealing inner content, and above all with the situation of confronting the mask as embodiment of his fears, initially experienced as an exclusively hostile, persecutory object. At that point the team taking part in the session had the task of reassuring the patient and explaining to him, step by step, what was going to happen. An important stage in this process was also talking about the patient's life history and attempting to find out exactly when he started hearing this voice.

In his interaction with the patient, the therapist also used material obtained from previous contacts (doctor's visits and individual psychotherapy) and attempted to help Mr B. understand how events from his childhood – parental rows and persecution by his peers at school – contributed to the emergence and content of the voices he hears. Although the patient was quick to reveal the content of the words spoken by the voice – "You little shit! You son of a bitch! You're filth!" – he initially denied that the voice and the words it spoke reminded him of any specific situation or person that he knew. Thus the first intention was to understand the source of these voices, and to find the situation in his life that might in some way be associated by the patient with the fears that he experienced. Encouraged by the

questions, Mr B. turned his thoughts back to his childhood, during which time he was repeatedly witness to dramatic arguments between his parents, which frightened him so much that he would hide under the table. It was then that he heard from his mother aggressive content identical with that spoken by the voices. Thus the hypothesis was mooted that the voice heard by the patient was that of his mother, but the patient denied this, saying that the voice itself did not remind him of anyone he knew. He admitted that he sometimes tried to fight the voice, by concentrating on an action of some kind, which he repeated for extended periods of time – "I try to continue a particular action to turn THAT off."

The intervention

Our next step, after familiarising ourselves with the patient's life history and obtaining the vital material that was the specific content usually heard by the patient from the voice, was to proceed to the next stage of the session, i.e. confrontation with the voice. Attempting to oppose such voices and refute the truth of the content they speak is a very important point in mask therapy. Given that confrontation with the voice, which was often aggressive and spoke unpleasant, damaging words, might prove too stressful for the patient, we decided that the first session should be short, no longer than 15 minutes. The therapist explained to the patient that now the mask would say to him what he usually heard from his voice.

***Therapist**: Bernard, I am here to support you in your dispute with the voice. It will now say the unpleasant things that you hear. Are you ready?*

***Patient**: Yes, I think so.*

Mask: You son of a bitch! You're filth!

P: I'm not.

T: You are someone valuable …

P: I am someone valuable.

T: Louder, say it louder!

P: I am a good person.

M: You son of a bitch! You're filth!

T: I don't think the voice can have heard you?! You are someone valuable – I think the voice ought to know that?

P: You're talking rubbish!

T: And?

P: I felt good! (smiles)

At first the patient said in a very quiet voice that he wasn't filth. After the therapist's intervention he changed his statement to a positive one. He said that he was someone valuable, that he was a good person. Gradually, encouraged by the therapist, the patient spoke louder and louder, looking the mask in the face. The next intervention was an attempt to find out how Mr B. construed the voice's message. Although at the early stage of the session the patient denied that the voice came from anyone he knew, after his first confrontation with the mask, asked by the therapist who the voice belonged to, he said that perhaps it was his mother's after all – the same one that he had always heard during the family rows. After a moment Mr B. shared his observation that perhaps the words that he had heard back then had been directed not at him but at his father. His parents' arguments that he had witnessed had been a difficult experience for him. Mr B. stressed that during those rows "Mum would fly

into a fury", but nevertheless in his narrative about relations within the family he expressed himself positively with regard to his mother, which prompted the therapist to ask whether the voice that the patient hears might be his mother's voice.

T: Were they your mother's voices?

P: They were directed at Dad, but I took them to myself.

T: Perhaps those arguments stressed you and that's why you took the voices to yourself?

P: Mum would fly into a fury.

T: Did you want to oppose that at the time?

P: I think so.

T: That must have been difficult, because you were a small boy back then.

P: Mhm...

T: From what I remember of our conversations, you felt very lonely in that situation?

P: Yes.

During the first session the patient, in his dialogue with the voice, attempted to refute what the voice was saying loudly and decisively. With the therapist's help he reformulated the voice's offensive comments into positive assertions about himself. He said he was a good man, that he was wise, intelligent, persevering and sensitive. He took issue with the voice, telling it to stop talking nonsense about him. In situations when the patient spoke too quietly and unclearly, the therapist urged him to repeat his words louder and more decisively, straight in the mask's face. After this intervention the patient breathed a visible sigh and said he felt funny.

