

Giving context and meaning to hearing voices: The Maastricht approach as a technology of the self for the care of the self

Dotando de contexto y sentido a la escucha de voces: el enfoque Maastricht como tecnología del yo para un cuidado de sí

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ABSTRACT Within the biopsychiatric model, hearing voices is understood as an auditory hallucination, usually associated with a diagnosis of schizophrenia. In contrast, the Maastricht approach understands hearing voices as a survival mechanism and holds that it is possible to learn to live with voices and to make sense of them. Using a qualitative design and drawing on a governmentality perspective that conceptualizes the Maastricht approach as a technology of the self, this study conducts a discourse analysis of the Maastricht interview guide. The analysis is organized around the following categories: the aims and actions promoted by the approach; how it conceptualizes the voice-hearer, the voices, and the relationship between the voice-hearer and their voices. The Maastricht approach differs from biopsychiatric forms of self-management in three respects: voices are understood as meaningful and situated experiences; the subject is conceived as relational; and the relationship between the subject and their voices is characterized by mutual influence. Consequently, this tool for self-knowledge and self-transformation makes visible a situated form of suffering rooted in personal, collective, and structural contexts, in which voices are part of the ecosystem of a subject engaged in the practice of taking care of the self.

KEYWORDS Mental Health; Self Care; People with Psychiatric Disorders; Dissent.

RESUMEN En el modelo biopsiquiátrico, escuchar voces es una alucinación auditiva ligada, usualmente, al diagnóstico de esquizofrenia. Sin embargo, en el enfoque Maastricht, escuchar voces es un mecanismo de supervivencia, es posible aprender a convivir con ellas y dotarlas de sentido. Desde un diseño cualitativo y una perspectiva gubernamental se realiza un análisis del discurso del guion de entrevista del enfoque Maastricht como tecnología del yo, partiendo de las siguientes categorías analíticas: los objetivos y las acciones que moviliza el enfoque; cómo conceptualiza al escuchador de voces, a las voces, y a la relación entre el escuchador y las voces. Difiere de la gestión de sí biopsiquiátrica en tres aspectos: las voces son significativas y situadas, el sujeto es relacional, y se da influencia mutua entre el sujeto y sus voces. En consecuencia, esta herramienta para el autoconocimiento y la autotransformación visibiliza un sufrimiento situado, enraizado en contextos personales, colectivos y estructurales en los que las voces son parte del ecosistema de un sujeto que ejerce el cuidado de sí.

PALABRAS CLAVES Salud Mental; Autocuidado; Personas con Enfermedades Psiquiátricas; Disidencias.

Introduction

In Western culture, hearing voices is directly associated with madness. Within the biomedical psychiatric model, hearing voices is understood as an auditory hallucination that generally leads to a diagnosis of schizophrenia. From this perspective, biopsychiatry establishes a clear and definitive separation between the subject and the voices they hear, with the ultimate aim of reducing and/or eliminating those voices. Accordingly, voices categorized as auditory hallucinations are assumed to bear no correspondence or relationship to reality and are considered devoid of meaning. Consequently, psychiatric patients who hear voices are expected to manage them either by ignoring them or by denying their existence.

Throughout this study, biopsychiatry serves as an analytical model, both because of its predominance and because, in countries of the “Global North,” hearing voices is generally situated within the realm of acute psychological suffering, framed in clinical and hospital settings where the hegemonic medical model, in Eduardo Menéndez’s terms,⁽¹⁾ encounters fewer forms of resistance and dissent. Following Nikolas Rose in *Our Psychiatric Future*,⁽²⁾ it can be argued that biomedical psychiatry remains hegemonic within European and North American research and that, in cases of acute psychological suffering, psychiatric medication constitutes the primary intervention in clinical and hospital settings, while non-adherence to pharmacological treatment is regarded as a matter of serious concern.

Nevertheless, several nuances highlighted by Nikolas Rose regarding the predominance of the biopsychiatric paradigm should also be acknowledged. Although most psychiatrists regard psychiatric medication as essential, they do not usually adopt an exclusively biological approach. Diagnostic and treatment guidelines vary across countries, evolve over time, and are implemented to different extents. Moreover, people experiencing mild or moderate psychological suffering are often cared for by networks of family members, friends, and other non-professionals outside the mental health system. Beyond hospital settings and medical supervision, a wide range of healthcare practices with little emphasis on the biomedical model continue to proliferate. Furthermore, biomedical psychiatry currently coexists with a number of theoretical and clinical perspectives that challenge its hegemony, most notably collective mental health⁽³⁾ and postpsychiatry.^(4,5)

The emergence of this hegemonic biomedical paradigm is rooted in the history of psychiatry itself, specifically in the European Enlightenment of the eighteenth century, shaped by the modernizing project concerned with reason and social order, the search for scientific and technological solutions to human problems through the positivist method—grounded in the dualisms of body/mind and individual/society—and the primacy accorded to individual subjectivity.⁽⁴⁾ Against this

historical background, biopsychiatry emerged as the application of the biomedical model to internal, individual mental processes. It is closely linked to developments in psychopharmacology and oriented toward identifying causal explanations of biological origin that claim universal validity.⁽⁶⁾ Its method relies on scientific research and technological development—primarily in the fields of genetics, molecular biology, and neuroscience⁽⁵⁾—with the aim of producing classifications of mental disorders understood as brain imbalances, that is, as natural phenomena detached from both social relations and cultural contexts.⁽⁷⁾

Among the principal sociological traditions concerned with mental illness, this article is situated within the framework of social constructionism⁽⁸⁾ and, more specifically, within the poststructuralist tradition inaugurated by Michel Foucault in his work on madness, psychiatric institutions, and the nexus of knowledge and power. This tradition is centered on the critical examination of discursive practices, particularly their relationship to processes of subjectivation and modes of governance. It has exerted considerable influence on critical psychiatry and has been further developed by Nikolas Rose^(2,9,10,11,12,13,14) and, subsequently, by scholars who have applied biopolitical critique to contemporary practices of self-management in the field of mental health, including Allan V. Horwitz,⁽¹⁵⁾ Simone Fullagar,^(16,17,18,19) Bianca Brijnath,⁽²⁰⁾ Victoria Pitts-Taylor,⁽²¹⁾ and Talia Rose Weiner,⁽²²⁾ as well as by contributions from critical anthropology.

While acknowledging the multiple debates that currently shape the field of mental health in both Europe and Latin America and challenge the hegemony of biopsychiatry, this model functions here as a theoretical construct and conceptual tool against which the Maastricht approach, developed by the social psychiatrist Marius Romme and the researcher Sandra Escher,^(23,24,25,26) is analytically contrasted. Based on a critique of the biopsychiatric model and the depathologization of hearing voices, the Maastricht approach emerged in Maastricht, the Netherlands, during the 1980s through the collaboration between Marius Romme, Sandra Escher, and the voice-hearer Patsy Hague. Within this approach, hearing voices is understood as a human experience arising in response to traumatic or extremely stressful life events that can be made meaningful within the context of the voice-hearer’s life. Moreover, people can learn strategies for engaging with and managing their voices. One of the approach’s principal tools is the Maastricht Hearing Voices Interview. This instrument consists of a structured interview and self-interview guide designed to map voices and relate them to the various contexts within which the voice-hearer’s life experience has unfolded.⁽²⁷⁾ From a governmentality perspective, conceptualizing this (self-)interview guide as a technology of the self⁽²⁸⁾—that is, as a practice oriented toward self-knowledge and self-transformation—makes it possible to examine how it shapes the subjectivity of

the voice-hearer, namely, how they think about, understand, and act upon themselves.

Within the broader field of biomedically oriented healthcare, practices of self-management are typically reifying and individualizing, having become widespread to the extent that service users are encouraged to become “expert patients” capable of governing their own health.^(29,30,31,32) In the field of mental health, however, such practices of self-management are both relatively recent and deeply ambivalent. On the one hand, it was the U.S. psychiatric survivor, user, and consumer movement that advocated for interventions centered on self-management within mental health systems. This movement introduced cognitive-behavioral models for the management of mental illness into healthcare systems in the United States and Europe, thereby implicitly recognizing the citizenship of people diagnosed with mental disorders.⁽³³⁾ On the other hand, biopsychiatric forms of self-management rest upon ambiguous premises, insofar as the notion of mental illness simultaneously recognizes and denies the subject’s rationality and capacity for self-government. As a result, they shape the subjectivity of people diagnosed with mental disorders as simultaneously deficient—whether psychologically and/or neurochemically^(11,34)—and responsible for restoring their autonomy through self-governance.^(15,21,35,36) Nevertheless, people with psychiatric diagnoses do not unambiguously embody this hegemonic model. Rather, they negotiate, problematize, and resist its highly individualizing character, its cognitive-behavioral orientation, and the hypercentrality of medication.^(16,17,22) Consequently, alongside biopsychiatric forms of self-management, other disruptive and innovative ways of working on the self have emerged, both in the practices of people with lived experience of psychological suffering and among members of movements led by psychiatric users, survivors, and ex-patients, as well as within peer support groups.^(37,38)

