CHAPTER ELEVEN

The Voices of Hallucination

By now it should be clear that it has been our modern scientific conceptions of reason and reality—and the social conventions that result from them—that have dictated our psychological theories of imaginal dialogues. These same conceptions are responsible for assigning pathology and devising treatment strategies. It should come as no surprise that the brand of imaginal dialogues commonly referred to as “hearing voices” or “hallucination” should have fallen prey to historical shifts toward secular and scientific conceptions of reason and reality—shifts which have led our society to laud imageless logic as the very apex of reason and thought and to promote the perceptible as the only legitimate reality.

Imaginal dialogues are often looked at askance by clinicians. The suggestion that a person ought to entertain more characters, allow them greater autonomy, and enable characterizations to unfold which are more vivid and articulated might lead many to believe that we are encouraging hallucination, dissociation or fragmentation of the personality, a dangerous weakening of the ego—and perhaps even that we recommend becoming a “split personality.”

However as we have seen, the entertaining of a multiplicity of autonomous and vivid characters is commonplace in the creation of literature and the practice of religion, and is hardly synonymous with pathology. The term “hearing voices” immediately warns us of the monological and non-reciprocal nature of many of these experiences where one receives, hears, the voice’s message but does not necessarily
respond to the voice or engage it in dialogue. It also warns us of the often undeveloped nature of the characters involved, as it is often just the voice that comes to be known.

What a culture designates as psychopathological reflects its values and assumptions, its goals for thought and behavior. We can see this when we examine “hallucinations.” The Oxford English Dictionary (1933) reveals that the word is relatively new, having entered the English language in 1646 with the Enlightenment, and only gaining its present meaning in the last century with the births of psychiatry and psychology as sciences.28 As a word it is derived from the Latin (b)alucinari, to wander in mind, to talk idly. Its first meanings (in 1652) were “to be deceived, suffer illusion, entertain false notions, blunder, mistake” (Compact Edition of the Oxford English Dictionary, 1971, 1245). In the nineteenth century it took on its modern meaning of an apparent perception which lacks an object (Larger Oxford English Dictionary, 1933, 44). The gist of the earlier definition—to mistake, to entertain false notions, to blunder—was certainly carried forward and helped allocate hallucinations to the bins of psychopathology. Gradually the definitions of “delusion,” “hallucination,” and “illusion” were again differentiated.29 The presence of hallucinations in persons not suffering from drug toxicity, neurological difficulties or fever was taken as a symptom of schizophrenia.

Where had hallucinations been in Western conceptions before the nineteenth century? Certainly the experience of what is now called “hallucination” was not an altogether new movement of mind. Before the rise of science with its focus on objectivity, and the secularization of experience, what are now designated as hallucinations, were probably thought of as visions: “The action or fact of seeing or contemplating something not actually present to the eye;” “something which is apparently seen otherwise than by ordinary sight; especially

28 Sarbin and Juhasz (1967, 1) note the first English use of the word hallucination in a translation of Lavater’s Of Ghostes and Spirites Walking by Nght in 1572. In this work hallucinations were “ghostes and spirites walking by nyght, and strange noyses, crackes, and sundry forwarnynges, whiche commonly happen before the death of menne, great slaughters and alterations of kyngdomes.”

29 Van den Berg (1982a) notes that Asclepiades made use of historical sources to differentiate between hallucinations and illusions, and that the Asclepian differentiation between these phenomena is much like our modern notions. Despite this early treatment, however, English definitions did not distinguish these phenomena until Esquirol’s work (1833, 1838) became widely known.
an appearance of a prophetic or mystical character, or having the
nature of a revelation, supernaturally presented to the mind in sleep
or in an abnormal state” (Shorter Oxford English Dictionary, 1933, 2363).

While many visions were valued as means of access to God and
His angels, to the Virgin Mary and other saints, other visions were
dealt with as blunders. As remote as psychiatry’s current notions of
hallucination may seem from the earlier treatment of visions by the
Church and its Inquisitors, the former derives in part from the latter.

Sarbin and Juhasz have traced the curious history of how the
mystic and Scholastic treatments of visions became assimilated into
the medical model of hallucination. Just as the psychiatrist must dis-
tinguish between “ordinary” imaginal experience and “hallucination,”
so did the early Church fathers distinguish between various kinds of
visions. The mystics’ treatment of vision is exemplified by St. Augustine
(1967, 354-430), who diagnosed how far removed the vision was from
immediate sense experience. He judged it superior the more intel-
lectualized and immaterial it was (as with a Platonic idea) and the further
removed from the sounds of time, space, and corporeality. The
Scholastics, exemplified by St. Thomas Aquinas (1225-1274), diagnosed
visions not in terms of level of embodiment (corporeal versus
intellectual or immaterial), but in terms of the source and content of
imaginary experience. While visions were valued as bridges between
man and the supernatural, the region of the supernatural with which
one was in contact was of the greatest concern. St. Thomas and his
followers had the difficult task of determining whether the source of
the vision was celestial, infernal or natural—whether the figures were
those aligned with God or those with the Devil.30 Their task was further
complicated by the fact that the Devil was known to tell falsehoods
and to disguise himself in the costumes of those closest to God.
Fortunately the Devil was more likely to appear corporeally than
intellectually. But the question of level could not definitively
differentiate between visions. Those visionaries entertaining figures from