M: I still think you're filth.

P: I'm not filth, I'm a valuable person.

T: Say it to the mask's face!

P: I'm a good person and I know it!

….silence

P: I feel funny now.

T: Tell the voice that you don't want to hear it again, that it's damaging you and it should go away.

P: You're ruining my life, I don't want you in my life any more, you're talking nonsense!

M: Tell me what's good about you.

P: I'm wise, intelligent, modest, persevering.

T: I think you're sensitive and good too.

P: (silence… smiles)

The aim of the final stage of the session was to have the patient reject the voice that was bothering him. The therapist thus asked the patient to tell the voice to go away. At that point, the mask toned down its criticism and started to cast doubt on its previous words. As a rule the mask – or, in the original version, the Avatar – only starts to be supportive in subsequent sessions, but in this particular case we decided that the patient needed positive reinforcement and the hope that the voice would leave him. The first session ended with the voice, played by a female therapist, starting to express doubts as to whether it was right.

M: Perhaps I'm wrong?

P: Perhaps it's time to stop this?!

M: In the future I'll think about leaving you alone.

T: Would that be good for you, if the voice left you in peace?

P: I think it would, because I wouldn't have to feel sorry for myself.

T: Can we end this session now? You managed very well with standing up to the voice.

P: (smiles)

At the end of the first session the therapist congratulated Mr B. on succeeding in tackling the voice, and discussed with the patient his feelings and experiences in connection with the session. The patient said that admittedly it had been a rather strange experience, but it hadn't been as terrible to deal with as he had thought.

An important element of the Avatar Therapy is giving the patient a recording (e.g. in MP3 format) so that he can listen again to what he said in his duel with the voice. This is so that at difficult times between subsequent sessions he can replay his battle with the voice and feel again/convince himself that opposing the voice is possible.

Subsequently, after saying goodbye to the patient, the other participants in the session put forward their reflections and preliminary hypotheses regarding the patient's past experiences which may have influenced the emergence and words of the voices. His regular doctor said that it was an immense success that the patient actually attended the session, formulated full sentences, and opened up in front of so many people, which undoubtedly demonstrated Mr B.'s determination to fight the voice. In the course of the session we also noticed that in spite of his difficulties talking, which are related to his dyskinesias, with every successive question and intervention the patient opened up further, increasingly willing to talk about himself, his experiences and his feelings. We felt that his relationship with his sister was also significant, as she has a dual role in relation to the patient; she is also Mr B.'s employer. The patient reports that his sister often treats him harshly, does not understand his health problems, and often underestimates them. She also believes that the patient exaggerates his difficulties, that he is just lazy and takes advantage of his illness in order not to work. We decided that it would be advisable to organize a meeting between the therapist and the patient's sister, or for her to attend psychoeducational classes, in order for her to learn more about and better understand her brother's illness and in particular the negative symptoms accompanying it. The reflecting team also made reference to the traumatic events in Mr B.'s childhood (bullying at school) and to the relationship with his elder brother, an important one for the patient. We decided that his relationship with his brother, the only important, supportive and protective point in his life, could have potential for further work with the patient in subsequent sessions with the mask. We decided to start the next session from that angle, formulating a question that would be connected with the patient's brother and at the same time a reference to the positive words that the patient spoke about himself during the first session.

After the first session there were three more. The first two were within six weeks of the index meeting (after two weeks, and then after another four), and the last after the summer holiday break, around three months after the first session. These sessions took place without the participation of the reflecting team, with the attendance of just three people: the patient, the patient's own doctor/therapist, and the therapist playing the voice of the mask. The second

session took place 10 days after the first meeting. During the session the patient was asked about his feelings following the first meeting with the mask. As he had directly after that session, he admitted that it had been a difficult experience for him, but at the same time something that had given him hope of overcoming the voice. Moreover, he emphasised that it had been another step in his own inner work on himself, and that it had helped him to feel better. In the next step the mask, referencing the previous session, asked the patient who else in his immediate environment also claimed that the patient is a good, sensitive person. Without hesitation, Mr B. mentioned his elder brother. Next, in line with the adopted strategy, the mask became gentler and more supportive of the patient. There was no more space for offensive messages such as the patient had heard during the first confrontation, because even then the voice had begun to doubt its own words. So the mask apologised to the patient and once again suggested that there was a chance that the voice would shortly leave.

