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A Short Note on Pseudo-Hallucinations

By E. H. HARE

Introduction

A recent examination paper for the Membership of the Royal College of Psychiatrists contained a compulsory question on pseudo-hallucinations. As is proper in a higher examination, the question was difficult, and at least one examiner (the present writer) had no idea what the answer should have been. While it is probably true that an examiner does not need to know a great deal about a question in order to assess a candidate's worth, yet if he is conscientious he will feel that he ought to know *something* about it. A rapid search through several textbooks proved curiously unhelpful; so this particular examiner awarded marks as best he could, and as soon as time permitted set out to discover what he should have known about pseudo-hallucinations. The present communication reports his findings and reflections. The findings are in no sense an exhaustive enquiry into the subject; they are the outcome of a search through those current textbooks and journals which may be taken to constitute as broad and as authoritative a background of study as can reasonably be expected of an examination candidate faced with a compulsory question.

The Findings

We may begin by noticing that the current textbooks of Curran and Partridge (1963), Henderson and Gillespie (Batchelor, 1969), Eysenck (1962), Price (Scott 1966), Rees (1967), Sim (1968)—to start with the British ones—and of Arieti (1966), Ewalt and Farnsworth (1963), Freedman and Caplan (1967), Solomon and Patch (1969)—to conclude with the American ones—contain no index reference to the subject of pseudo-hallucinations, nor (as far as I have been able to determine) any mention of the term in their texts.

Slater and Roth (1969) mention the term once only. In a discussion of sensory deprivation they say (page 380), 'the view that hallucinatory and pseudo-hallucinatory experiences reported in the course of perceptual isolation are due to intermittent reduction in the level of awareness is supported by the E.E.G. changes . . .'. They give no definition or description of pseudo-hallucinations. However, in an earlier passage on the visual imagery of sensory deprivation, they report the observations of Ziskind (1965) that these images 'were not hallucations, as there was no lack of insight' (page 379).* This statement might be taken to imply the authors' agreement with the view that lack of insight is an essential characteristic of a hallucination; and the alert student might draw the possible, though by no means necessary, corollary that the presence of insight is one of the qualities of a pseudo-hallucination.

The only other commonly available English-language textbooks that mention pseudo-hallucinations are those of Fish. The word does not occur in the text of *An Outline of Psychiatry* (1964) but is listed in its glossary. Here (page 247) pseudo-hallucinations are defined as 'hallucinations which lack the lively character of perceptions and can be distinguished from real perceptions'. This is too brief to be enlightening, but it may perhaps suggest that pseudo-hallucinations lie somewhere on a continuum which is bounded at one end by hallucinations and at the other by real perceptions. Fish has more on the subject in his book dealing specifically with

* Ziskind mentions pseudo-hallucinations in a footnote. The 'so-called hallucinations' which occur in sensory isolation are, he says, 'really pseudo-hallucinations since the wrong impression does not persist beyond confrontation with the facts'.

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schizophrenia (1962). There he says that illusions and hallucinations are disorders of perception and can be grouped together as sense deceptions; 'an illusion is a misinterpretation of an external stimulus, while a hallucination is a perception in the absence of an external stimulus' (page 33). He goes on to say that it is customary to distinguish between pseudo-hallucinations and true hallucinations—an observation which, though it may have been true in 1962, might puzzle the modern student who had found no reference at all to the subject in most of his other textbooks. Then follows this passage:

'A pseudo-hallucination is one in which the hallucination does not have all the qualities of a percept, so that it is not related to external space in a normal way, and it lacks the quality of bodiliness which is normally associated with a percept. The pseudo-hallucination is purely of academic interest and has no prognostic or diagnostic value in schizophrenia.'

The student must conclude, first, that Fish was sceptical of the clinical importance of pseudo-hallucinations, and second, that a pseudo-hallucination is a type of hallucination but is in some way a perception *manqué*, a kind of ghost-perception. Nothing is said here about insight, but two later passages might suggest that insight is an important factor in determining the presence of a pseudo-hallucination. Thus (page 40) the visual hallucinations of schizophrenia 'are usually pseudo-hallucations, being easily distinguished from normal perceptions, and often the patients refer to them as visions'. Again (page 68), in Leonhard's *shallow* type of schizophrenia excited patients may shout back at their voices but 'they have clear understanding of the morbid nature of these voices when the excitement dies away; Leonhard therefore suggests that they are of the nature of pseudo-hallucinations'. This suggestion of Leonhard's can only add to the student's difficulty, because it implies that hallucinations become pseudo-hallucinations merely through the patient gaining retrospective insight. As any hallucinated patient *may* later develop insight into his experiences, the clinician could never on this basis be sure whether hallucinations were not really pseudo-hallucinations until the case was finally closed.