30 The psychoanalyst Leston Havens (1981) has proposed that the difference
between saints and hallucinating patients may have to do with the kind or quality
of advice the voice or figure gives the patient. This is a kind of differentiation
based on what the voices have to say, rather than whether they are perceptual or
non-perceptual. It is thus analogous to the older differentiation between the interloc-
tors, the “who’s,” of imaginal dialogues. Development in this model is described as
“upgrading” the voices who give bad advice, by voices gradually becoming more
like the analyst’s voice.
non-Christian mythology were publicly derided, humiliated, and sometimes burned at the stake as witches along with those who were considered “demoniacal or out of their senses or if the source of their vision appeared Satanic” (Sarbin and Juhasz, 1967, 341).

St. Ignatius (1491-1556) also concerned himself with the source of the vision and created a precedent for *ex post facto* analysis of hallucination later to be borrowed by psychiatry: if the effect of the vision is good, it is from God; if it is bad, it is from the Devil (Sarbin and Juhasz, 1967, 342). The modern version goes as follows: if the person is considered insane, the imagining is thought of as a hallucination and as bad; if the person is considered of sound mind, the imagining is either creative or strange, but not bad.

St. Theresa of Avila (1515-1582) is given the critical role of being the first religious figure to favor turning over to medicine the diagnosis of visions and imaginings. To protect her visionary nuns from the purges of the Inquisition, she argued “that certain imaginings may be the effect of infirmities and sickness and, as such, persons experiencing them were not responsible” (Sarbin and Juhasz, 1967, 343). Natural sources such as melancholy, a weak imagination, drowsiness, and sleep or sleep-like states were seen to vie with celestial and infernal sources, thus liberating the seer from a negative diagnosis of demon dealings.

While saving visions from the Devil—and thus the visionary from the stake—this reassessment also caused visions to begin to lose their positive association with God and the angels. The visionary and her visions were delivered to the asylum, and there the doctor was given the task of diagnosing the reported imaginings of the patient. He already knew certain facts about the imaginer—that others suspected the patient of insanity, had observed what they considered inappropriate behavior (particularly inappropriate role behavior), and had found the patient disturbing to be around. The doctor needed these other facts to formulate a diagnosis:

The choice of words and the syntactical arrangement are not sufficient criteria for the diagnoster to make a confident judgment of hallucination unless he is willing to run the risk of mislabelling the imaginal and verbal products of poets and playwrights and nearly everybody else. Since spoken or written reports may obscure truth through ellipsis and metaphor, the diagnoster has no
choice but to use as his raw data observations other than the spoken or written reports of imaginings. These other observations focus on the psychological status conferred on the suspected hallucinatory concurrent with his other statuses, such as mental hospital patient, poet, novelist, etc. (Sarbin, 1967, 374)

The medicalization of the societal approach to imagining was unfortunate for a number of reasons. While St. Theresa had argued that it was “as if,” her sisters were ill, medicine dropped the “as if,” turning metaphor into fact. This “fact” then called for doctors to devise treatments for the imaginings that had always existed. Though the hallucination was no longer labeled in terms of level (higher or lower), content, or source (celestial or infernal), the hallucinator was labeled insane or sick (Sarbin and Juhasz, 1967).

Rather than discriminate between voices the physician needed only to discriminate between image and “reality” to determine whether or not the reported imaginings were erroneous.

This judgment, just as in the case of the Augustinian practitioner, was a rather complex inference requiring great language sophistication and a large number of shared concepts on the part of the both speaker and hearer. However, because of the new pseudo-objective terminology, the practitioner probably considered the judgment to be a simple, scientific diagnosis. For example, a memory-image of a picture of the Virgin that the subject had seen before would not have been an erroneous image. On the other hand, the image (memory-image) of the village washerwoman, if called “The Virgin Mary” by the seer would have constituted an erroneous image. By the scientific rules of the time, the image of any mythological figure, if taken for “reality” would have constituted an erroneous image. The physician was thus called upon to distinguish between the various senses of identical words: Whether they were meant literally [“I (corporeally) now see the Virgin Mary”] or figuratively [“(It is as if) I now see the Virgin Mary”]. (Sarbin and Juhasz, 1967, 345-346)

The doctor’s job was to judge the imaginings of people already considered insane. The presence of hallucinations was a criterion for being insane, but a patient’s presumed insanity predisposed the doctor to judge his imaginings as hallucinations—a diagnosis derived from circular reasoning.