Accordingly, the (self-)interview guide of the Maastricht Hearing Voices Interview belongs to the realm of non-hegemonic and non-normative practices of self-governance in mental health. Examining it as a technology of the self makes it possible to explore the kind of work on the self that it promotes, the relationships it constructs between the subject and their voices, and its points of convergence with and divergence from the forms of self-management advanced by the hegemonic biopsychiatric model. This tool produces a markedly novel relationship between the self and its voices, thereby fostering a form of subjectivity that diverges from the biopsychiatric model. By mapping the connections between voices and the contexts of lived experience, it situates voices within specific personal, collective, and structural—that is, social and cultural—coordinates. In doing so, it de-reifies the experience of hearing voices and enables the production of meaning. This new mode of subjectivation is grounded in a relational self that brings into view relationships of abuse, traumatic life

experiences, and the sociocultural determinants within which voices emerge. Ultimately, this leads us to conceptualize the (self-)interview guide of the Maastricht approach as a practice embedded within the logic of care⁽³⁹⁾ that promotes the care of the self.⁽⁴⁰⁾

Self-management in the biopsychiatric model: the mentally ill person who must deny the existence of voices

This article focuses on the biomedical psychiatric response to the experience of hearing voices because of its predominance in academic research, healthcare institutions, and public health policy. Although this model is challenged to varying degrees in both Europe and Latin America, it nevertheless produces particular forms of governing the self—that is, ways of thinking about ourselves, our emotions, and our relationships—which also aspire to the status of universal truths, irrespective of socioeconomic and cultural contexts. The psychologization of the social, as described by Nikolas Rose^(10,11) from a governmentality perspective, has entailed the contemporary reconfiguration of technologies of the self—the set of practices through which individuals transform themselves by means of self-knowledge^(28,40)—into practices of self-management. Consequently, subjects become responsible for constituting and reconstituting themselves as autonomous individuals through self-governance. Following Rose’s line of inquiry, mental illness is understood as the cognitive-behavioral expression of a psychological and/or neurochemical deficiency^(13,14,34) in the process of subjectivation through which the autonomous individual is constituted. Although the distinction between the cognitive-behavioral self and the neurochemical self characteristic of biopsychiatry lies in their respective explanations of the etiology of mental illness—a difference with important implications—both conceptualizations promote a process of subjectivation centered on the autonomous individual, the radical separation between the individual and the illness, and the individual’s ultimate responsibility to discipline themselves, restore their autonomy, and return to a productive life through self-management.⁽¹⁹⁾ Thus, regardless of where the etiology of mental illness is located, self-management disregards and/or denies the sociocultural dimensions that produce illness^(6,7) and mobilizes cognitive-behavioral technologies of the self oriented toward psychological management, medication management, or a combination of both.

With the aim of gaining control over mental illness in order to eliminate it and subsequently restore the patient as an autonomous individual, self-management may involve monitoring one’s thoughts, moods, and psychiatric medication dosages, based on the underlying assumption that mental illness can be known, distinguished from the self, and anticipated. In other words, it establishes a radical separation between mental illness and the

subject who experiences it.^(22,41) In order to know the illness, distinguish it from the self, and anticipate its manifestations, the person diagnosed with a mental disorder must cultivate a form of hyper-rational self-surveillance that combines constant reflexivity with an equally constant suspicion toward that very rationality.⁽²²⁾ The enduring threat of a future depressive, manic, or psychotic self simultaneously affirms and undermines the existence of a rational and authentic self.⁽⁴²⁾ This structural paradox inherent in self-management means that people diagnosed with mental illness can never fully position themselves as coherent, intelligible, and available subjects capable of working on themselves.⁽⁴³⁾ Instead, it establishes a permanent internal questioning, a struggle over power, a battle—or even a war—within the self.^(18,44) Consequently, regardless of how the etiology of mental illness is conceptualized, these technologies of the self form part of a cognitive-behavioral mode of self-management exercised from the standpoint of a deficient and individualized self in relation to a decontextualized illness, and within the asymmetrical relationship between expert and patient.

With respect to self-management, both the psy disciplines and the field of biomedical psychiatry are marked by multiple tensions concerning the conceptualization of mental health, as well as by the practices and subjective perceptions of people diagnosed with mental disorders. In other words, the ways in which individuals embody these practices of the self encompass a broad spectrum of positions that may reinscribe, problematize, negotiate, resist, and/or subvert this individualizing and reifying mode of subjectivation. In Emily Martin's terms, this gives rise to different "self-making projects",⁽⁴⁵⁾ through which individuals variously negotiate the imperatives of self-management in their everyday lives and their identification with either the cognitive-behavioral or the neurochemical etiology of mental illness.⁽⁴⁶⁾ Among these different positions, four may be highlighted. First, there are those who regard behavioral work on the self as the "genuine" form of self-management, in contrast to the "easy" management afforded by medication.⁽²⁰⁾ Second, there are individuals who internalize the psychiatric diagnosis and its neurochemical explanation while rejecting the notion of psychological deficiency.⁽⁴⁶⁾ Third, there are those who identify with both neurochemical and psychological deficiency and therefore simultaneously rely on medication and psychotherapy.⁽¹⁹⁾ Finally, there are individuals who reject medication altogether, along with the neurochemical explanation of mental illness.⁽¹⁷⁾

With regard to the experience of hearing voices, the same logic of self-management outlined above is reproduced: self-governance is simultaneously denied and demanded, with the ultimate aim of reducing and/or eliminating the voices. As noted previously, voices categorized as auditory hallucinations have generally been associated with a diagnosis of schizophrenia, which, in turn, is characterized by a presumed lack of insight and

an impaired capacity for self-governance, thereby limiting the possibilities for self-management. Nevertheless, the psy disciplines and the biopsychiatric model de facto provide a framework for managing voices. As Lisa Blackman has argued, this framework requires individuals to work "against the voices"^(37,47) by practicing distraction, denying the voices' existence, nullifying their subjective meaning, and rejecting any potential positive effects they might have. These strategies establish and reinforce a complete separation between the voices and those who hear them, their life experiences, and the sociohistorical contexts in which the voices emerge. In seeking to gain control over the voices and ultimately eradicate them, they reproduce the internal dynamic previously described as a struggle or even a war of the self against itself. Just as the management of psychological suffering within the hegemonic model of self-management is embodied in a wide range of ways, the experience of hearing voices likewise gives rise to alternative ways of transforming the self that escape this mode of subjectivation. Among these, the approach promoted by the Maastricht framework is particularly noteworthy.

Self-management in the Maastricht approach: the voice-hearer as a survivor engaged in a relationship of power with their voices

Alongside the development of their research program on hearing voices and the consolidation of the Maastricht approach, Romme and Escher founded the *Intervoice: The International Hearing Voices Network*, an international network that brings together professionals and voice-hearers and has since fostered the creation of numerous national networks, among the most prominent being the *National Hearing Voices Network* in England. Today, the network is active in more than 26 countries. Its perspective converges with the new social movements in mental health that emerged during the 1980s, particularly the psychiatric user, survivor, and ex-patient movements in the Netherlands and the United States, which advocate for the human rights, social justice, and citizenship of people with psychiatric diagnoses.^(48,49) Intervoice constitutes the central node of the *Hearing Voices Movement* (HVM), known in the Spanish-speaking world as the *Movimiento de Escuchadores de Voces* (MEV). Led by people with lived experience together with allied professionals, the movement has developed into an international agenda for both research and activism concerning the experience of hearing voices. The *Hearing Voices Movement* challenges psychiatric authority and conventional diagnostic models^(50,51) and is composed of numerous local networks that bring together professional and experiential expertise.^(52,53,54) Among its principal tools are peer support groups and the (self-)interview guide known as the *Maastricht Hearing Voices Interview*.^(27,55,56,57)

In Spain, following the 7th World Congress of Intervoice: The International Hearing Voices Network, held in

Madrid in 2015 and organized by *Entrevoces*—the Spanish hearing voices network—several peer support groups emerged around experiences of psychological suffering outside the biopsychiatric model. These included *Flipas GAM* and *Fliparte GAM* in the Community of Madrid, *Xixón Voices* in Gijón, and *Escuchadores de Voces de Granada*. The congress also increased the visibility of already existing initiatives, such as the *Xarxa GAM* in Catalonia, together with other peer-led projects organized by and for people with a range of psychiatric diagnoses.

