

# Is hearing voices a sign of mental illness?



**IVAN LEUDAR**

LET me start by proposing the terms of the debate. I do not accept that auditory and verbal hallucinations must be studied only as hallucinations. The term 'hallucination' implies an intrinsic confusion – something subjective is wrongly experienced as 'real' – but in fact most voice hearers are not confused in this way. Even before we investigate the experience, the term tinges it with a logically intrinsic pathology where there may be none. The term 'hallucination' also implies that the (social and personal) dilemma is always whether the experience is private and psychological, as opposed to objective and social. This is simply not the case.

The question we are to debate is meant to elicit controversy, and it does; but I am not sure it is one to bring out what is most interesting about 'hallucinatory' voices. The questions I like are, for instance, 'Does everybody take hallucinations to be a sign of insanity?' or 'Was hearing voices always a sign of insanity?'; and the answers to these are clearly 'no'. One should ask what exactly these experiences have indicated, to whom, and on what grounds. Psychiatry is not in a privileged position here. Why were these experiences always noticeable and controversial, historically speaking? Not always on the grounds of their intrinsic pathology and confusedness.

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**TONY DAVID** says yes, **IVAN LEUDAR** disagrees.

One historical debate was held by the French Société Médico-Psychologique in 1855. The debate was essentially about how to distinguish hallucinations of the insane from those of artists, visionaries and more ordinary others, but this turned out surprisingly difficult. The comparisons were made in terms of (i) control over the experiences, (ii) confusing imagination and memories for perceptions, and (iii) confusing private experiences with the shared public ones. Some argued that hallucinations were inconsistent with reason, and that visionaries such as Socrates or Joan of Arc were mentally ill simply because they had them and acted on them. Others disagreed and distinguished physiological from pathological hallucinations. The former were seen as reasonable – relevant and sensible in content and appropriate emotionally, providing proper grounds for actions. The lesson is to judge hearing voices (and other such experiences) according to whether they are reasonable, and in terms of their consequences for life: in other words, pragmatically.

A second relevant debate concerned the visions of St Teresa of Avila. Her autobiography detailing them in support of her religious practices was examined by the Inquisition, who clearly distrusted visions. They declared that one should be very careful before granting sainthood on their grounds, but they did not see them as signs

of insanity. Visions could be categorised as 'mere imagination', as 'the work of the enemy of mankind' and as messages from 'the angel of light'; and the assignment into a category was a matter of their consistency with theological dogma and consequences for life.

What I would suggest then is that hearing voices (and the experiences we may categorise as hallucinations) should be judged as sane or insane in terms of their consequences for life. They are not in themselves signs of madness, any more than, say, thinking and remembering; even though some people can have bizarre and false memories, and some people think delusional thoughts. The madness of some hallucinations is in their involuntariness, delirious content, falsity, childish terror of the hallucinator: in other words, nothing specific to hallucinating.

Epidemiological research implies that hallucinations are not necessarily concomitants of insanity but may happen to people without any psychiatric problems. My own work implies that hearing voices is intrinsically rather mundane in content and not necessarily deluded or deluding. There is a problem though. We always have experiences under a description, never just the bare experiences. It is possible that hearing voices under the description 'a hallucination' and 'a symptom' is not so much an indication of mental illness as a cause of psychological distress.



**TONY DAVID**

CONTRARY to popular myth, psychiatrists do not go around searching for people to diagnose, with the purpose of restraining or controlling them in some sinister way. A voice-hearer who is not in any distress, who lives a fruitful and productive life according to commonsense

criteria, would never even enter the arena in which the possibility of mental illness was up for discussion. Take another case of a person, who through despair or distress is driven to a suicidal act. A full history and examination reveal that they experienced 'voices' goading them to take their life. The presence of this additional 'symptom' would not be decisive in making a

judgement about mental illness. It may, however, influence which kind of treatment would be offered, and it should alert the clinician to an additional element of uncertainty about the nature of the person's dilemma and prognosis. It is the combination of ill health or dysfunction with a recognised cluster of symptoms and signs observed over time that enables a diagnosis to be made reliably and with some validity.