Thus, among English textbooks only those of Fish pay any significant attention to the subject of pseudo-hallucinations, and this doubtless reflects Fish's special interest in German studies of schizophrenia. The concept of pseudo-hallucination was originated and developed by German psychiatrists: thus we read in Sedman (1967) that the term was first used by Hagen in 1868 to describe hypnagogic experiences, was fully discussed by Kandinsky in 1885, and was used by E. Bleuler in 1911 to distinguish between hallucinations projected outside the body and 'inner voices'. It was in 1911 too that Karl Jaspers formulated his ideas on this subject and it is from his account that the serious student must derive most of his information.

The seventh edition of Jaspers' famous textbook, *Allgemeine Psychiatrie* (first published in 1913) has been translated into English by Hoenig and Hamilton (1962) and contains an extended account of pseudo-hallucinations. The student who reads this needs to bear in mind, of course, that Jaspers' ideas may suffer something even in the most excellent translation.* Jaspers drew heavily on Kandinsky's monograph of 1885, and Kandinsky's views stemmed from his own psychotic experiences. According to Jaspers, there are three varieties of abnormal perception: illusions, hallucinations proper and pseudo-hallucinations. *Hallucinations* he describes (page 65) as 'perceptions that spring into being in a primary way and are not transpositions, or distortions, of any genuine perception'. *Hallucinations proper* (page 66), are 'actual false perceptions which are not in any way distortions of real perceptions but spring up of their own as something quite new and occur simultaneously with and alongside real percepts; this latter characteristic makes them a different phenomenon from *dream-hallucinations*'. In addition, there are phenomena comparable to hallucinations proper: these are retinal after-images, sense memories, the fantastic visual phenomena of J. Mueller, and eidetic imagery. *Pseudo-*

* In his foreword to Hoenig and Hamilton's translation E. W. Anderson writes 'even for those familiar with the German language Jaspers' thought and style are difficult . . . and his consequent use at times of terms specially devised to express some nuance of meaning not easily, if at all, to be translated intelligibly'.

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hallucinations, on the other hand, are described as follows (page 67):

'A certain class of phenomena were for a long time confused with hallucinations. Looked at closely, these proved to be not really perceptions but a special kind of imagery . . .. The phenomena in question are seen by an "inner eye": they are not within the black visual field . . . nor do they possess the reality of perception.'

As an example, he gives the case of a patient who while recovering from an acute psychosis 'could imagine things vividly for a time; he inwardly visualized a chess-board with all the men on it, but he soon lost this capacity'.* Jaspers lists six differences between sense-perception and imagery, but only two of these distinguish hallucinations from pseudo-hallucinations. These two are: first, that whereas perceptions are of concrete reality and have a characteristic of objectivity, images are figurative and have a characteristic of subjectivity; and second, that whereas perceptions appear in external objective space, images are in inner subjective space. 'These two opposing characteristics divide perception sharply from imagery as by a gulf, and there are no transitions' (page 70). Lower on the same page he says, 'We draw a clear distinction between sense phenomena and the phenomena of imagery (i.e. between hallucination and pseudo-hallucination)', but he immediately continues, 'this does not prevent us from finding actual "transitions" in that pseudo-hallucination can change over into hallucination . . .'. The only way of reconciling these statements is to suppose that while at any given moment of time a phenomenon is either a hallucination or a pseudo-hallucination, yet with the passage of time a pseudo-hallucination may change into a hallucination—though this would leave dark the nature of the change. On the distinction between hallucinations and imagery the student may be further perplexed to read later (page 151) that hysterical patients 'live their imaginary situations, which they experience in the form of vivid hallucinations'.

It is instructive to compare this account with one from an American textbook dealing with what appear to be a similar range of phenomena, though without reference to pseudo-hallucinations. Freedman and Caplan say (page 567) that 'at times hallucinations are perceived with great intensity, at other times . . . as barely audible whispers, or barely visible shadows. At times the hallucination is clearly placed in the outer world; at other times it is experienced within the body . . . the images and words may be distinct or blurred. They shade off from unmistakable sensory experiences at one extreme, through vivid imaginations and inspired thoughts, to ordinary thoughts and ideas at the other extreme'. They observe that psychiatric patients who are hallucinated 'slip in and out of the hallucinatory state, with intervals of insight and lucidity (hence Hughlings Jackson's term *mental diplopia*)'. They further indicate that insight—or the lack of it—is not a characteristic of hallucinations, though the degree of insight may have diagnostic and prognostic significance.