Accordingly, the (self-)interview guide of the Maastricht Hearing Voices Interview occupies a central place not only within the Maastricht approach but also within the Intervoice network and the broader Hearing Voices Movement. Within the Maastricht approach itself, the interview guide has served as a methodological tool throughout the successive research projects conducted by Romme and Escher and has been consistently referenced across their publications. Prior to developing this instrument, Romme and Escher had carried out a pilot study examining the relationships between voice-hearers and their voices, the interpretive frameworks through which they understood these experiences, and the effects of sharing them with other voice-hearers.^(58,59,60) They had also explored the personal histories of voice-hearers and developed a non-pathological analytical framework through which these unusual experiences could be understood and addressed.⁽²³⁾ It was at this stage that they created the interview guide as a methodological research tool for exploring the relationship between voices and the life trajectories of those who hear them. The guide was subsequently applied to the analysis of the relationship between hearing voices and different psychiatric diagnoses,^(61,62) to the examination of similarities and differences in how voice-hearers with and without psychiatric diagnoses engage with their voices,⁽⁶³⁾ and to the development of a therapeutic approach for mental health professionals.⁽²⁴⁾

This body of work was subsequently expanded through a three-year follow-up study involving children and adolescents who heard voices, using the Maastricht Interview for Children;^(64,65,66,67,68) a specific exploration of the relationship between hearing voices and traumatic experiences;⁽⁶⁹⁾ and an analysis of fifty recovery narratives recounted in the first person by voice-hearers.⁽²⁶⁾ The Maastricht approach developed by Romme and Escher has since been applied and further elaborated in numerous subsequent publications,^(70,71,72) including collaborative work with several other researchers.^(25,50,73,74)

Finally, although the interview guide is designed to be conducted as an interview or self-interview with a single individual, the broader research trajectory from which it emerged characterizes hearing voices not as an intensely individual and incommunicable experience but, rather, as a common human experience with shared features. Accordingly, the guide explicitly recognizes that

the interview should not only benefit the interviewee but also generate knowledge that may prove valuable to others undergoing similar experiences—that is, it acknowledges that experiential knowledge can be transferred and shared.⁽²⁷⁾ In this way, the collective dimension of hearing voices becomes visible, as do voice-hearers as a collective and the possibility of collectively producing knowledge in the field of mental health.⁽⁷⁵⁾

The specific analysis of the interview guide as a technology of the self builds upon the pioneering work of Lisa Blackman,^(37,47) who examined the everyday practices of people who hear voices and participated in peer support groups within the Hearing Voices Movement. To capture the distinctive form of self-management developed by her participants, Blackman coined the concept of “hallucinatory technologies of the self.” These practices of self-governance articulate a non-biopsychiatric approach to engaging with voices, organized around two key principles: expansion and integration. The logic of expansion understands the experience of hearing voices as fundamental to the expansion of the self, personal development, and even spiritual transformation.⁽⁴⁷⁾ The logic of integration, in turn, holds that the aim of self-management is not to eliminate voices but to incorporate them—that is, to seek their collaboration in the work on the self rather than opposing them.⁽⁴⁷⁾ The wide range of techniques employed within this framework includes practices of selective listening, directed attention, meditation and visualization, psychic insulation, symbolic practices, regimes of secular solitude, and forms of physical and mental economy.

Following this line of inquiry into the technologies of the self associated with the experience of hearing voices, this article focuses specifically on the *Maastricht Hearing Voices Interview* as one of the tools for working on the self that constitutes a mode of subjectivation diverging from biopsychiatric self-management through the practice of the *care of the self*.^(40,76) and the logic of care.^(39,77,78) This practice promotes self-knowledge through which individuals seek to cultivate themselves, transform themselves, and ultimately achieve self-transformation. Unlike self-management, however, it is concerned with the place one occupies in relation to others. Accordingly, the question of one’s relationship with others runs throughout the practice of the *care of the self*, since the complex power relations in which individuals are embedded are regarded as crucial. Centered on the everyday practice of living, the *care of the self* constitutes a form of work on the self that enables individuals to inhabit the roles they occupy within their families, friendship networks, communities, collectives, and society.^(40,76)

In a similar vein, care as a logic and mode of practice privileges practical engagement through a continuous process of (re)adjusting to context and persevering in the effort to make life more livable.^(39,77,78) This logic stands in contrast to the prevailing logic of the consumer, the citizen, or the active patient that

characterizes the biopsychiatric perspective, revealing both the impossibility of exercising complete control over vulnerability and illness and the multiple ways in which agency remains possible from within such conditions. Consequently, the primary emphasis of the logic of care is not on autonomy or the individual's right to decide independently but rather on the ongoing work of living and on the ensemble of practices that sustain everyday life, within which the roles of caregiver and care recipient remain fluid and interchangeable. Practices of care therefore lead us to conceptualize subjects in ways that diverge from the cognitive-behavioral and rationalist conceptions of the human being upon which self-management is based.

Methodological notes

Using a qualitative research design, the empirical interpretive analysis focuses on the Spanish-language version of the *Maastricht Hearing Voices Interview* guide, translated as *Entrevista con una persona que escucha voces*, which appears in the appendix to Romme and Escher's book *Making Sense of Voices* (published in Spanish as *Dando sentido a las voces*).^(24,27) The quotes correspond to the Spanish version.

With regard to the object of analysis, it should be noted that although the Spanish version of *Making Sense of Voices*⁽²⁷⁾ includes not only the interview guide itself but also instructions for conducting the interview, as well as guidelines for subsequently preparing a report and a construct, only the interview guide constitutes the object of analysis in this study. The guide is organized into thirteen sections covering the principal dimensions of the experience of hearing voices: the characteristics of the voices; the personal history of hearing voices; the situations, places, and emotions that trigger the voices; the content of what the voices say—whether literal and/or metaphorical; the voice-hearer's own interpretation of the origin of the voices; the impact of the voices on everyday life; the (im)balance in the relationship between the voice-hearer and their voices; the strategies each interviewee uses to cope with the voices; adverse childhood experiences; personal medical history; and, finally, the social environment and support network available to the voice-hearer.

An earlier English-language version of the interview guide exists, differing only in minor respects, together with two subsequent adaptations of the instrument.⁽⁷⁹⁾ The first, developed by Escher and Romme, was designed for children and adolescents,⁽⁶⁴⁾ while the second, developed by Escher, Bullimore, and Romme,⁽⁸⁰⁾ was intended to explore unusual thoughts commonly referred to as paranoia.

In order to examine the role of the interview guide from a governmentality perspective as a technology of

the self and to investigate its role in the production of the subjectivity of voice-hearers, this study takes the interview guide itself as its object of analysis for two reasons. First, it provides the foundational structure from which other interventions may be developed. Second—and more importantly—it was published as a publicly accessible questionnaire intended for individual use and has been disseminated by organizations, networks, and peer support groups as a resource for fostering a deeper understanding of the experience of hearing voices, whether used in the form of an interview or a self-interview.

With regard to the period of analysis, this study derives from the postdoctoral research project entitled “Experiential knowledge and self-management at the margins of the biomedical model: The emergence of peer support groups in Spain” (2019–2022). The methodological strategy consisted of discourse analysis⁽⁸¹⁾ conducted across three analytical levels.⁽⁸²⁾

At the first level, the content analysis involved fragmenting the text into meaningful units of information corresponding to the analytical categories. At the second level, these categories were examined in relation to the two core concepts mobilized by technologies of the self—self-knowledge and self-transformation⁽²⁸⁾—together with a third concept, the *care of the self*, which refers to concern for the place one occupies in relation to others^(40,76) and is embedded within the logic of care, a mode of practice that privileges pragmatic engagement, continuous adaptation to changing contexts, and the work of sustaining everyday life.⁽³⁹⁾

Finally, the interpretive level was based on sociological rewriting, examining both the continuities and the disruptions that this tool introduces with respect to the hegemonic forms of self-management promoted by the biopsychiatric model. This analytical strategy made it possible to interrogate how the subjectivity of voice-hearers is produced through engagement with the *(self-)interview guide*. The analytical categories employed were as follows: (a) the aims of the interview guide and the practices it mobilizes (subcategories: self-knowledge, self-transformation, mediation); (b) the conceptualization of voices and their role (subcategories: dynamism, contextualization, agency, intentionality); (c) the conceptualization of the subject who hears voices (subcategories: experiential knowledge, agency, relationality); and (d) the conceptualization of the relationship between the voices and the person who hears them.

Results

The aims of the interview guide and the practices it mobilizes: mediation through mapping

With regard to the aims of the interview guide,⁽²⁷⁾ these are explicitly stated in its opening section:

“1. THE NATURE OF THE EXPERIENCE: This questionnaire has been designed for people who hear voices. It is intended to help you gain greater insight into your experience of hearing voices. It is also designed to encourage a dialogue between us about your experience and the way you cope with the voices. This will enable us together to work out the best way of dealing with them.”⁽²⁷⁾

This instrument seeks to foster self-knowledge among voice-hearers. Although this objective guides the interview from beginning to end, it is closely intertwined with a second overarching aim: to facilitate self-transformation by enabling interviewees to discover the most appropriate way of relating to their voices, since an imbalanced or abusive relationship with them gives rise to psychological suffering.

The self-knowledge that makes self-transformation possible is grounded in the mapping of the interviewee’s relational landscape throughout the interview. This emphasis on relationality is operationalized through mapping specific contexts, thereby making it possible to *make sense of voices* by situating them in relation to concrete events and interpersonal relationships. The concern with relationality—and with the place occupied by both the voice-hearer and the voices in relation to other people and situations—moves the interview guide beyond its function as a technology of the self, centered on self-knowledge and self-transformation, toward a practice of the *care of the self*, in which relationality becomes the central organizing principle. Moreover, the interview guide functions as a mediating device, not only between the individual and their voices but also between the voice-hearer’s self-knowledge and mental health professionals, family members, and friends.

The conceptualization of voices: situated, meaningful, and agentic

In contrast to the biopsychiatric model, in which talking with voices—or even talking about them—is regarded as potentially dangerous, this interview guide is explicitly designed to foster dialogue with the voices in order to understand them more deeply and expand the voice-hearer’s self-knowledge.

Accordingly, from the very first question in the opening section— 1.1 I would like you to tell me about your experience of hearing voices. How many voices do you hear? Do you also hear sounds? Do you have visions?⁽²⁷⁾—the interview is structured around understanding the subjective experience of hearing voices. It explores whether the voices or sounds can also be heard by other people (Question 1.2); where, from the voice-hearer’s perspective, the voices and/or sounds originate or are located (Question 1.3); whether the voice-hearer

considers the voices to come from themselves or from someone else (Question 1.4); and whether they are able to enter into dialogue or otherwise communicate with the voices (Question 1.5).