M: Last time you said a lot of nice things about yourself. Who else thinks of you like that?

P: My brother.

T: Could you give some specific situations?

P: For example I'm sensitive because I sympathise with my brother; it makes me upset to see him tired or sad. So I tell him to have a rest.

T: OK, so what do you want to tell the mask today?

P: To leave me in peace, and then my life will be better. I don't want it to carry on insulting me.

M: I'm sorry. The words I spoke weren't directed at you.

T: What do you think now?

P: I feel good. I'm pleased that it wasn't to me but to somebody else.

M: Once again, I'm sorry. I'll try not to do it again.

P: Great, I'm pleased.

The third session was held three weeks after the second one. During this session we decided that it was important that the patient initiate a dialogue with the mask, in order for him to feel that discussion with the voice was possible, that he could oppose it and regain control. At the beginning, the patient was asked, as is standard, what had happened in his life since the previous meeting. He reported having become bolder in his interpersonal contacts, happier to talk to people, calmer, and that the voice was no longer bothering him so often and he was able to deal with it. He also admitted that he had had an argument with his sister, who had once again threatened to sack him from work for his lateness and lack of motivation. In this situation we decided to use the figure of his sister for the dialogue with the mask, in order also to draw out material regarding the patient's desires and needs in respect of relationships.

M: Why didn't you show up for work again?

P: Because I'm ill, and anyway I didn't feel well after my drugs.

M: Ill?! I'm ill too, I've got everything to deal with – work, the house, the kids, and I have to manage somehow, without drugs!

P: But I'm all alone! I don't feel well, nobody supports me.

M: What is it you really want from me?

P: For you not to get at me, for you to be gentler, kind of… sisterly.

M: I'll try to be gentler… what else?

P: I want to talk to you.
M: About what?
P: I don't know… About your children, for you to tell me about them sometimes.
M: What else?
P: About the World Cup!! (laughs)
M: OK, I'll try to be gentler to you, and if there's a situation when I'm not, please talk to me about it.
P: OK.
M: So when can we talk frankly?
P: Maybe today, but I'm very scared of it.
M: I think it can work. Can we agree that next time you tell me how it went?
P: OK, I will!

The final, fourth session, took place a month later. The patient cancelled a previously arranged session, perhaps out of fear of confrontation, as at the previous meeting he had enthusiastically agreed to have a talk with his sister, saying that he would do it "even today". The planned talk with his sister was to be an attempt to improve their relations, to end their conflicts at work (the patient works for his sister), and an attempt to have a "normal conversation, e.g. about my sister's children or about the World Cup". With the therapist's earnest persuasion, Mr B. agreed to a final "farewell" session with the mask.

The patient was markedly more chatty, and was more open to talking about what had happened in his life. The mask asked the patient what had happened since the previous meeting, at which the patient at once started to recount yet another conflict with his sister, who had finally sacked him from his job. She had said that that had been the last chance, which the patient had wasted, and that he was not to come back. "She said I should sit (at home) with my parents". The reason for his dismissal had been the patient's failure to carry out a disposition of his sister and wishing to put it off until later.

Most of the themes raised by the patient during his final session were connected with his relationship with his sister, or rather with the conflict between them. He spoke about how important that relationship is to him, as is the work, which gives him satisfaction, money, and contact with people, and hence motivation to leave the house. The mask tried to encourage the patient to be active in other ways – perhaps to look for work elsewhere. Mr B. resolved to consider other things that he could and would like to do on a day-to-day basis. At the end, the patient smiled and thanked "Ms Mask" for her part in the sessions and all the questions.

In addition to the sessions with the participation of the third person, the female therapist who was the voice of the mask, there were also regular therapy sessions every three to four weeks, where the changes taking place in the patient's health and life were discussed and the possible influence of the "mask" sessions on those changes considered.