As for the nature of the experience itself, Ivan is right that research (e.g. Nayani & David, 1996) has shown that the classic description of a hallucination as a voice experienced in external space where one would logically expect it to be heard by others, and for which the individual feels no sense of agency, is actually rather uncommon. However, it does occur and is rightly given weight diagnostically because of it being outside the realm of normal experience. Contrast this with an internal dialogue with, say, a known figure in the past or a known aspect of one's personality that occupies subjective space; such a dialogue seems to carry on somewhat autonomously and unbidden in the way that thoughts sometimes come into one's head. This is a common enough experience. However, this is much more often found in those who, for other reasons, have attracted a diagnosis of mental illness, particularly schizophrenia. Hence, though the experience on its own seems only marginally pathological, the fact that it frequently (in about 70 per cent of cases) occurs alongside other more bizarre hallucinatory experiences, does suggest that bracketing them under a heading of illness is not unreasonable.

Is Ivan claiming that certain kinds of auditory experiences would count as hallucinations and are indeed pathological, but that the more common inner voice dialogue should not be regarded in this way? This really is a very fine point. Traditionally psychiatrists play down content as having no real pathological significance, concentrating instead on form. By the latter they mean whether a hallucination is in external space, alien in origin, has a certain grammatical construction, such as a voice commenting upon the individual in the third person. Again, a disembodied, fragmented agency of this type is very uncommon and is not noted by famous 'hallucinators' through history. Generally such figures are spoken to directly by their hallucination, which is a meaningful entity to them.

What about content? On the one hand,

hallucinations can be banal, repetitive, running commentaries. While this in itself may cause little or no distress, it is certainly not a helpful distraction and is seldom valued by the voice hearer. At the other extreme, there is the abuse, criticism and lack of privacy that one patient described as 'an open mental wound'. So whatever the origins of such experiences may be, the upshot is a painful interrogation. If there was a therapeutic intervention available for this, then it should surely be offered to the sufferer. Ivan locates 'the madness of some hallucinations' in their delirious content, their falsity and their terror. These are to my mind highly specific to hallucinations, they are part and parcel and not mere add-ons, particularly in people who suffer from mental illness. It is the hallucinatory form plus the typical content that gives the experience an 'otherness' which is so frightening.

I am not willing to take this to an extreme. I have known plenty of patients who, for example, leave their room in

a mess because 'the voices told me to'. How many adolescents up and down the country would love to use this as an excuse!

People who describe a complex and at times valued set of experiences they call hearing voices, yet in whom there are no strong indications of a psychotic illness or even clear-cut affective disorder, very seldom respond to medical treatment, such as neuroleptic drugs. For this group, and only if the person wishes it, there are now some clinical psychologists who are looking at cognitive-behavioural approaches to treatment. The task is to reintegrate the experiences – if they are memories, fantasies, fears, why not call them that? The alternative is to collude with the compartmentalisation of experiences, which leads down a road to multiple personality and other contrived aberrations.

While there are dangers in seeming to denigrate a person's experience with a pathological label, there are equivalent dangers in reifying them.



ADY COUSINS

We both accept that the mere hearing of voices does not indicate mental illness (or schizophrenia in particular). But when does it? My view is that, in general, whether hearing voices indicates psychological problems or not is socially and culturally contingent. But where we live, I would say that voices tend to indicate problems when:

- they are out of touch with mundane reason;
- they stand apart from the remainder of personal experience; and
- they are a source of unreasoned and impulsive action.

The problem is that these conditions are not

mentioned in diagnostic manuals, such as DSM-IV, in which auditory hallucinations are a symptom of mental disorders irrespective of whether they have these properties or not. (As Tony himself said, medical psychiatry ignores content of symptoms.)

Moreover, it is quite irrelevant that some voice hearers will never see a psychiatrist. The problem is, the very fact of hearing voices becomes a cause of mental distress, and this is because of the meaning of the experience in our culture, which is grounded in psychiatry. Psychiatrists are not responsible for media categorisations, but the fact is that media represent these experiences almost exclusively as

symptoms, and often as concomitants of unreasoned violence (see Leudar & Thomas, 2000, chapter 8). So if I start hearing voices, does this mean that I am going insane, cannot trust myself, even with my family?

Would I say that voices are a secret and forgotten source of wisdom? Clearly not today – the content and pragmatics of contemporary voice talk tends to be



It seems we have whittled the issue down to the content of the hallucinations: put simply, what the voices are saying and the effect they have on the voice-hearer.