The interview also elicits a description of the trajectory of the voices by exploring the changes between how they are experienced in the present and how they were experienced in the past (Question 2.1), together with their names, content, tone, and frequency (Questions 2.2, 5.1, and 5.2). In addition, it systematically maps the contexts in which the voices first emerged and subsequently reappeared by examining in detail the period during which the voices were first heard and the later periods in which they continued to be experienced (Questions 2.1, 3.1, and 3.2).

The interview is based on the premise that voices emerge within contexts characterized by specific circumstances and that the voices themselves possess distinctive characteristics comparable to those of a person. This is reflected in the second question of Section 2: 2.2 Can you tell me who the voices belong to? Have you given them names? What is their general theme? Is their tone negative or positive? How often do you hear them?⁽²⁷⁾ This assumption is reinforced by the following question: 2.3 Does the manner or tone of the voices remind you of someone you know or used to know? If yes, who?⁽²⁷⁾ Accordingly, the interview explores the possibility that the voices are directly connected to specific life experiences or relationships in the voice-hearer’s biography.

However, the interview guide not only asks voice-hearers to describe the contexts in which the voices emerge (Questions 2.1, 3.1, and 3.2), but also invites them to consider whether the voices are related to a range of life circumstances, including stressful changes, illness, bereavement, love, sexuality, religion, or spirituality: 3.3 We have put together a list of difficult circumstances and situations that people might experience in their lives. Which of these life events have happened to you? At what age?⁽²⁷⁾ Finally, childhood is treated as a particularly significant period in the life course. The interview first invites the voice-hearer to describe this stage of life through the following open-ended question:

“10. YOUR EXPERIENCE OF CHILDHOOD: Childhood can be a very different experience for each of us. Some people like to look back to their childhood, while others prefer to put it behind them as soon as possible. What is your perception of your childhood?”⁽²⁷⁾

The interview then proceeds with a series of more specific questions aimed at mapping possible experiences of emotional, physical, and sexual abuse (Questions 10.2–10.8). Thus, the first sub-question seeks further detail while maintaining the possibility of a broad, open-ended response: “10.1. Was your childhood pleasant or

stressful? Can you describe what your childhood was like?”⁽²⁷⁾ The second refers to the interviewee’s subjective perception of safety in both public and private spaces: “10.2 *Did you feel safe at school, in the streets and at home? If not, please explain.*”⁽²⁷⁾ The third refers directly to situations recognized by the voice-hearer as abuse: “10.3 *As a child were you mistreated? How?*”⁽²⁷⁾ The fourth, fifth, and sixth inquire more specifically into possible forms of abuse by asking the voice-hearer the following:

“10.4 As a child, did you ever receive unusual punishments? For example, were you ever locked in a bathroom or tied up?

10.5 Have you ever, as a child or a teenager, been yelled at or belittled? Did you ever experience the feeling of not being wanted? Did you feel that you were never able to do anything right?

10.6 Have you ever witnessed the maltreatment of another family member? Who?”⁽²⁷⁾

Finally, the last two focus on mapping experiences related to sexual abuse:

“10.7 Have you ever witnessed sexual abuse in the family or elsewhere? Who was involved?

10.8 Have you been touched in a way that made you uncomfortable? Have you been in a situation where you were unable to resist or escape from?”⁽²⁷⁾

Accordingly, we can identify that the fundamental strategy deployed consists of mapping difficult and potentially traumatic experiences in order subsequently to seek connections between the specific characteristics of the voices, the contexts in which the voices are expressed, and the life experiences and relationships in which the voice-hearer has been involved.

Within the biopsychiatric model, voices, insofar as they are reified as auditory hallucinations, are assumed to possess an inherently negative nature and an abusive communicative style. In contrast, this interview guide considers voices to influence the person who hears them to varying degrees while allowing for multiple possible responses, some of which may be harmful and others more beneficial for the voice-hearer:

“7.1 How are the voices trying to influence you? Please give examples. 1. They offer a solution to a problem; 2. They offer you advice and help you; 3. They describe what you do or think; 4. They comment on what you do or think or comment about the people you are dealing with; 5. They take over your thinking; 6. They swear at you or are very critical about what you are doing; 7. They forbid you to do the things

you like to do; 8. They strengthen the feelings you have; 9. They strengthen the thoughts you are busy with; 10. They interrupt things you enjoy doing; 11. They interfere when you are talking to someone else; 12. They command you to do things: How do these voices affect you and/or others? How do they manage to have this effect—through their presence or the way they say things?”⁽²⁷⁾

The interview then continues by exploring in greater depth whether the content of the voices and their communicative style are positive, neutral, or negative (Questions 7.2 to 7.5). Particularly noteworthy is that it explicitly investigates the possibility that some voices may be perceived by the person who hears them as both beneficial in their influence and positive in their mode of communication with the voice-hearer: “7.2 Are you happy with some of the voices? Why? Has this always been so?”⁽²⁷⁾ This is a possibility that is not contemplated within biopsychiatric approaches. Furthermore, the voices are conceptualized throughout the interview as dynamic, since they are understood to be capable of changing over the course of the interviewee’s life trajectory.

Thus, as this interview guide functions as a tool that mediates the mapping of the characteristics of the voices, the contexts in which they originally emerged and in which they are currently expressed, and the people involved, we may argue that the interview attributes agency to the voices and grants them a central role, so that they cease to be abstract, meaningless, unintelligible, and ineffable entities. It approaches the nature of voices in a complex and comprehensive manner, without denying the possible difficulties caused by negative and abusive voices, yet without reducing their nature to this single dimension. Consequently, the interview breaks with the assumption that voices are reified, separate phenomena unrelated to the self and instead proposes a conceptualization of voices as agentic, meaningful, and deeply embedded in the personal, social, and collective contexts experienced by the voice-hearer.

The conceptualization of the voice-hearer: an expert by experience with agency

Within the Maastricht approach, the person who hears voices is not referred to as a patient or mentally ill person, but rather is described through the experience itself as a voice-hearer. This interview schedule starts from the premise that the voice-hearer possesses agency and exercises it in different ways and to different degrees, as stated in the following:

“9. COPING STRATEGIES. We have just discussed your relationship with the voices. I would like to know what exactly you do when you hear the voices. If the answer to any of the

following questions is yes, please tell me how many times you have tried this and what the effect has been.”⁽²⁷⁾

Thus, the interview seeks to map the everyday strategies already present in the lives of voice-hearers for managing their voices, practices defined as “cognitive, behavioural, and physical strategies” (Questions 9 to 9.18), which may range from ignoring the voices (Question 9.2) to writing down what they say (Question 9.12) or engaging in activities to distract oneself from the voices, such as eating (Question 9.17). These exercises in self-management may be used more or less frequently (Question 9.18), have a greater or lesser impact on the voices (Question 9.20), and, in turn, afford a greater or lesser capacity to regulate the influence of the voices over oneself. Finally, the explanations provided by interviewees regarding the origin of their voices receive attention and consideration in the following section of the interview schedule:

“6. HOW DO YOU EXPLAIN WHERE THE VOICES COME FROM? 6.1 As a voice hearer you have probably wanted to find an explanation for why you hear voices. You may already have developed your own interpretation of the meaning of the voices just like professionals do, and just as we all tend to do. However, we may not have the same ideas, since we are trained to consider the meaning of the voices from a different frame of reference—usually from a medical or biological perspective. Here we are interested in what you might think causes the voices and how you identify them.”⁽²⁷⁾

The fact that voice-hearers seek and develop explanations that differ from biopsychiatric explanations does not invalidate them; on the contrary, these personal interpretations are regarded as being of equal relevance to those of professionals (Questions 6.1 and 6.2). Thus, the conceptualization of the voice-hearer rests on two main pillars: on the one hand, the knowledge that they possess—or may acquire—about their own experience as an expert by experience; on the other, the possibility of self-transformation grounded in their capacity for agency. Consequently, the mapping process is based on voice-hearers as experts on their own voices, as well as full participants in the process of finding strategies for reaching an understanding with them. This is expressed throughout the interview, which is entirely structured around the interviewee’s knowledge of their voices, and even more explicitly in the direct questions addressed to the voice-hearer concerning the existence of connections—since only those that they themselves recognize are considered valid and meaningful—and the subjective explanations for the existence of the voices.

The conceptualization of the relationship between the voice-hearer and the voices: an ecosystem of contexts, people, and voices traversed by power

The mapping of relationships is central to this interview schedule, indicating that the self-transformation of the self is conceived from the position we occupy in relation to others, that is, from the perspective of *care of the self*.⁽⁷⁶⁾ This cartography of relationships takes two main forms: by exploring the relationships between the voices and the interviewee’s personal contexts, including the people who were part of those contexts; and by exploring the relationship between the voices and the interviewee.

First, regarding the relationships between the voices and personal situations, as noted above, the interview explores the possibility of a relationship between the attitude or tone of the voices and someone known to the interviewee (Question 2.3); it also examines the relationship between changes in the characteristics of the voices and changes in context (Question 3.4), as well as the relationship between the subjects and people mentioned by the voices and the voice-hearer’s own interest in those subjects or people (Question 5.3).