After the final parting session and the farewell with the mask, the patient's auditory hallucinations essentially ceased. They were replaced with obsessions connected with counting, and with sexual strands. These were far milder and less destructive from the patient's point of view than the auditory hallucinations. As the therapy team we were curious as to the permanence of the change described here. With this in mind we resolved to wait a

year from beginning the mask therapy in order to assess the longer-term effects of the therapy. Throughout that year, medical contact was maintained. As the psychotic symptoms had desisted, the dosage of anti-psychotic drugs could be considerably reduced. The patient's social activeness was a significant problem. In view of the above-mentioned conflict with his elder sister, who was also his employer, he could not count on a return to his previous job. For a few months he spent most of his time at home not knowing what to do with himself. As the mask therapy took place in the context of the community psychiatric treatment system, which runs facilities including a community care home, the patient was offered the chance to participate in the activities there. After a few unsuccessful attempts, the patient ultimately began to attend therapy regularly. He proved to be a very engaged and active participant, liked by those around him and eager to help others.

At present, a year on from the beginning of the mask therapy, he remains essentially in remission from his positive symptoms. If some auditory hallucinations do occur, they are negligible and have no significant disruptive effect on the patient's social functioning. He continues to participate in the activities and therapeutic programme of the community care home, with great satisfaction, and wants to start work in a protected environment. He is also planning a trip to the mountains for a therapy camp. This will be his first trip and chance to spend time outside the city independently for many years.

Discussion

The described therapeutic methods forms part of a larger project intended for patients who chronically hear cruel voices which is currently being conducted under the Krakow system of community therapy using the mask or monodrama [12]. Therapeutic intervention using a mask is a variation on the Avatar Therapy developed by Julian Leff et al. [9]. The Avatar method is expensive but has already proved its efficacy for patients who have for years been relentlessly hearing voices, usually cruel and taunting ones that do not respond to pharmacological intervention. While successive therapies have confirmed the efficacy of the mask therapy, an additional value may be seen in the relatively low costs of this form of intervention (low-tech), which in comparison with the Avatar Therapy (which is high-tech) could make it particularly valuable in many low-income countries in Africa, Central and South America, and Asia, where the culture is rich in strong connotations with masks. Mr B. unquestionably fell into the category of patients with chronic auditory hallucinations, which had a very negative impact on how he felt and functioned socially. The impotence of the therapeutic system – the lack of effects of pharmacotherapy, the poor efficacy of both inpatient and day hospitalisations, and the lack of availability, rejection, inefficacy of classic psychotherapy were all arguments in favour of use of alternative treatment methods.

It is our firm belief that among the factors that may have been particularly useful in Mr B.'s case we should mention above all the opportunity to initiate an external dialogue with the voices previously present in his inner mental space. These two elements – dialogue with others and externality – made a significant difference to the previous monologue of the voices in his inner mental space. Dialogue with the Others offers a sense of agency in the situation, because the voice changes as a consequence of what the patient says. The person thus feels that they are no longer defenceless in the face of an all-powerful, omniscient voice, which in Hacker's opinion [13] is a key element in the severity of auditory hallucinations. Similar observations and first promising results were obtained by Bielańska [12] in her interventions

in patients with chronic auditory hallucinations using psychodrama. In this case patients who had heard voices for many years also displayed alleviation of symptoms. Externalisation of the dialogue also facilitates support from the environment. The person finally experiences that they are not alone with their voices, and that there are others around them who understand, want to help, suggest, advise. This time the Others are kind, they perceive the patient's value as the patients themselves describing the situation.

Another significant therapeutic element is for the patient to link the words they hear from the voices with traumatic events from the past. Understanding this dependence enabled Mr B. to find the meaning of the symptoms he was experiencing, and also to defend himself from them more effectively than before. The links between trauma and psychotic disorders have been addressed many times in the literature [14–16]. Our experiences indicate that there is a way of working therapeutically with psychotic patients that can help to reduce the effects of trauma.

It is also important to recognise the contribution of non-specific factors to the usefulness of this method – the special atmosphere that comes at the beginning of every newly introduced therapeutic method, the feeling of being the centre of attention of a group of people important to the patient, and of greater interest, which can help to improve their sense of their own value and leave the hallucinations "less free space" to occupy, as Leff et al. [9] pointed out.

Conclusions

1. Mask therapy is a potentially useful method in therapy for patients with schizophrenia and chronic auditory hallucinations, including those with the experience of early childhood trauma.
2. An additional advantage of this form of therapeutic intervention may be its low cost compared to the Avatar method.

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