Let's just backtrack a little. We accept that the mere hearing of voices does not indicate mental illness. Where I think some voice-hearers get into conflict with psychiatric services is where a diagnosis has been made on other grounds (including hallucinations of a problematic kind) and treatment is recommended. The patient may see the whole episode in a different light from the psychiatrist:

resolutely ordinary, and like everyday private speech (see Leudar *et al.*, 1997). But was this so in the past? Our finding is that even then religious voice talk was pragmatically rather mundane. But what religious reformers and visionaries inferred from it, and could do with it, was certainly not. We really do need to treat history with respect – it may tell us the limits of our certainties.

*Patient: Why should I continue with the medication, which by the way has side-effects, as I now understand much more of what happened to me?*

*Psychiatrist: Well, there is the risk that things could get bad again and that would be very destructive...and you are still hearing voices.*

So 'The Voices' become the bone of contention. This scenario, albeit a caricature, is one which we often get drawn into. My view is that voices in this context – often mundane, such as running commentaries on everyday actions – are

clinically significant because they indicate continued vulnerability to relapse. Nevertheless, we – users and carers – must endeavour to engage in a more collaborative discourse about symptoms and treatment.

As for diagnostic criteria, while we would like to see more emphasis on content there are dangers. Ivan is critical of what he sees as a devaluing of the experience of voices by mainstream psychiatry, but his compromise, that certain voices 'indicate problems' when they are 'out of touch with mundane reason', is dangerous. Ivan will have to justify whose reason is his gold standard, and what are the criteria for 'out of touch'? Whether the fact that psychiatry categorises certain experiences as pathological actually causes mental distress is highly debatable. I would like to see a controlled study on this before accepting such an extreme view.

All experiences, perceptions, memories, fantasies, hallucinations, whether deemed normal or pathological, are capable of being turned to good use. This is not sufficient justification for abandoning some kind of normative classification. They may

be a source of inspiration, spiritual guidance or the catalyst to questioning whether all perception is 'real' and whether certain phenomena are 'merely' the products of illness, and hence not worth clinging on to. It is also no reason to abandon the search for the biology, physiology and biochemistry of such phenomena (along with their historical and cultural context).

Let us both now ponder on the meaning of observations of the activity in the auditory association cortex coincident with the experience of auditory hallucinations (Shergill *et al.*, 2000), or the 'auditory' quality of hallucinations in the prelingually deaf (du Feu & McKenna, 1999) as well as what it was like to be Joan of Arc. Indeed, this is the only way we will achieve a richer appreciation of brain and mind (Amador & David, 1998; David & Busatto, 1998).



We do indeed agree that the mere hearing of voices does not indicate mental illness.

Yet in the end I am not sure how deep our agreement is. Tony disallows the pragmatic criteria which I suggested might be used to judge the rationality or otherwise of voices, pointing out how difficult it would be to formulate the standards. This puzzles me – do psychiatrists not have to decide, as a matter of their everyday practice, whether, say, beliefs and fears are justified or delusions? And do they not do this without recourse to specialist knowledge, and simply by using their commonsense competences (as they must)? So if one can assess the thoughts and feelings of others, why not the experiences which we are considering here? In fact, I think that is exactly what Tony did in proposing the rule of thumb: voices can be considered as pathological if there are other mental



ADY COLEMAN

pathologies. Interestingly, this treats meaning of voices as indexical – that is, not purely intrinsic but depending on other concomitant pathologies.

Perhaps I should clarify. I did not try to formulate general standards for assessing the rationality of voices – I sketched out what likely local commonsense considerations might be. It would be at best redundant to try to formulate any such norms; my project is instead to investigate empirically how the voice hearers, psychiatrists and others reason and argue about these experiences and what they do with them. This turns out to be clearly culturally bound, and that is why I am interested in history – you get information from a world that was different and not

globalised. In the end I hope we both also agree that investigating cultural and social aspects of ordinary and pathological experiences is as valid an approach as searching for the biology, physiology and biochemistry of such phenomena.

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We have gone full circle. I have explained a little more about the diagnostic process and how a clinical psychiatrist approaches

the issue of hearing voices in particular. No symptom taken in isolation should be regarded as pathognomonic of mental illness – the context needs to be taken into account. Historical context is also important for reasons that Ivan has outlined.

However, the less we resort to the shifting sands of cultural values and the more we seek to apply universal standards (e.g. third person commenting voices are usually pathological), the less open to abuse and innocent mistakes psychiatry will become.

But a balance must be struck. The aim is not to ignore history and culture, but to benefit from the interplay and tension between our understanding of subjective and objective realities.

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