Second, the interview starts from the premise that the voice-hearer and their voices mutually influence one another; that is, the voices may exert influence over the voice-hearer, but the voice-hearer may also exert influence over the voices. This premise breaks with the biopsychiatric assumption that the voices have no relationship or meaning for the person who hears them and that there is only a unilateral and negative influence from the voices toward the individual. The relationship between the voices and the interviewee is addressed throughout the interview by asking whether the person engages in a dialogue with the voices (Question 1.5); and, more specifically, systematically, and in greater detail, first through the mapping of the relationship between contexts, everyday activities, emotions, and the voices (Questions 4.1 to 4.5), of which the following question is a clear example:

“4.1 Have you noticed whether the voices tend to be present when you take part in particular activities or in certain kinds of situations? Can you describe what these are? (For example, shopping, watching TV, cooking, being alone, etc?).”⁽²⁷⁾

And second, by examining the influence that the voices have on the voice-hearer, including an exploration of the emotions that the voices evoke in the person who hears them (Questions 7.1 to 7.5).

It becomes evident that this relationship between the voices and the interviewee is conceived as a power relationship that may or may not be abusive, placing

particular emphasis on encouraging the voice-hearer to reflect on the positive or negative character of the voices (Questions 5.1 to 5.3 and 7.1 to 7.5). For example, among these, the following question is key to a possible process of self-transformation:

“7.4 Do the voices disturb your daily activities? How do they do this? What are the effects? How powerless do the voices make you Please give an example.”⁽²⁷⁾

This becomes even more explicit in the eighth section: “8. BALANCE OF THE RELATIONSHIP. We would like to ask you what kind of relationship you have with the voices.” (Questions 8.1 to 8.8). This section contains a set of eight key questions because they demonstrate that the voice-hearer may play an active role and possess the capacity to persuade, control, and influence their voices; that is, they are conceived as a subject with agency who constitutes an ecosystem of mutual influence with their voices.

Accordingly, the first question seeks an open-ended response: “8.1 Are you able to influence the voices in any way? Please give an example.”⁽²⁷⁾ Whereas the second inquires into the possibility of exercising control over the voices and whether this has changed over the course of the person’s life trajectory, that is, their dynamic character: “8.2 Are you in control of the voices? Has this always been the case? Please describe how you affect or manage them.”⁽²⁷⁾ The third points to the possibility of holding a conversation with the voices:

“8.3 Are you able to hold a conversation with the voices? Do you speak out loud or in your mind when you talk to them (or both)? How do the voices react? Have they always reacted in this way? How have they changed?”⁽²⁷⁾

It also acknowledges that it may be the voice-hearer who initiates the conversation: “8.4 Do you ever call the voices names? In your head or out loud?”⁽²⁷⁾ The fifth and sixth questions seek to explore the possibility of exercising personal power in relation to the voices:

“8.5 Are you able to refuse orders? If yes, which orders can you refuse and which ones cannot be refused? What happens if you refuse to do what the voices order you to do?

8.6 Are you able to cut yourself off from the voices and to open up to them again?”⁽²⁷⁾

Finally, the seventh and eighth questions point to the possibility of voluntarily concentrating either on what the voices are saying or on what the voice-hearer is doing—that is, of remaining present in their activities and current reality—while also considering each voice as a distinct entity and, therefore, opening up the possibility

of multiple and diverse interactions and power relationships between the voices and the person who hears them:

“8.7 Can you concentrate on the voices when they are present so that you now exactly what they are saying? Does this differ with each voice and each time? If so, why? Give an example.

8.8 When you hear the voices do you mainly concentrate on them or on what you are doing? does this differ with each voice and each time?”⁽²⁷⁾

It should be noted that the significance of Section 8 and the subsequent section, “9. COPING STRATEGIES” (Questions 9.1 to 9.21), lies not only in mapping the type of relationship and the balance—or imbalance—of power between the interviewee and their voices. Within this approach, the mere fact of hearing voices is not itself identified as problematic—there are voice-hearers for whom their voices have not entailed mental distress—but rather the potential abuses of power that may arise in the relationships the voice-hearer has with them. This ninth section seeks to identify the cognitive (Questions 9.1 to 9.7), behavioural (Questions 9.8 to 9.13), and physical (Questions 9.14 to 9.17) strategies that the voice-hearer already puts into practice; how frequently they use them (Question 9.18); what they do when they are about to enter a situation that usually makes their voices stronger (Question 9.19); and the strategies they have used in the past.

Consequently, the use of self-knowledge—the detailed analysis of the actions or strategies that the voice-hearer has been using in relation to their voices, both in the eighth and ninth sections—places the emphasis not only on their capacity for agency but also on their capacity for self-transformation, that is, on the new balances of power that they might establish.

Therefore, the possibility that connections may exist between the voices and the context experienced at the personal, collective, or structural (social and political) levels runs throughout this instrument, which explicitly seeks the voice-hearer’s validation of these relationships, a premise that is central to this movement: voice hearing as a survival mechanism in response to traumatic experiences within the context of personal and collective relationships. Accordingly, this mapping seeks to generate a situated self-knowledge that explores the multiple connections surrounding voice hearing and de-reifies the voices. Far from being an abstract and radically individual experience, voice hearing is presented as part of a broad network of relationships with individuals and groups of people—including medical professionals, about whom the interview asks whether the person consulted them, what type of assistance they received, whether they told any of them about their voices, what those professionals did, and whether they sought help from practitioners of alternative therapies (Questions 11.1 to 11.4)—who have

formed or continue to form part of the voice-hearer's life trajectory. The voice-hearer is thus conceptualized as a relational subject who is able to make sense of their experience through those relationships that resonate as meaningful to them.

Finally, with regard to mediations, the interview enables at least two. The first occurs between the voice-hearer and the professional with whom they ordinarily work, the interview serving as a tool for creating a space for dialogue, since dialogue about the voices itself constitutes a break with the biopsychiatric socialization of voices as a taboo and creates a new space for therapeutic work. The second concerns the interview as a mediation between the voice-hearer and their voices. Because responding to the questions that map the voices necessarily entails creating an internal space for dialogue with them, the voice-hearer systematically produces knowledge about their voices, mediated by the interview items and by the professional facilitating the interview.

Taken together, the Maastricht Hearing Voices Interview not only maps the voices, the contexts, and the relationships in which they are manifested, but also functions as an active mediating agent that provides a space for dialogue promoting the voice-hearer's self-knowledge and self-transformation. Insofar as the voice-hearer is an expert by experience, the ultimate aim of this technology of the self is to mobilize, systematize, and deepen a situated self-knowledge of the voices that makes self-transformation possible at three levels: first, toward a greater capacity for agency in relation to the voices; second, toward a greater balance in the power relationship with them that enables coexistence; and, finally, toward the construction of the meaning of those voices on the basis of the experiences and connections recognized as significant.

Discussion

This article has contrasted biomedical psychiatry, as an analytical model, with the Maastricht approach, specifically the *Maastricht Hearing Voices Interview* schedule as a technology of the self, with the aim of analysing how subjectivity is produced in relation to voice hearing. The principal finding is that this interview schedule is a tool that differs markedly from the reified and individualizing self-management characteristic of the psy-complex and biopsychiatry.

The analysis of the management of voices through the *Maastricht Hearing Voices Interview* highlights three relevant aspects. First, with regard to the voices themselves, they are meaningful, can be endowed with meaning, and are situated within specific socioeconomic, cultural, and biographical contexts. Second, with regard to the voice-hearer, who is defined by the action they perform rather than by diagnostic categories, they are relational and embedded in networks of relationships;

they also possess experiential knowledge and, most importantly, exercise their agency in different ways in relation to their voices. Finally, regarding the relationship between the subject and the voices, there is a relationship of mutual influence that may display varying balances—or imbalances—of power throughout the life trajectory and in relation to present or past lived experiences. Consequently, the *Maastricht Hearing Voices Interview* is a tool for mapping biographical trajectories that produces self-knowledge and seeks self-transformation. To this end, it renders visible a situated and deeply rooted form of suffering in which the voices constitute part of the ecosystem of a relational subject who is called upon to exercise *care of the self*.

The Maastricht approach shows multiple and substantial points of convergence both with postpsychiatry, which originated within the Anglo-Saxon tradition of critical psychiatry, and with the Latin American tradition of collective mental health, particularly well established in Brazil, also present in Spain, and emerging in other countries such as Colombia.⁽³⁾ With regard to postpsychiatry, it shares this tradition's rejection of coercive policies, its emphasis on the experiences and agency of survivors and service users, the importance it attributes to social, political, and cultural contexts, and its understanding of madness as something that is not devoid of meaning but rather embedded within complex networks of meanings and interpretations.^(4,5) Likewise, its understanding of the biographical trajectory as situated converges with the epistemic and practical rupture brought about by collective mental health, particularly through its emphasis on social determination, its critique of the medicalization of suffering, and its recognition of experiential forms of knowledge together with a collective reflection on the shared experiences of becoming ill, caring, recovering, and, more broadly, the practices that sustain life,⁽⁸³⁾ which in turn converge with the *logic of care* inherent in care of the self.