Esquirol’s (1833, 1838) work set the stage for the consolidation of the medical model of hallucination. He distinguished illusions
from hallucinations and argued that while illusions may appear in healthy people, hallucinations are invariably pathological. This meant that despite people’s commitment to systems of reality different from that of modern science, their visions, in retrospect, could be diagnosed as crazy. Socrates, St. Catherine of Siena, Dante, and countless others now became victims of the medicalization of imagination.

In the late 1800s the new psychologists in their treatment of hallucination, looked back to such experiences as the inner voice Socrates relied upon to admonish him when doing something undesirable to a god, the being who followed Descartes down streets urging him not to abandon his search for truth, to Swedenborg’s conversations with angelic visitors, and to Saint Catherine’s espousal to Christ and called these all hallucinations, “fallacies of perception” (Parish, 1897, 39, 77-78). The possible desirability of such experiences was rarely acknowledged as the emphasis was on differentiating the perceptual from the imaginal, on establishing the claim that such experiences are internal and psychological rather than external and “real.” Rather than searching for distinctions between various imaginal experiences, the focus was on differentiating the “purely” perceptual from the imaginal.

The psychologists who took part in this movement began to meet with protest beginning in the middle of the last century and continuing into the present century ( Michea, 1846; Brière de Boismont, 1859; Ball, 1883; Gurney and Myers, 1884; William James, 1892). But the protest was interrupted by World War I and its message faded away as behaviorism displaced the study of consciousness, thought, and imagery (Sarbin and Juhasz, 1967, 352). An interesting opposition to the equation of hallucination with pathology emerged at the International Congress of Psychology in Paris in 1889. Psychologists such as Sidgewick protested that hallucinations occurred not just in persons of “morbid” personality but in perfectly healthy people as well and proposed a census (The International Census of Waking Hallucinations in the Sane) to prove it. In 1894 Sidgewick studied 15,316 people of good health, who had not suffered from mental illness. He found that 7.8 percent of the 7717 men and 12 percent of the 7599 women reported having hallucinatory experiences. Given the prevalent equation of severe mental illness with the occurrence of hallucination, it would not be surprising if the actual percentage were even higher due to people’s fears of admitting to such experience. The census, however,
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did not successfully dissolve the equation between hallucination and mental illness. Before this equation could be challenged psychology’s commitment to a scientifically defined notion of reality would have to be addressed.

On close inspection of examples of hallucination in the psychiatric literature, one finds that the term “hallucination” is a general category for a broad array of experiences. In all instances it is a pejorative term. For example, hallucinations can be experienced through all the sensory modes. They can be experienced as occurring inside or outside the body, confused with the perceptual or merely experienced alongside the perceptual, or fleeting impressions or almost continuous presences. Fundamental to the various theories, however, is the notion of the perceptual or quasi-perceptual nature of hallucinations and, correspondingly, their appearance in “normal” space, be that inside or outside the physical body. Here we confine our interest to hallucinations which involve an imaginal figure, although our critique of the treatment of these kinds of hallucinations in the literature will have more general implications for other forms of hallucination as well.

The emphasis in theories of hallucination lies predominantly on the following two commitments and priorities: 1) that which arises from perception and sensation should be more vivid than that which arises from imagination;31 the objective world, the consensually agreed upon, should be more vivid than the imaginal and the subjective; 2) external space should be reserved for perceptual and objectively verifiable phenomena. Thus the imaginal, which is subjective, should be experienced in internal “psychological” space. When these rules are broken—when an imaginal figure appears perceptually and externally, or rivals the perceptual in intensity—the resulting experience is labeled a hallucination. The hallucination breaks in upon the usual vision of reality. Pathology becomes coincident with a failure to experience images as internal and/or a preoccupation with imaginal persons or events that rival the perceptual in intensity or compromise its agreed-upon priority. When one experiences an event

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31 Sarbin points out that commitment to the assertion that perception and sensation should be radically distinguishable from the imaginal was falsified over a century ago by Galton and by the classic experiments of Seashore in 1895, Perky in 1910, and Wilson in 1941. In these experiments images and percepts are confused by normal subjects “under conditions of poor illumination and sound or in ecological settings that are impoverished for familiar cues” (Sarbin, 1967, 377).
which breaks through the usual conventions concerning the internal and the external, the imaginary and the perceptual, one can "feel" crazy or fear craziness. Hallucinations most threaten those who conceive of themselves as "in control" (by virtue of their obedience to the perceptual).

The usual psychiatric approach to hallucination is one of efficient cause. The hallucinator, as a result of his "inability to discriminate between thoughts and perceptual experience" (Freeman, Cameron, and McGhie, 1966) or his "failure to maintain an adequate differentiation between internal experiences and the perception of experiences occurring outside the self" (Blatt and Wild, 1967, 18), confuses an internal thought with the objects occurring in ordinary perceptual space. Thus hallucination becomes defined as "an internal image that seems as real, vivid, and external as the perception of an object" (Horowitz, 1970, 8).

