Hallucinations are definable as the experience of something that is not there, an event that is present only in the experience of the individual and not as a fact in the world. In this sense we can talk about acoustic or visual hallucinations, but also bodily hallucinations. This paper will examine the experience of hallucinators and the problems that arise when treating them. It will also offer a suggestion of a theory of health that might go some way towards easing these ethical concerns.

There are people who experience auditory hallucinations, but who do not consider them to be either problematic or symptomatic. The Hearing Voices Movement seeks to challenge the popular stereotype of auditory hallucinations as being a symptom of illness by providing examples of people who have experienced their auditory hallucinations as a positive experience, or who have learned through therapy or home exercises to render their hallucinations positive. The HVM attacks the notion that auditory hallucinations appear to exist outside of the norm of human experience. Research suggests that auditory hallucinations appear in 2-4% of the population, and that not all of those who experience hallucinations are ever in need of psychiatric treatment. Since hallucinations are more prevalent than previously thought, and since they are not invariably the sign of a mental illness, the HVM refers to hallucinations as a “form of perception,” a variety of human experience – “a faculty or differentiation - something like homosexuality, that is definitely not open to cure.” Although the voices may not be a sign that there is immediate danger to the patient or those around him, Romme’s suggestion is that the experience of hearing voices is related to a problem in the hearer’s life: the voices are “messengers”, and they are a sign that something is wrong. What is wrong might be as simple as loneliness, where the voices represent the desire of the hearer for social contact or companionship. In this regard, the voices are no more sinister than a child’s imaginary friend, although Romme makes it clear that the two ought to be carefully differentiated in case the voice heard is the voice of someone familiar to the hearer and is

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5 Romme and Escher, ibid, p.158
saying things that the real owner of the voice would not. Reality testing excluded, the voices are simply fulfilling a need in the hearer, and they do necessarily not pose a threat.

Alternatively, hearing voices might signify a more worrying underlying problem. Romme suggests self-aggrandisement and self-injury as two possible events surrounding the experience of hearing voices that are signs of something wrong on some level of the voice-hearer’s self. Self-aggrandisement might be a person’s “looking for a super-solution to his own inner chaos,” while self-injury is usually accompanied by a feeling of depression, dissociation, guilt or a traumatic experience. Even taking into account the potentially traumatic reasons why voice hearers hear voices, the voices themselves may not, according to Romme and the Hearing Voices Movement, need to be treated. They may be a coping mechanism, a means of alleviating the problem. This notion is clearest when we think of those people whose voices keep them company. Extreme loneliness is not a disease but rather an unfortunate social lacking in the person who experiences it. That person could continue to be unhappy, or he could listen to the voices that talk to him when no one else does and take a measure of comfort from them.

Also a problem in terms of hallucination is the question of rationality: there seems to be an element of choice to the beliefs of a person who hallucinates, in that he or she may prefer the beliefs that arise as a result of the hallucinations to the more mundane explanations offered by others. Stone and Young suggest that patients who have Capgras delusions may ignore the evidence that it is entirely unlikely that their loved ones have been replaced by automata in favour of other kinds of evidence, such as the patient’s own absolute conviction that their loved one has been replaced by an impostor. It seems that such wilful ignorance should, at some stage, become apparent to the patient: the most patient observer would become frustrated with a clear refusal on the part of the sufferer to accept what is patently obvious to those who are not deluded. There are an infinitesimal number of cases outside of Hollywood movies where one person has been replaced by another, who just happens to be identical in every possible way. The chances of that happening to someone outside a Hollywood script are so tiny as to make the suggestion ludicrous. Most hallucinators, however, choose to hold onto

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6 Ibid, p.160-61
7 Ibid, p.160
8 Ibid, p.161
the beliefs formulated as a result of these hallucinated experiences: why do they do so, and how can we consider them to be uncontroversially sane and rational in the light of it?