The implications of the Maastricht approach, in which the management of voices is grounded in self-knowledge and relationality, are multiple and far-reaching within the broader field of mental health. First, it profoundly challenges the very core of biomedicine, namely the conception of a subject separated from their illness and from the structural conditions of their life, thereby provoking a crisis in the legitimacy of the biopsychiatric practices that currently predominate. It destabilizes the asymmetrical expert-patient relationship; highlights interventions that do not directly involve psychiatric drugs and/or coercive practices; and renders visible forms of care that are not institutionalized, as well as informal spaces which, far removed from the dynamics and logics characteristic of hospitals and clinics, accompany experiences of mental suffering. Among these elements, it is particularly significant that people who hear voices and have been psychiatrized, who have historically occupied discursive margins—when they have not been denied the very possibility of

articulating their experiences in the public sphere—have, through their experiential knowledge, become one of the fundamental pillars of this process of delegitimizing biopsychiatry.^(84,85,86,87,88,89,90,91)

Consequently, second, it challenges the ways in which public policies are designed and implemented because, particularly in the Global North—and, more recently, in Spain—health systems and professional settings are now shaped both by processes of collaboration⁽⁹²⁾ and by the incorporation and/or assimilation of experiential knowledge and practices,^(93,94) for example, through the incorporation of peer support groups for voice-hearers into institutional services.^(95,96,97) This is also where unavoidable debates arise concerning epistemic injustice and epistemic appropriation within academia and mental health research.^(98,99)

Third, within the Maastricht approach the subject is not only understood as relational but is also embedded within a network of relationships that may enable the articulation of voice-hearers as a collective subject.⁽¹⁰⁰⁾ In the broader field of mental health, despite the processes of neoliberalization of recent decades, new social movements and mental health activism likewise display logics of relationality and the collective construction of networks for advocacy, exchange, and/or care. Particularly noteworthy are the self-organized spaces of peer support groups,^(101,102) because of their exchange and production of experiential knowledge and practices—which, in countries with a Mediterranean tradition, entails a shift away from the care-oriented model and the centrality of family members within the associative landscape—alongside the affirmation of first-person narratives, practices, and forms of organization, as well as the (re)emergence of the Mad Pride movement in some countries.^(103,104,105)

Fourth, it is important to emphasize that, both in the development of Romme and Escher's research programme and in their activities within mental health activism through the founding of the Intervoice network, collaboration with voice-hearers has been central. This has given rise to the emergence of hybrid roles in which voice-hearers and/or psychiatric survivors are also researchers or academics, creating new epistemic spaces and new spaces of enunciation. In this regard, particularly noteworthy within the Anglo-Saxon context are Mad Studies and Survivor Research,⁽¹⁰⁶⁾ emerging fields of inquiry grounded in the hybridization of roles and in the alliance of those who possess both expert and experiential forms of knowledge.

Finally, regarding the limitations of this analysis, the principal one lies in the fact that it is conducted by contrasting two analytical models and by analysing an interview schedule that constitutes a theoretical tool. Consequently, it does not address the specific ways in which this approach is implemented in different settings with their particular socioeconomic, institutional, and cultural characteristics. Furthermore, the

identification of traumatic experiences as one of the origins of psychological suffering requires a critical examination of how the notion of trauma is culturally constructed, how it is translated into different contexts, and how it produces subjectivity.

Conclusion

Voices as part of the ecosystem of a relational subject

Within the biopsychiatric model, voice hearing is not only understood as a pathological experience that must be eradicated, but is also linked to self-management, that is, to practices of self-transformation that are individualizing, ahistorical, and reifying. By contrast, within the Maastricht approach we find the Maastricht Hearing Voices Interview, a tool for exploring this experience that may be conceptualized as a technology of the self, because it mobilizes both the situated self-knowledge of the voices possessed by the interviewee and the self-transformation of the voice-hearer in their power relationship with the voices. In this case, the self-management made possible by this interview schedule departs from the management of the psychological and/or neurochemical self,^(11,34) since its central practice is the mapping of the links and connections between the contexts in which personal, collective, and structural life experiences occur, the people involved in those contexts, and the voices, thereby giving shape to a relational subject.

The voice-hearer emerges as an interlocutor who is not only legitimate but also intrinsically necessary and valuable for addressing the issues associated with voice hearing through their experiential expertise and the exercise of their agency, thereby rendering these experiences intelligible. Moreover, they are the only person capable of establishing the meaningful connections that give this experience its meaning—a meaning that, from the perspective of this tool, is not radically personal but rather traversed by the power relations and the people involved in the voice-hearer's life contexts.

Beyond this, we are confronted not only with a relational mode of subjectivation, but also with an understanding of the voice-hearer as a collective subject. Although this appears less prominently in the instrument because its purpose is individual use, the Maastricht Hearing Voices Interview nevertheless conceptualizes the voice-hearer as part of a collective, because voice hearing, far from being a radically individual experience, is a shared one. Therefore, if mobilizing, systematizing, and deepening self-knowledge is what makes possible the self-transformation toward which this tool is directed, this process is not sustained by the emptiness of an individual conceived as a *tabula rasa*, but rather rests upon and is nourished by the

knowledge and practices of self-management that the voice-hearer has been developing, with greater or lesser capacity to influence the voices.

From the perspective of this tool, the relational and/or collective subject confronts a situated form of psychological suffering, such that distress is no longer located within an isolated individual but rather within past and present relationships rooted in specific sociopolitical, historical, and cultural contexts, where the voices emerge as part of the relational ecosystem of the subject. The analysis of this tool renders visible non-normative practices and divergent ways in which care of the self may take place in relation to mental suffering, as well as the implications that these ways of exercising self-knowledge and self-transformation have for how subjects understand themselves and their experiences.

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CONFLICT OF INTEREST

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REFERENCES

- Menéndez E. Modelos de atención de los padecimientos: de exclusiones teóricas y articulaciones prácticas. *Ciênci a & Saúde Coletiva*. 2003;8(1):185–207. doi: [10.1590/S1413-81232003000100014](https://doi.org/10.1590/S1413-81232003000100014)
- Rose N. *Our psychiatric futures*. Cambridge: Polity Press; 2018.
- Hernández-Holguín DM, Arias López BE, Martínez-Hernández Á. Salud mental colectiva: una revisión del concepto en la literatura académica de Brasil, Colombia y España. *Salud e Sociedade*. 2023;32(3):1–12. doi: [10.1590/S0104-12902023210693es](https://doi.org/10.1590/S0104-12902023210693es)
- Bracken P, Thomas P. Postpsychiatry: a new direction for mental health. *British Medical Journal*. 2001;322:724–727. doi: [10.1136/bmj.322.7288.724](https://doi.org/10.1136/bmj.322.7288.724)
- Bracken P, Thomas P. *Postpsychiatry: Mental health in a postmodern world*. Oxford: Oxford University Press; 2005.
- Good B J. *Medicine, rationality and experience: An anthropological perspective*. Cambridge: Cambridge University Press; 2008.
- Martínez Hernández Á. La copia de los hechos: La biomedicina, el poder y sus encubrimientos. *Quaderns de l'Institut Català d' Antropologia*. 2011;(27):45–64.
- Pilgrim D, Rogers A. *A sociology of mental health and illness*. Berkshire: Open University Press McGraw-Hill; 2005.
- Rose G. Place and identity: a sense of place. En: Massey D, Jess P, (eds.). *A place in the world?: Place, culture and globalization*. Oxford: Oxford University Press; 1995. p. 87–132.
- Rose N. *Inventing our selves: psychology, power, and personhood*. New York: Cambridge University Press; 1998.
- Rose N. *Governing the Soul: The shape of the private self*. London: Free Association Books; 1999.
- Novas C, Rose N. Genetic risk and the birth of the somatic individual. *Economy and Society*. 2000;29(4):485–513. doi: [10.1080/03085140050174750](https://doi.org/10.1080/03085140050174750)
- Rose N. Neurochemical selves. *Society*. 2003;1(41):46–59. doi: [10.1007/BF02688204](https://doi.org/10.1007/BF02688204)
- Rose N. The neurochemical self and its anomalies. En: Ericson R, Doyle A, (eds.). *Risk and Morality*. Toronto: University of Toronto Press; 2003. p. 407–37.
- Horwitz AV. Creating an age of depression. *Society and Mental Health*. 2011;1(41–54). doi: [10.1177/2156869310393986](https://doi.org/10.1177/2156869310393986)
- Fullagar S. Negotiating the neurochemical self: anti-depressant consumption in women's recovery from depression. *Health*. 2009;13(4):389–406. doi: [10.1177/1363459308101809](https://doi.org/10.1177/1363459308101809)
- Fullagar S, O'Brien W. Problematizing the neurochemical subject of anti-depressant treatment: The limits of biomedical responses to women's emotional distress. *Health*. 2012;17(1):57–74. doi: [10.1177/1363459312447255](https://doi.org/10.1177/1363459312447255)
- Fullagar S, O'Brien W. Immobility, battles, and the journey of feeling alive: Women's metaphors of self-transformation through depression and recovery. *Qualitative Health Research*. 2012;22(8):1063–1072. doi: [10.1177/1049732312443738](https://doi.org/10.1177/1049732312443738)
- Fullagar S, O'Brien W. Social recovery and the move beyond deficit models of depression: A feminist analysis of mid-life women's self-care practices. *Social Science & Medicine*. 2014;117:116–124. doi: [10.1016/j.socscimed.2014.07.041](https://doi.org/10.1016/j.socscimed.2014.07.041)
- Brijnath B, Antoniadis J. "I'm running my depression:" Self-management of depression in neoliberal Australia. *Social Science & Medicine*. 2016;152:1–8. doi: [10.1016/j.socsci-med.2016.01.022](https://doi.org/10.1016/j.socsci-med.2016.01.022)
- Pitts-Taylor V. The plastic brain: Neoliberalism and the neuronal self. *Health*. 2010;14:635–652. doi: [10.1177/1363459309360796](https://doi.org/10.1177/1363459309360796)
- Weiner T. The (Un)managed self: Paradoxical forms of agency in self-management of bipolar disorder. *Culture, Medicine and Psychiatry*. 2011;(35):448–483. doi: [10.1007/s11013-011-9231-1](https://doi.org/10.1007/s11013-011-9231-1)
- Romme M, Escher S, (eds.). *Accepting voices*. London: Mind Publications; 1993.