The usual therapeutic strategy is to "help" the patient return to the usual notions and values about reality agreed upon in our psychology: namely, that what is not consensually validated should be experienced as internal, residing in psychic space; that this internal experience should not compete with or impair relations to "real" others; that the proper contents of this internal space are not figures but thoughts. An example of this kind of approach to hallucinations is given in Leston Havens' psychoanalytic paper "The placement and movement of hallucinations in space: Phenomenology and theory" (1962). Here a developmental line proposed for hallucinations is a gradual movement of the hallucinated presence from outside the self to inside the self, and ultimately to becoming integrated into the self.

From Havens' point of view the hallucinated figure is experienced in external space in order to satisfy specific needs for external objects (i.e., people). Havens speculates that in some cases the person, because of a failure of introjection, needs an external figure to compensate for the absence of an internal one. For Havens the more "mature position" for the imaginal object is "the position closer to identification" (1962, 432). Thus hallucination becomes defined as "the substitution of an imaginary object for a real one that was never identified with" (434). The rule of thumb is summarized by Jaynes: "When the illness is most severe, the voices are loudest and come from outside; when least severe, voices often tend to be internal
whispers; and when internally localized, their auditory qualities are sometimes vague” (1976, 91).

Some phenomenologists (Merleau-Ponty, 1962, 334ff and van den Berg, 1982a) have disputed whether the “hallucinator” actually cannot discriminate between a perceptual experience and a hallucinogenic one. Although their examples and arguments do not disprove the existence of such a lack of discrimination, their work introduces differentiation into the less than subtle “perception vs. fallacies of perception” distinction. If one looks closely at first-person accounts of hallucinations, one finds accounts where the patient does not confuse the imaginal voice or figure with his or her perceptions. In The Autobiography of a Schizophrenic Girl (Sechelhaye, 1951) many such examples are given by the patient, Renee:

...strident noises, piercing cries began to hammer in my head. Their unexpectedness made me jump. Nonetheless, I did not hear them as I heard real cries uttered by real people. The noises, localized on the right side, drove me to stop up my ears. But I readily distinguished them from the noises of reality. I heard them without hearing them, and recognized that they arose within me.

I threw things to the right, toward the locked French windows where I localized my Persecutor, the System, Antipiol—pillows, the water pitcher, my comb. I wanted to chase Antipiol, to crush him so that I would no longer hear his voice.

Actually in all honesty, I saw no one. I heard no voice. Yet there it was, not an emptiness, not a silence. There was a considerable difference between this part of the room and the others. The corner at the right was alive, personalized; there was someone very real there, empty though it was.

I continued to respond to voices which, though I actually did not hear them, existed nonetheless for me.

After I left the hospital I no longer heard Antipiol’s voice. I say “heard” for I do not know what other word to use to convey the impression of actually hearing an invisible something occupying a corner of the room and saying disagreeable things to which I was obliged to answer. Just the same, I did not really hear them. (42, 62-64)

In these examples the hallucinated figure occurs alongside or
amidst perceived objects but is not seen as the same. Such examples allow us to differentiate experiences where the imaginal is confused with the perceptual and those where it is differentiated from the perceptual but granted an equal or greater priority to objective thought and reality. That these two kinds of experience are so rarely differentiated in the literature on hallucination—examples of the latter being identified as the former—points to a failure not just on the patients' parts but on the doctors; a cultural failure to which doctor and patient are prone in different ways. Hallucinating people do not ask us to come and see the figure, to listen for his words. They are aware that this spectacle, this voice, is in their world and not in the one we share (van den Berg, 1982b). They create special names for these voices and their conversations, differentiating them from those we share: “language magic,” “secret language,” “painful long-distance conversation,” “cold castigation language,” “court-of-law punishment language,” “deadly language,” “grand onanism concert” (Gruhle, 1929). By this language, they make clear to us that the disturbing features of these imaginal experiences lie in the quality of relationship between themselves and the figures—the abusive, cold, distant, judging, deathly forms of being together. When hallucinations are scrupulously imitated by the doctor, and the patient given the task of differentiating this perceptual experience from the hallucinatory one, all non-delirious patients are able to tell the difference (Zucker, 1928).