Gold and Hohwy⁹ make the claim that schizophrenic delusion ought not to be considered in the light of traditional notions of rationality. Delusions that arise as a result of schizophrenia are, they say, “brought about by a violation of a constraint on rational thought we call egocentricity,”¹¹ and they wish to consider schizophrenic delusions in the light of what they call “experiential rationality”. Traditional notions of rationality tend towards procedural rationality, where rationality is a matter of adhering to the rules. If a rule is to be universally applied, then the same premises will always bring about the same conclusion. Thus, one can be said to be irrational when one’s actions are not governed by the relevant rule or reasoning process. The procedural account minimises the importance of the content of one’s thoughts: they are not, generally speaking, relevant to the analysis of whether or not the thought is rational. The other standard account, content rationality, claims that some beliefs or desires can be irrational, but that if the irrational desire is combined with an irrational belief then the failing lies outside the normal notions of rationality. The irrational content of these beliefs or desires is irrational precisely because it is assigned in place of an alternative, better-fitting content. Gold and Hohwy’s response is that cases of delusion fit neither the procedural nor the content approach to rationality, drawing on Frith’s hypothesis that delusions in schizophrenia are caused by the “failure of the monitor to represent willed intentions”.¹² Normal self-monitoring entails the awareness of one’s intentions, one’s actions and the awareness of the causal connection between the two. If I have the desire to ease my hunger, I form the intention to go to the kitchen and make a sandwich, and I will then do so. The “monitor” represents the intention-action pair, the hunger and the sandwich-making.¹³ This monitoring has the crucial effect of bringing the intention into the consciousness of the subject so that the subject is aware of the causal connection between intention and action. Gold and Hohwy rely on Frith’s notion here of the monitor as a “model of metarepresentation”,¹⁴ which represents the action-intention pair in the consciousness of the subject. The notion of a representationalist self-monitor is problematic, but even if we remove this layer of representation and suggest instead that direct perception of causal relations between intention

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¹⁰ Gold, Ian, and Hohwy, Jakob: “Rationality and Schizophrenic Delusion”, in Mind and Language 2000, 15:1, pp.146-167
¹¹ Ibid, p.147
¹³ Frith, ibid, in Gold and Hohwy, ibid
¹⁴ Ibid
and action is possible, then the end result remains the same. Monitoring these mental events directly, and creating a representation of them in the conscious mind, will bring us to the same conclusion, and so although there are potential problems of superfluity with this model, the mechanism remains largely the same and it is that which is interesting in this context.

Let us suppose now that this system of monitoring is defective, and so the intention is not available to the consciousness of the subject. I would find myself in my kitchen, making a sandwich, with no idea of the causal process that led me to be there. I would of course attempt to formulate an explanation for this strange occurrence: I did not (at least so far as I am aware) make the decision to do this, so why am I doing it? One possibility would be that some external force is responsible; this external force moved my body into the kitchen and surrounded it with cheese and bread for reasons of its own. This belief would of course be delusional. Assuming that I was able to be rational, I might conclude that perhaps I’d forgotten that I wanted to make a sandwich, or that I’d wandered into the kitchen and started making the sandwich without really paying attention to my actions, in the same way that I might not remember walking home because the route is so familiar that I did not have to be aware and so my thoughts were elsewhere. With my self-monitor being defective or absent, however, it is possible that such an explanation might not occur to me, or that I might reject it, thinking that there is no way that my own intentions could be opaque to me. What would happen then is that I would search for an answer that would explain the strangeness of finding myself in a place where I had not expected to be. This explanation would have to satisfy my criteria for sufficient explanation but would not necessarily have to fit any universal criteria for rationality, depending how rigorous my criteria for a satisfactory explanation were. Assuming I was unwilling to accept that I was suffering some sort of mental disorder, I could conceivably conclude that aliens had briefly abducted me and deposited me in my kitchen instead of on my sofa for reasons of their own. There is no evidence to the contrary, and all the evidence I have suggests that this actually happened: I started out on my sofa, and was then transported without my knowing to my kitchen. The only possible explanation that does not involve my serious mental (or possibly physical, as in amnesia) illness is that something external to me moved me there. If I am unwilling to accept that I am ill, and it is by no means certain that I would accept this, since I presumably feel quite well, then I may well accept the alien abduction scenario and thus become convinced that I had been temporarily abducted.
Further to this temporal confusion, there is an alternative scenario that is more relevant to our purposes here: the hearing of voices. If I am forming the intention to go outside, it is logical to expect that I will then make the decision to perform all the steps in the process that will enable me to go outside successfully. If the first action in the process of getting ready to leave is to put on my shoes, I will, immediately after forming the intention to go outside, have the thought that I need to put on my shoes. If I have this thought without being aware of having had the intention to go outside and thus contextualising the putting on of shoes within an intention-action process, I might experience this thought as an ego-alien command, rather than as a step in the process of carrying out my intentional action.