24. Romme M, Escher S. Making sense of voices: A guide for professionals who work with voice hearers. London: Mind Publications; 2000.
25. Corstens D, Escher S, Romme M. Accepting and working with voices: The Maastricht approach. En: Moskowitz A, Schäfer I, Dorahy MJ, (eds.). Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology. West Sussex: Wiley-Blackwell; 2008. p. 319-332.
26. Romme M, Escher S, Dillon J, Corstens D, Morris M. Living with Voices: 50 stories of recovery. Monmouth: Pecs Books; 2009.
27. Escher S, Romme M. Entrevista con una persona que escucha voces. Fundación para la Investigación y el tratamiento de la esquizofrenia y otros trastornos [Internet]. Primera Voz: Archivo de materiales sobre salud mental y crítica del capitalismo; 2005 [cited: 10 Oct 2025]. Available from: <https://tinyurl.com/urc5caan>
28. Martin LH, Gutman H, Hutton PH, (eds.). Technologies of the Self: A seminar with Michel Foucault. Amherst: University of Massachusetts Press; 1988.
29. Lupton D. Foucault and the medicalisation critique. En: Peterson A, Bunton R, (eds.). Foucault, Health and Medicine. London: Routledge; 1997. p. 94-110.
30. McLean AH. From ex-patient alternatives to consumer options: consequences of consumerism for psychiatric consumers and the ex-patient movement. International Journal of Health Services. 2000;30(4):821-847. doi: [10.2190/3tyx-vrrk-xkha-vb1q](https://doi.org/10.2190/3tyx-vrrk-xkha-vb1q).
31. Kendall E, Rogers A. Extinguishing the social?: state sponsored self-care policy and the Chronic Disease Self-management Programme. Disability & Society. 2007;22(2):129-143. doi: [10.1080/09687590601141535](https://doi.org/10.1080/09687590601141535).
32. Rogers A. Advancing the expert patient? Primary Health Care Research & Development. 2009;10:167-176. doi: [10.1017/S1463423609001194](https://doi.org/10.1017/S1463423609001194)
33. Mueser KT, Corrigan P, Hilton D, Tanzman B, Schaub A, Gingerich S, et al. Illness management and recovery: A review of the research. Psychiatric Services. 2002;53(10):1272-1284. doi: [10.1176/appi.ps.53.10.1272](https://doi.org/10.1176/appi.ps.53.10.1272)
34. Rose N. The politics of life itself: biomedicine, power, and subjectivity in the twenty first century. Princeton: Princeton University Press; 2007.
35. Davidson L. Recovery, self management and the expert patient: Changing the culture of mental health from a UK perspective. Journal of Mental Health. 2005;14:25-35. doi: [10.1080/09638230500047968](https://doi.org/10.1080/09638230500047968)
36. Blackman L. Psychiatric culture and bodies of resistance. Body and Society. 2007;13:1-23. doi: [10.1177/1357034X07077770](https://doi.org/10.1177/1357034X07077770)
37. Blackman L. Hearing voices: Embodiment and experience. London & New York: Free Association Books; 2001.
38. Fletcher EH. "Boundary Formation" Within Mutual Aid Assemblages. Culture, Medicine, and Psychiatry. 2019;43(1):93-115. doi: [10.1007/s11013-018-9600-0](https://doi.org/10.1007/s11013-018-9600-0)
39. Mol A. The logic of care: Health and the problem of patient choice. Oxon and New York: Routledge; 2008.
40. Foucault M. The ethic of care for the self as a practice of freedom: An interview with Michel Foucault on 20 January 1984. Philosophy & Social Criticism. 1987;12(2-3):112-131. doi: [10.1177/019145378701200202](https://doi.org/10.1177/019145378701200202)
41. Miller P. Governing by numbers: Why calculative practices matter. Social Research. 2001;68:379-396. doi: [10.1002/9780470774274.ch10](https://doi.org/10.1002/9780470774274.ch10)
42. Martin E. Bipolar Expeditions: Mania and depression in American culture. Princeton: Princeton University Press; 2007.
43. Keane H. Setting yourself free: techniques of recovery. Health: 2000;4:324-346. doi: [10.1177/136345930000400305](https://doi.org/10.1177/136345930000400305)
44. Foucault M. Psychiatric power. New York: Palgrave; 2006.
45. Martin E. Self-making and the brain. Subjectivity. 2010;3(4):366-381. doi: [10.1057/sub.2010.23](https://doi.org/10.1057/sub.2010.23)
46. Reneses M. Subjetividad farmacéutica en tiempos de crisis en Madrid: Entre la supervivencia, la cronificación y el "Debo ser yo". Salud Colectiva. 2025;21:e5563. doi: [10.18294/sc.2025.5563](https://doi.org/10.18294/sc.2025.5563)
47. Blackman L. Ethics, embodiment and the voice-hearing experience. Theory, Culture and Society. 2000;17(5):55-74. doi: [10.1177/02632760022051392](https://doi.org/10.1177/02632760022051392)
48. Rogers A, Pilgrim D. "Pulling down churches": accounting for the British Mental Health Users' Movement. Sociology of Health & Illness. 1991;13(2):129-148. doi: [10.1111/j.1467-9566.1991.tb00093.x](https://doi.org/10.1111/j.1467-9566.1991.tb00093.x)
49. Crossley N. Contesting Psychiatry. Social movements in mental health. London & New York: Routledge; 2006.
50. Romme M, Morris M. The recovery process with hearing voices: accepting as well as exploring their emotional background through a supported process. Psychosis: Psychological, Social and Integrative Approaches. 2013;5(3):259-269. doi: [10.1080/17522439.2013.830641](https://doi.org/10.1080/17522439.2013.830641)
51. Corstens D, Londgen E, McCarthy-Jones S, Waddingham R, Thomas N. Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. Schizophrenia Bulletin. 2014;40(4):S285-S294. doi: [10.1093/schbul/sbu007](https://doi.org/10.1093/schbul/sbu007)
52. Collins H, Evans R. The third wave of Science Studies: Studies of expertise and experience. Social Studies of Science. 2002;32(2):235-296. doi: [10.1177/0306312702032002003](https://doi.org/10.1177/0306312702032002003)
53. May R, Hayes J. Le mouvement Hearing Voices: une approche émancipatrice du fait d'entendre des voix. En: Gardien É, (ed.). Des innovations sociales par et pour les personnes en situation de handicap. Toulouse: Éditions Érès; 2012. p. 195-214.
54. Tracy S, Ford A. Chez les entendeurs de voix: une réalité vivante. Québec: Éditions L'Hybride; 2025.
55. Baker P. La voz Interior: Guía práctica ¿Cómo tomárselo cuando se escuchan voces? Hearing Voices Network [Internet]. 1999 [cited 15 Oct 2025]. Available from: <https://tinyurl.com/35ndcswv>
56. Dillon J, Hornstein G. Hearing voices peer support groups: a powerful alternative for people in distress. Psychosis. 2013;5(3):286-295. doi: [10.1080/17522439.2013.843020](https://doi.org/10.1080/17522439.2013.843020)
57. Downs J. Creación y apoyo de los grupos de escucha de voces. Hearing Voices Network, La Red de Escucha de Voces [Internet]. Primera Voz: Archivo de materiales sobre salud mental y crítica del capitalismo; 2013 [cited 11 Oct 2025]. Available from: <https://tinyurl.com/3pyedjsd>
58. Romme M, Escher S. Hearing Voices. Schizophrenia Bulletin. 1989;15(2):209-216.
59. Romme M, Escher S. Effects of mutual contacts from people with auditory hallucinations. Perspectief. 1989;(3):37-43.