Our cultural failure is a failure to identify a realm of experience which is not hallucinatory in the strict sense of a confusion with perception, but whose images rival or supplant the priority given to the objective. When this realm is active, a person

...does not see and hear in the normal sense, but makes use of his sensory fields and his natural insertion into a world in order to build up, out of the fragments of this world, an artificial world answering to the total intention of his being. (Merleau-Ponty, 1962, 341)

When this intention is given attention the interruptive nature of such experiences—interruptive to the priority of interpersonal and

32 Van den Berg (1982b) emphasizes this quality of the imagining being amidst the perceptual: “Hallucinating, according to its nature, is to see (hear, etc.) that which another does not see, amid that which everyone, including the patient himself, sees. This ‘amid’ is a prerequisite in the same way as light is a prerequisite of darkness. To hallucinate means to have a world strictly of one’s own in the framework of reference in the social world” (160-161).
intersubjective reality—recedes. Too rarely are patients queried closely enough about the nature of their “hallucinatory” experiences to determine whether they are hallucinatory in the strict sense. Such a distinction does not matter to those whose point of view gives unqualified priority to the objective.\(^{33}\) For instance Havens (1962, 430) describes a woman who experiences her dead father as a constant companion, sitting on her shoulder and talking to her at length. But she does not see him. She knows he is dead, and she comes to know that she should speak to him internally rather than audibly.\(^{34}\) This experience is more like that of an “imaginary companion” than of a hallucination.

In childhood as in ancient Greece, dreams are experienced as happening in the world—the bedroom, the hall, the closet (Piaget, 1960).

\(^{33}\) Explanations of hallucinations “presuppose the priority of objective thought, and having at their disposal only one mode of being, namely objective being, try to force the phenomenon of hallucination into it. In this way they misconceive it, and overlook its own mode of certainty and its immanent significance since, according to the patient himself, hallucination has no place in objective being” (Merleau-Ponty, 1962, 335).

\(^{34}\) The person whose imaginings are diagnosed as pathological and/or as “hallucinations” has breached some of the following implicit social contracts (among others) which resulted in having his or her imaginings diagnosed at all: (1) One should either attend to the “real” people present, or pretend to do so (Goffman, 1981). If a person speaks aloud to an imaginal figure in the company of others, he has openly displayed that his attention is elsewhere. (2) One should not request or demand, implicitly or explicitly, that other people attend to one’s own inner concerns when one is not attending to these other people (Goffman, 1981). By speaking aloud to an imaginal figure in the company of others, one demands their attention to a reality which is not their own. (3) One should not argue that a world one has access to that others do not equals or exceeds in importance the world that is shared by all. (4) One should not engage in conversation with “imaginary” people when “actual” people are present and presumably willing to converse. (5) When imagining, one should do so internally. One should not experience one’s imaginings amidst one’s perceptions (i.e., externally). (6) One should ensure that the most vivid experience is intersubjective experience, not private imaginings. Corollary 1: Perception of material reality should always be more vivid than imagining. Corollary 2: Material, secular reality should supplant spiritual reality, if the latter entails entertaining the imaginal figures of a belief system other than the scientific. (7) One should present oneself as unitary. If multiplicity of self is experienced, it should be dealt with through forms of speech that do not challenge a unitary vision of the self (e.g., calling the figures “aspects of myself,” “parts of myself,” “my personae,” “representations of people I have experienced in the past”). (8) One should assume responsibility for one’s imaginings: “It is I who create the characters; “Even though it may seem like she who did it, it was actually I.”
In childhood, “The world is still the vague theatre of all experiences” (Merleau-Ponty, 1962, 343). Then the child is taught that his experience is “only a dream:” “Oh, you were only dreaming,” says the helpful, reassuring parent, who opens the door of the bedroom closet to show that there is no lion there. “It is just in your mind.” The child is taught to withdraw fantasy and dream from the world. When and if it appears there again in adulthood the adult, like the child, becomes terrified; more terrified than the child, not because of the lion but because of the fear of being crazy. What the child is not taught in our culture is that fantasy does sometimes look like perception; how to differentiate the two when they do look alike; how to make it clear to others that one can differentiate between them; and how to treat such experience metaphorically rather than literally. If one can learn these things one is not so pressured to turn one’s back on the figures who so clamor to be heard and understood. The patient whose imaginings are subject to the doctor’s diagnostic eye must be linguistically sophisticated enough to supply the appropriate qualifiers when under examination: “It is as if I hear a voice,” or ‘it appears to be a ghost,’ or ‘I imagined I saw the Virgin Mary’” (Sarbin, 1967, 371). When an individual has the linguistic skills necessary to convince the doctor that he is speaking metaphorically but does not use them, the individual is involved in a breach of social contract.

We can approach our preoccupation with hallucination as a by-product of our modern model of mind and reality. Were the imaginal mode more valued in our culture, hallucinations would most likely be seen as visions, as entrances to another, equally or more valued world than the perceptual. The externality, vividness, autonomy, perceptual or quasi-perceptual nature of some imaginal dialogues would not appear problematic. Pathology would have to be redefined in relation to an alternative vision of reality and purpose. Hallucinations signal the power of the imaginal to intrude on ego consciousness. It is a power that is unwelcome to the modern organization and conceptualization of mind, a power that threatens the ego’s sense of control and reality.