Gold and Hohwy postulate that there is a procedural violation going on in these cases:15 for most people, there is a methodological principle involved in the processing and relating of intentions to actions that requires that one suspend explanation in those situations where there is no reasonable explanation available. If I return to my oft-mentioned kitchen to make a cup of tea, only to find that the milk carton is empty, I would search for an explanation, questioning the other person who uses the kitchen and making sure there was no leak in the carton. If, after my investigation, there is no apparent reason for its emptiness, I as a person with normal thought processes would suspend my explanation because I simply would not have one: the missing milk would be a mystery. It would be maximally rational for me not to infer the existence of a milk-drinking poltergeist, or believe that Schrödinger’s cat had taken up residence in my refrigerator and was stealing accordingly. If I were schizophrenic, however, the option to abstain from making an explanation without full possession of the facts might be lacking. Rather than being puzzled by the absent milk but then moving on to something more important, the schizophrenic would consider it necessary to fill in this explanatory gap with something, no matter how unlikely, and if the schizophrenic were also paranoid, then this explanation could plausibly involve some sort of attack on the refrigerator by hostile agents with the aim of damaging the refrigerator’s owner.

The aim of the therapist, then, is at least in part to overcome the problem of this explanatory gap. A further problem arising in this situation is that the patient may not believe there is a problem to be addressed. As in the case of the Hearing Voices Movement, the hallucinations may be seen as a normal process, and as such treatment is unnecessary. A hallucination arising from schizophrenia may be accompanied by paranoia, and an attempt to bridge the

15 Gold and Hohwy, ibid, p.156
explanatory gap may be seen as a sinister move to be treated with appropriate suspicion. It is theoretically possible to do so using a normative construction of illness, whereby the states we value are considered healthy states, and the ones we do not, disease states. Thus, a hallucination that offered advice or comfort would not be a disvalued state except insofar as it signified a possible lack of confidence in one’s own conclusions or an absence of a close social circle.

The problem here is that there are states that we consider undesirable, but their designation as disease is controversial. The obvious example is addiction: it is an undesirable state to be an addict to, say, heroin, but whether or not that addiction is a disease is not clear. Some may answer is that it is not, and the addict’s behaviour is the problem, making the addiction a moral issue rather than one that comes within the scope of disease. It is not clear however whether addiction is caused by an underlying abnormality or poor behavioural choices, and so normativism cannot supply an acceptable designation of disease or otherwise to cover it.

A further problem with normativism is its inability to account for conditions that were considered diseases in the past but are no longer so designated. Homosexuality is an obvious example: the normativist would not be able to say that psychiatrists in the 1960s who considered homosexuality to be a disease were wrong, merely that their values were different. Englehardt explains that the reasons for determining a condition a disease or not is ideological rather than biological thus: “disease explanations are often favoured in order to classify a state of affairs a disease state for social or ideological reasons.”16 While the normative claim that their position accurately depicts the common usage of terms like “health” and “disease” may be true, they thus fail to capture the intuition that there is more to the disease state and the process of defining it than prevailing social values.

In the case of mental illness, the normative position becomes complicated: in mental illness there are usually no physical symptoms that can be valued or disvalued by bystanders as well as sufferers because of their physical effects.17 The empathic aspect of the value judgement is not available; the onlooker knows that chicken pox is unpleasant because she knows what it is like to be itchy and feverish, but can usually only imagine what it is like to have a mental illness. There are larger problems than this, however: the stigmatisation of mental illness may lead to inappropriate disvaluation of symptoms that may not actually be damaging. Also,

17 There may be psychosomatic symptoms, however these are not prevalent in the majority of cases.
someone in the grip of some mental illness may not be rational enough to recognise that there is a problem, and so determination of the illness rests on people around the sufferer rather than the sufferer himself. This leads us into the problem of paternalism: at what stage of a mental illness, and under what circumstances ought a professional to intervene?