60. Romme M, Honing A, Noorthoorn E, Escher S. Coping with hearing voices: an emancipatory approach. *British Journal of Psychiatry*. 1992;(161):99–103. doi: [10.1192/bjp.161.1.99](https://doi.org/10.1192/bjp.161.1.99)
61. Romme M, Escher S. Empowering people who hear voices. En: Haddock G, Slade PD, (eds.). *Cognitive-Behavioural interventions with psychotic disorders*. London: Routledge; 1996. p. 137–150.
62. Romme M, Escher S, (eds.). *Understanding voices: coping with auditory hallucinations and confusing realities*. London: Handsell Publications; 1996.
63. Honing A, Romme M, Ensik B, Escher S, Pennings M, deVries M. Auditory hallucinations: a comparison between patients and nonpatients. *The Journal of Nervous and Mental Disease*. 1998;186(10):646–651. doi: [10.1097/00005053-199810000-00009](https://doi.org/10.1097/00005053-199810000-00009)
64. Escher S, Romme M. *Young People Hearing Voices*. Monmouth: Pccs Books; 2010.
65. Escher S, Romme M, Buiks A, Delespaul P, van Os J. Independent course of childhood auditory hallucinations: a sequential 3-year follow-up study. *British Journal of Psychiatry*. 2002;181(181):S10–S18. doi: [10.1192/bjp.181.43.s10](https://doi.org/10.1192/bjp.181.43.s10)
66. Escher S, Romme M, Buiks A, Delespaul P, van Os J. Formation of delusional ideation in adolescents hearing voices: A prospective study. *American Journal of Medical Genetics (Neuropsychiatric Genetics)*. 2002;114:913–920. doi: [10.1002/ajmg.10203](https://doi.org/10.1002/ajmg.10203)
67. Escher S, Romme M, Buiks A, Delespaul P, van Os J. Coping defence and depression in adolescents hearing voices. *Journal of Mental Health*. 2003;12(1):91–99. doi: [10.1080/09638230021000058](https://doi.org/10.1080/09638230021000058)
68. Escher S, Morris M, Buiks A, Delespaul P, van Os J, Romme M. Determinants of outcome in the pathways through care for children hearing voices. *International Journal of Social Welfare*. 2004;13:208–222. doi: [10.1111/j.1369-6866.2004.00315.x](https://doi.org/10.1111/j.1369-6866.2004.00315.x)
69. Romme M, Escher S. Trauma and hearing voices. En: Larkin W, Morrison AP, (eds.). *Trauma and psychosis: New directions for theory and therapy*. London: Routledge; 2006. p. 162–192.
70. Romme M, Escher S, (eds.). *Research to practice in Community Psychiatry*. Maastricht: van Gorcum; 1988.
71. Romme M, Escher S. Managing Distressing Voice Hearing Experiences. En: Copeland ME, Allot PK, (eds.). *Wellness Recovery Action Plan*. Liverpool: Sefton Recovery Group; 2005. p. 114–118.
72. Romme M, Escher S, (eds.). *Psychosis as a personal crisis: An experience-based approach*. London: Routledge; 2012.
73. Waddingham R, Escher S, Dodgson G. Inner speech and narrative development in children and young people who hear voices; three perspectives on a developmental phenomenon. *Psychosis*. 2013;5(3):226–235. doi: [10.1080/17522439.2013.845594](https://doi.org/10.1080/17522439.2013.845594)
74. Woods A, Romme M, McCarthy-Jones S, Escher S, Dillon J. Special edition: Voices in a Positive Light. *Psychosis*. 2013;5(3):213–215.
75. Correa-Urquiza M. La irrupción posible del saber profano: Hacia una construcción colectiva del conocimiento en salud mental. *Temps d'Educació*. 2014;(47):63–75.
76. Foucault M. *The care of the self*. London: Penguin; 1986.
77. Mol A, Moser I, Piras EM, Turrini M, Pols J, Zanutto A. Care in practice: On normativity, concepts, and boundaries. *Tecnoscienza Italian Journal of Science & Technology Studies*. 2010;2(1):73–86. doi: [10.6092/issn.2038-3460/16996](https://doi.org/10.6092/issn.2038-3460/16996)
78. Mol A, Moser I, Pols J, (eds.). *Care in practice: On tinkering in clinics, homes and farms*. Bielefeld: transcript Verlag; 2015. p. 7–26.
79. Escher S, Hague P, Romme M. Hearing Voices: A structured questionnaire [Internet]. 2011 [cited 11 Nov 2025]. Available from: <https://tinyurl.com/cywzt8np>
80. Escher S, Bullimore P, Romme M. Maastricht Interview with a person who experiences paranoia [Internet]. 2004 [cited 12 Oct 2025]. Available from: <https://tinyurl.com/5f7hkj66>
81. Lupton D. Discourse analysis: a new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health*. 1992;16:145–150. doi: [10.1111/j.1753-6405.1992.tb00043.x](https://doi.org/10.1111/j.1753-6405.1992.tb00043.x)
82. Ruiz Ruiz J. Sociological discourse analysis: Methods and logic. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*. 2009;10(2). doi: [10.17169/fqs-10.2.1298](https://doi.org/10.17169/fqs-10.2.1298)
83. Pié-Balaguer A, Correa-Urquiza M, Martínez Hernández Á. *Soltar amarras: una introducción a la salud mental colectiva*. Barcelona: Universitat Oberta de Catalunya; 2021.
84. May R. Routes to recovery from psychosis: the roots of a clinical psychologist. *Clinical Psychology Forum*. 2000;1(146). doi: [10.53841/bpscpf.2000.1.146.6](https://doi.org/10.53841/bpscpf.2000.1.146.6)
85. Dillon J. The tale of an ordinary little girl. *Psychosis: Psychological, Social and Integrative Approaches*. 2010;2(1):79–83. doi: [10.1080/17522430903384305](https://doi.org/10.1080/17522430903384305)
86. Longden E. Learning from the voices in my head. TED Conference [Internet]. 2013 [cited 10 Oct 2025]. Available from: <https://tinyurl.com/sw2u95vn>
87. Balias F, Pellejer M. *Desmesura: Una historia cotidiana de locura en la ciudad*. Barcelona: Edicions Bellaterra; 2018.
88. Balias F. *Oír voces en la cabeza*. En: *Las voces que no escuchamos*. Valladolid: La Revolución Delirante; 2023. p. 1–16.
89. Balias F. Barrio, clase, voces en la cabeza y un médico de cabecera. En: *Las voces que no escuchamos*. Valladolid: La Revolución Delirante; 2023. p. 17–23.
90. Balias F. 20 años no son nada. Dos décadas oyendo voces en la cabeza. En: *Las voces que no escuchamos*. Valladolid: La Revolución Delirante; 2023. p. 25–32.
91. Balias F. Sobre la necesidad de crear nuevas e individualizadas estrategias para afrontar el hecho de oír voces. En: *Las voces que no escuchamos*. Valladolid: La Revolución Delirante; 2023. p. 33–38.
92. Mejías Rosa P. *Las voces que no escuchamos*. Valladolid: La Revolución Delirante; 2023.
93. Comelles JM. Profanos y profesionales del discurso de la evidencia al conocimiento local y la participación. *Trabajo Social y Salud*. 1999;(32):241–258.
94. Noorani T. Service user involvement, authority and the ‘expert-by-experience’ in mental health. *Journal of Political Power*. 2013;6(1):49–68. doi: [10.1080/2158379X.2013.774979](https://doi.org/10.1080/2158379X.2013.774979)
95. Martínez Barbero MA, Coca Pereira MC, Pérez Villalba G, Martínez Hernández MV. Escuchando la voz de las personas que escuchan voces. *Revista de la Asociación Española de Neuropsiquiatría*. 2017;37(131):39–61.

96. Ortega Moreno B. Escuchadores de voces: Grupo de ayuda mutua por y para el usuario diagnosticado de psicosis. *Revista ROL de Enfermería*. 2018;41(5):36-41.
97. Mendonça Corradi-Webster C, Sicaroni Rufato L, Augusto Leão E, Bien C, Reis G. Grupo de Ouvidores de Vozes: experiência inovadora realizada por suporte de pares. *Revista Iberoamericana de Psicología*. 2021;14(2):75-85.
98. Kidd IJ, Spencer L, Carel H. Epistemic injustice in psychiatric research and practice. *Philosophical Psychology*. 2025;38(2):503-531. doi: [10.1080/09515089.2022.2156333](https://doi.org/10.1080/09515089.2022.2156333)
99. Gonzalez-Mañas D, Correa-Urquiza. Saberes profanos y justicia epistémica en salud mental: análisis crítico del agente de apoyo entre iguales en el Estado español. *Salud Colectiva*. 2026;22:e6041. doi: [10.18294/sc.2026.6041](https://doi.org/10.18294/sc.2026.6041)
100. Woods A. The voice-hearer. *Journal of Mental Health*. 2013;22(3):263-270. doi: [10.3109/09638237.2013.799267](https://doi.org/10.3109/09638237.2013.799267)
101. Canals J. Els Grups d'ajuda mútua: una presentació actual de la reciprocitat. *Quaderns de l'Institut Català d' Antropologia*. 2002;(17-18):139-151.
102. Canals J. El regreso de la reciprocidad: Grupos de ayuda mutua y asociaciones de personas afectadas en la crisis del Estado del Bienestar. [Tesis doctoral]. Tarragona: Universitat Rovira i Virgili; 2003.
103. Correa-Urquiza M, Pié Balaguer A, Coll-Florit M, Hernández i Encuentra E, Climent Roca S. Orgullo loco y metáforas para una disidencia: un análisis lingüístico y simbólico. *Salud Colectiva*. 2020;16:e2886. doi: [10.18294/sc.2020.2886](https://doi.org/10.18294/sc.2020.2886)
104. De Juan Franco E. Voces de la locura: Una aproximación desde la antropología social a las experiencias en el activismo loco y los grupos de apoyo mutuo. [Tesis Doctoral]. Barcelona: Universitat Autònoma de Barcelona; 2023.
105. Guzmán Martínez G, Pujal i Llombart M, Mora Malo E, García Dauder D. Antecedentes feministas de los grupos de apoyo mutuo en el movimiento loco: un análisis histórico-crítico. *Salud Colectiva*. 2021;17:e3274. doi: [10.18294/sc.2021.3274](https://doi.org/10.18294/sc.2021.3274)
106. Faulkner A. Survivor Research and Mad studies: the role and value of experiential knowledge in mental health research. *Disability & Society*. 2017;32(4):500-520. doi: [10.1080/09687599.2017.1302320](https://doi.org/10.1080/09687599.2017.1302320)

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