If we were to adjust our priorities the problematic features of imaginal dialogues would not have to do with their experienced externality, vividness, quasi-perceptual nature, or the autonomy of the figures—as these all contribute to the vivification of an imaginal
world—but with those features of some imaginal dialogues that negate or flatten the complexity of each character, making drama superficial and dialogue either impossible or stereotypic. In instances where the imaginal is equated with the perceptual, one would hope to allow it a sense of reality apart from perceptual reality. This is necessary not only for the sake of reality testing but also so that the figures can be heard metaphorically rather than literally. From the viewpoint of valuing the dramatic quality of mind it would not be the quasi-perceptual quality per se of an imaginal dialogue that would be worrisome, but the quality of relation between self and imaginal other. It is precisely this focus that Erwin Straus pursues in his classic phenomenological study of hallucinations, “Aesthesiology and Hallucinations.”

Hallucinations, says Straus, are pathological variations of the relationship between self and other. In hallucination the relation between self and imaginal other is most often non-reciprocal. The hallucinator feels reached, touched, spoken to by the other—his boundaries are intruded upon—but he cannot reach or touch the other. The self is infinitely reachable, offering no resistance to the other: “[The] patient is denied any spontaneous and free survey of the world; his thoughts being heard, his mind being read, denote that the barriers of his intimate life have been leveled off, that the innermost sphere of his existence has been invaded” (Straus, 1958, 168). Indeed the Self is characterized by a passivity which “removes the reachable to a limitless remoteness” (Straus, 1958, 165). The passivity is often joined by a feeling of impotence.

The common order of things, in which each object has its place, with its own limited range and sphere of influence, is no longer valid. There are no boundaries...there is no organization of space into danger- and safety-zones. (Straus, 1958, 166)

To reflect, says Straus, one must have a space of detachment in which to stand. While these qualities do not characterize all hallucinations, they are true of a certain class of hallucinations (often associated with schizophrenia and paranoia) in which the imaginal other is an intrusive, condemning, abusive and commanding presence. On inspection it is generally only when the hallucinated imaginal figures take this posture and the hallucinator either responds with acute fear and passivity or takes action in our shared reality to counter the attacks that hospitalization and/or a diagnosis of acute psychosis
occurs. The focal feature is not the hallucination’s vividness or quasi-perceptual nature, but the nature of the structure of relation between self and imaginal other that is a reflection of that psychical totality which is called pathological. This structure of relation is not specific to imagining and its “hallucinations,” but characterizes the person’s relation to “actual” others and their other modes of existence.

Straus stresses the annulment of reciprocity between self and other in hallucinatory experiences. The sensory modalities—usually our means of gaining access to the reality of the other—are distorted and inverted. Rather than being our path of access to the richness of the world, it is the hostile other’s route to the abnegation of our freedom. Vision is blinded by light rays, by movies projected upon the self. Audition is deafened and defeated by the willful voices of the other. One cannot defend oneself by removing oneself in space or covering one’s ears. Touch becomes inverted so that while I cannot touch the other, I am overcome by being sprayed at, blown at, electrified.

The imaginal others turn all their attention on the self. The self feels that all these voices are concerned only with him:

The Other is a realm of the hostile, in which the patient finds himself quite alone and quite defenseless, delivered up to a power that threatens him from all sides. The voices aim at him, they have singled him out, and they separate him from all others. He is certain that they mean him and no other; he is not surprised that his neighbor can hear nothing. Indeed, he is not surprised at all; he does not question, neither himself nor others nor things; he does not test his impressions, nor evaluate them according to general rules. (Straus, 1958, 166)

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35 “In my experience hallucinatory objects are most often helpful, approving and loving early in the course of their relationship. The paranoid person is hospitalized only after this friendly period is over and accusations and reproaches have set in” (Havens, 1962, 430).

36 The Dutch phenomenologist J. H. van den Berg argues, as did Moreau de Tours (1845) earlier, that “A hallucination like any other artificially isolated phenomenon, can only be rightly observed in a study of the psychical totality, which is disturbed in some way. This being-disturbed should be the first and foremost subject of the study. The result of the study can only be called satisfactory when it can be shown that hallucination is possible—even necessary—on the basis of this being-disturbed or within the context of a disturbed existence” (van den Berg, 1982a, 103). Instead of hallucinations being seen as a sign of pathology, it is the presence of a disturbed state that predisposes us to look at the structure and function of imaginings. As we have seen, not all hallucinations are troublesome, nor is the general healthy population exempt from these outbursts of the imaginal.
Between self and other there is “no co-partnership, no discursive elucidation” (Straus, 1958, 166). Dialogue would be rare between such figures, as would the deepening of characterization. Contrary to claims that the hallucinated figures are so vivid that they rival perception, one finds that their characterization is shallow and superficial. The voice most often appears disembodied and motivations for the figure’s actions are unarticulated, except from the external perspective—as in paranoid states when the habitual ego attributes motives to the figure.