The naturalist position seeks to answer this question, and is closely related to the biomedical model of therapeutic treatment. According to Boorse, one of the more well-known naturalist theorists, A disease is an illness if and only if it is serious enough to be incapacitating, and therefore is

1. undesirable for its bearer;
2. a title to special treatment; and
3. a valid excuse for normally criticisable behaviour.\(^{18}\)

Here Boorse contrasts disease and illness to show the distinction between the theoretical concept of health, which is value-free, and the value-laden state of freedom from illness.\(^{19}\) He later acknowledges this to be a mistake, since the terms “sick” and “ill” are synonymous, and yet “illness” is a term that in normal usage is applied only to humans, while buildings, animals and plants can be “sick”. His second reason for rejecting this construction is that disease and illness cannot be seen as the same essential thing, only in different degrees of severity. An illness is a systemic disorder, invading the whole organism, whereas a disease could be more specific, e.g., paraplegia or arthritis, affecting some of the organism’s limbs or its joints respectively but without permeating the entire organism in the way that, say, the flu does. Under this construction, “disease” is an objective fact about the state of the organism. “Illness” is also an objective fact, although it may become a value-laden one if there is some level of subjectivity involved in the level of incapacitation required in determining the severity of the set of abnormal conditions in question: at what point, for example, does a sniffle become a fully fledged illness? I may insist that I am at death’s door with the flu, while an unsympathetic observer may be equally convinced that I am malingering and should take an aspirin and stop complaining. The theoretical concept of illness in this account is value-free, but its practical application may require a degree of evaluation, which is necessarily subjective. A diagnostic tool such as the Glasgow Coma Scale or the DSM provides some

\(^{18}\) Boorse, Christopher: “A Rebuttal on Health”, in J. Hunter and R. Almeder (eds), What is Disease?, Totowa, New Jersey: Humana Press, 1997, p.11
\(^{19}\) In practical discussions of health, we speak of blood tests coming back “clean”, implying that if a disease were present the test would be “dirty”. This is a clearly value-laden statement, which would be missing in a purely theoretical discussion.
measure of practical objectivity, but the interpretation of signals and symptoms remains largely subjective.20

One alternative to the normative position is a hybrid theory combining elements of normativism and naturalism. Wakefield’s is the most well-known of these hybrid theories, and the statement he makes is that disease simply is “harmful dysfunction”. Thus the disease concept includes a value criterion related to any harm or loss of benefit caused by the condition, as determined by the person’s cultural values, and an explanatory criterion involving some loss of natural function. This approach narrows the field from the normative position, requiring that a disease be a condition that is disvalued and is a biological state with defined aetiology, thus removing counterexamples such as drapetomania from the class of disease. It is possible to argue that this narrowing of the scope of the disease concept is too heavy-handed, in that it becomes overly restrictive and so it rules out disorders that do not fit the biological and value criteria, but which we would intuitively consider diseases.

What, then, would be an appropriate alternative? A hybrid theory seems indicated, given the problems with pure naturalism and pure normativism. What is suggested is an alternative hybrid theory that allows for both the objective, naturalistic facts and the normative judgements based on those facts to be examined in tandem, without conflating the two. Health and disease are value-laden terms that reflect the existence or non-existence of physical conditions that may be valued or disvalued. Their usage in the absence of further information about the state of the body or the mind is insufficient, because it can only tell us how the person feels about their state of body or mind. This is obviously useful information, particularly in the case of non-physical illnesses, because it allows insight into what we might call “how a person feels about how they feel.” Further information is required in a medical setting, however, because an accurate judgement of whether or not a person is suffering some sort of disvalued condition requires a rational agent to make the judgement, and in the case of mental disorder this rationality is not guaranteed. The terms health and disease, therefore, comprise statements of fact about the value placed upon a condition. They do not inform us of anything inherent in the condition itself, and in a medical context they should not be treated as such. It is necessary that there is a concomitant description of how the body (or the mind) is: why is the discussion taking place?

20 The increased diagnosis of specific disorders in which a doctor is interested was noted by Laing and has been supported in other research.
In terms of hallucinations, then, a person who experiences them need only become a patient if there is an objective claim to be made that the hallucinations being experienced are negatively toned and therefore undesirable. While their presence in a person who does not consider them a problem and is rational might still be significant of some underlying problem – for example, the case of a person who is lonely and who hallucinates voices as company – this problem is not a medical one, and so the therapist-patient paradigm is inappropriate. What might be indicated is some sort of social program for the hallucinating agent, to enable development of social relationships to preclude the necessity for hallucinated social experiences.

There is a fine line to walk between the over- and under-medicalisation of mental health issues, and both extremes have their charms and their downfalls. Attention to both the medical and the social or subjective data available, without conflating the two, is a step in the direction of a treatment alternative that is ethically robust and avoids the traditional ethical pitfalls of paternalism and relativism.