The schizophrenic hears voices, not persons. Occasionally, it is but one voice, but more often it is some, many or “they” voices emanating from an anonymous group: the Communists, the Masons, the Jews, or the Catholics. (Straus, 1966, 286)

The relation of the voices to other characters is not pursued. All focus is on the self.

Understanding, shared or individual, demands some kind of indifference, the possibility of detaching oneself from the impact of impressions, of reflecting about oneself, of putting oneself into a general order in which places are interchangeable. (Straus, 1958, 166-167)

But in hallucinatory experience this interchangeability, this indifference and detachment are precisely those qualities that are absent.

In Secheye’s The Autobiography of a Schizophrenic Girl, Renée realizes when she begins to become well that not only have her hallucinations disappeared but the people around her are “no longer automatons, phantoms, revolving around, gesticulating without meaning,” as were her hallucinated figures. “They were men and women with their own individual characteristics, their own individuality” (1951, 71). She says of her therapist:

Mama too had changed in my eyes. Before she had appeared like an image, a statue that one likes to look at, though it remains artificial, unreal; but from this moment on she became alive, warm, animated, and I cherished her deeply. (71-72)

At the same time Renée begins to feel as though she can influence things. She realizes for the first time that she can rearrange the furniture in her room: “What unknown joy, to have an influence on things; to do with them what I liked” (71). As her hallucinations recede, a passive ego role changes into a more active one, stereotypic figures into more animated and particularized ones.
In Hannah Green’s account of schizophrenic experience, *I Never Promised You a Rose Garden*, a change in the nature of the relation between self and imaginal others signaled psychosis and the need for hospitalization. Initially Deborah had enjoyed the companionship of gods in an imaginal kingdom called Yr.

"Its gods were laughing, golden personages whom she would wander away to meet, like guardian spirits. But something changed, and Yr was transformed from a source of beauty and guardianship to one of fear and pain." (Green, 1964, 61)

Deborah then felt imprisoned in Yr. The Collect chanted curses at her, as she was “subject and slave to the Censor.” “Once her guardian, the Censor now turned against her” (62). She did not challenge these characters as to the justness of their punishment and persecution of her, but suffered them passively during her period of greatest sickness. A crucial part of her therapy was her therapist’s suggestion that she might take a more active role.

"The doctor rose to mark the session’s end. “We have done very well this time, seeing where some of the ghosts of the past still clutch at you in the present.” Deborah murmured, “I wonder what the price will be.” The doctor touched her arm. “You set the price yourself. Tell all of Yr that it dare not compromise you in this search of ours.” (113)

As Deborah began to fight the mercilessness of the Collect, becoming less passive, more distanced and reflective, the gods’ characters changed again. Once again Deborah enjoyed their banter, wit, laughter and poetry. They became “amiable spirits” (268). For Deborah, successful treatment did not necessarily mean the disappearance of her gods, but an increased freedom to join in the world of other people, which entailed her being able to disobey her gods and stand firm against their relentless punishments. She differentiated herself from their rule.

The tyrannical and punitive nature of the voices in many hallucinations is also evidenced in *Perceval’s Narrative: A Patient’s Account of His Psychosis, 1830-1832* (Bateson, 1974). The period which led to Perceval’s hospitalization was marked by voices commanding what he should do and think. When he would carry out their orders, the voices would criticize his attempts to obey, making him feel impotent and worthless. Perceval relates that during a year of his illness he
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scarcely uttered a syllable or performed an act that was not inspired by his “spirits.” Perceval understood his cure as coinciding with a change in how he heard and understood the spirits, not with their disappearance. In short, he came to realize that “the spirit speaks poetically but the man understands it literally,” that he was not supposed to do literally what his spirits had dictated but to hear them poetically. This shift from the literal to the metaphorical required a differentiation of self from the spirits so that command by the spirit and obedient action by the self was not a reflexive sequence. The self learned to stand apart from the spirits and hear them, rather than surrendering the ability to act and speak to the spirits. Straus remarks that it is no wonder that in many languages (Greek, Latin, Hebrew, French, German, Russian, English) “the words ‘hearing’ and ‘obeying’ are derived from the same root” (1966, 281). In English “to obey” stems from the Latin obaudire meaning to listen from below.

In an anthropological account of hallucinations, The Spirit Possession of Alejandro Mamani (Sanders, 1976), a Bolivian Indian commits suicide to escape the voice of a spirit. As his tribe was accustomed to hearing the voices of spirits, it was not the presence of the voice that drove him to desperation but the loss of his own freedom and autonomy with respect to the spirit. In short the voice would not stop speaking to him even when he tried to sleep. His activities and thoughts were constantly interrupted by the spirit’s voice. He felt impotent, passive, and denuded of his agency. Ritual ceremonies did not give him distance from the voice, and so he turned to death as a means of silencing his tormentor.

It may at first appear contradictory to say that the person who is judged to be hallucinating may at the same time be both seeing the imaginal other egocentrically and feeling overwhelmed and threatened by the other’s presence. Asking the person to hear the voice of the imaginal other might be seen as encouraging a toppling of the ego. But perhaps it is precisely the egocentric stance toward the voice that makes it seem so frightening (he or she is known only from one point of view), that increases its degree of insistence and intrusion into the conscious life of the “hallucinator.” When a voice is finally listened to, and not just denied or struggled against, it frequently complains about how the imaginer never listens to it or takes it seriously.
Despite different metapsychologies (phenomenological, Jungian, psychoanalytic), a number of clinicians have turned to meet the voices of their patients, encouraging a more active and mutual relation between patient and voices. Lockhart, in “Mary’s dog is an ear mother: Listening to the voices of psychosis,” describes the treatment of a patient who had been hospitalized for head-shaking and auditory hallucinations. Lockhart reports that the patient felt “controlled” by the voice of his neighbor, Teresa, and complained of “being weary of being her puppet. He wanted nothing to do with her, resented this constant sexual battering and wanted to be rid of her” (1975, 149). Instead of focusing on the head-shaking behavior or reality testing, and instead of siding with the patient’s desire to be rid of Teresa, Lockhart attempted to create an environment where the voice could be talked to and about. The clinical result was that the voice became less intrusive and the character of the imaginal figure changed from that of a controlling woman, preoccupied by sex, to a quasi-religious figure. The religious aspect, however, did not appear until the patient had satisfied in fantasy the sexual demands made by Teresa. A relation of control was transformed to one of greater mutuality. In Lockhart’s words, “Once an individual begins to relate actively to the inner images, the controlling nature of these autonomous psychic processes is softened and often transformed” (1975, 152).

Medard Boss, in Psychoanalysis and Daseinanalysis, describes a series of attempts to treat an intelligent woman, suffering from visual and auditory hallucinations. At first Boss used Dubois’ “persuasion” method, trying to help the woman “gain distance from the ugly visual and auditory phenomena by calling them mere hallucinations without any reality” (1963, 8): no success. Boss then treated them physiologically, as “expressions and results of a disturbed metabolism in the brain tissues” (8-9), showing the patient an EEG as proof, again with no success. The woman laughed at all his physiological and naturalistic explanations. Boss then conceded to his patient that her hallucinations “were not simply nothing,” but insisted that they did not “correspond to an external reality, but represented only an internal, purely psychic reality, consisting of hidden emotions and tendencies of the patient herself.” (10). He argued that these psychic realities were being projected onto external objects. But the patient did not accept this either, objecting to Boss’ attempts to make mere fictions
of the spying figures of her experience, to "dispose of them as mere hallucinations and projections of my own unconscious or some other psychic reality" (10). Much like Jung, Boss found himself turning to listen to the voices and to studying their materialization in the patient's drawings. The patient said her drawings "come out of nowhere, just suddenly appear, emerge from somewhere behind the drawing paper, and all of a sudden they are there, looking at me" (11). They are not experienced as internal voices but as beings who approach her from without, indeed who spy on her. The therapy began to move when Boss finally said to her,

You are perfectly right. There is no sense in granting one reality priority over another. It would be quite futile for us to maintain that the fable before us is more real than your motorcycling spies merely because they elude my perception and are perceptible only to you. Why don't we let both of them stand as the phenomena they reveal themselves to be? Then there is only one thing worth our attention. That is to consider the full meaning-content of that which discloses itself to us. (13)

Boss begins to hear not just the woman's reality of being the victim of spies but to hear the reality of the spies—that is, that these spies occur because of two enemies, "mutually barred against each other and consequently antagonistic to one another, and where one party wants to annihilate the other or at least to conquer it and bring it under its own dominion" (13). From the spies' point of view the woman has been fighting them off as enemies. Boss, interpreting the war as the woman's rejection of her own erotic nature encourages her to stop fighting the spies: "Let the spies come and give them full power to do as they wish, and just see what happens" (14). Boss reports the woman now felt understood and placed her confidence in the treatment.

In each of these cases the voices initially sounded destructive, intrusive. But this was so not from the voices' point of view but from the ego's. As a mutual relation was fostered—in place of ridding, negating, defensive plays against the voice—it became possible to see what the imaginal figure wanted and how he or she saw the ego. In each case there was a granting of reality to the voice, and at the same time an attempt to hear it metaphorically, to satisfy it in fantasy. The voice's attempt to control is viewed finally in relation to how the
ego is treating the figure, rather than as a contextless attack to be avoided by patient and therapist.

Of great importance is the fact that improvement was brought about not by arguing the priority of intersubjective reality over the preobjective reality of the imaginal (i.e., not by urgently attempting to ensure that the person could differentiate between percept and image). The work of doctor and patient was to understand the figure and to find a more reciprocal mode of relating.