Turning from textbooks to journals, I have been able to find only three papers dealing with pseudo-hallucinations in British psychiatric journals over the last ten years (I have not examined American journals: it seems probable from their textbooks that the concept of pseudo-hallucinations has not found favour with American psychiatrists). These three papers, none of which are referred to in the textbooks, are all by the same author, Sedman (1966a, b; 1967). Sedman, it must be granted, gives a very fair and lucid account, with adequate examples. Like Fish, he describes a pseudo-hallucination as being a type of hallucination: 'under this term (pseudo-hallucination) are included those hallucinations which are perceived through the senses, but recognized by the patient as not being a veridical perception' (1966a). Yet his general conclusion is that pseudo-hallucinations form a continuum with imagery and have no overlap with hallucinations. The student may then wonder how a type of hallucination which is 'perceived through the senses' can at the same

* Jaspers' examples are strangely unsatisfactory. Of one of them, taken from Kandinsky, Sedman (1966) has observed, 'Here Jaspers seems to have regarded a schizophrenic "passivity experience" as a pseudo-hallucination'.

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time be a form of imagery, and he may be driven to conclude that the term 'sense' is being used in different senses.*

In clouded consciousness, Sedman says, pseudo-hallucinations may be produced by 'hallucinatory' drugs, by sensory deprivation and by the hypnagogic state. In clear consciousness, pseudo-hallucinations may occur in persons with obvious psychiatric illness (particularly depressive psychoses and obsessional states), and then characteristically in the form of 'inner voices'. But pseudo-hallucinations in a setting of clear consciousness are also common in personality disorders, particularly in females with attention-seeking traits.

Comment on the Findings

The concept of pseudo-hallucination stems from Jaspers and ultimately from Kandinsky. The phenomenon is scarcely referred to, and discussed not at all, in modern English textbooks. The up-to-date student might be excused for supposing (as had the present writer) that the term was of merely historical interest. But its appearance in a compulsory examination question indicates that it is not yet dead —or at least that it won't yet lie down—and a further consideration of the concept seems worthwhile on that account.

If our student had made a reasonable study of the literature, he would possibly have found himself in some perplexity. For he would have found the evidence conflicting on whether pseudo-hallucinations were essentially morbid phenomena; on whether insight, current or retrospective, was a necessary feature; and on whether a pseudo-hallucination was a variety of hallucination or a type of imagery, or a bit of both, or now one and now the other. He would have found no indication whether tinnitus, or the fortification spectrum of migraine, or the epileptic aura should or should not be classed as pseudo-hallucinations. And he would have found nothing to indicate whether the finding of a pseudo-hallucination had any particular clinical value.

The simplest solution to such perplexities is to conclude that, since authorities either differ or take no notice and since they adduce nothing to suggest clinical relevance, the term is better abandoned. There is always something to be said for this kind of solution. An incurable vagueness infects much of psychiatric terminology, perhaps because language cannot grapple with the complexities of psychiatric phenomena. Another difficulty in understanding psychiatric symptoms is that they tend to change more rapidly in their manifestations than do those of most other disorders, perhaps because of their greater dependence on cultural factors. In consequence, systematists may spend much of their time delineating shapes in the clouds and constructing edifices on shifting sands. Yet to abandon the attempt at delineating and classifying is an abrogation of our duty to understand and prevent disease. When a new concept is formulated, no one can be certain how enduring, and therefore how important, it will prove to be. What is therefore needed is a periodic reappraisal of the concept to consider whether it maintains its value or could maintain it by some change of emphasis.

A Reappraisal

It is a fairly common clinical observation that some patients, particularly patients with depressive psychoses or obsessional states, complain of hearing a voice (in the absence of anyone speaking), and when pressed as to the origin or cause of the voice say that it is perhaps the voice of conscience, or one part of the mind speaking to the other part, or that it only *seems* like a voice and is really their own thoughts. We may start from this observed experience, as it seems probable that if anything is to be called a pseudo-hallucination this will be. It remains to determine how far other phenomena should be included in the term and how far it has a clinical value.

* The word 'sense' suffers from the same ambiguity as the word 'nerve'. It is used to indicate either a primarily physical process (as in the terms sense-perception, sensory nerves, or a sensation of redness) or a primarily mental process (as in the terms common sense, a sense of injustice, sensational). The reason for the ambiguity no doubt lies in the fact that such physical processes are generally associated with corresponding mental processes and vice versa. This ineluctable interpenetration of the physical and mental suggests that there can be no very profound distinction between sense-perception and imagery.

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First we must consider what other sorts of similar experience there are. Sensory experiences may be broadly classed as objective or subjective.* Let us define a subjective sensory experience as a sensory experience not derived from normal stimulation of the sensory nerve endings. All such experiences will then, to that extent, be abnormal. They may arise from a demonstrable (organic) disturbance in the nervous system, from a functional psychiatric disorder, or from some alteration in the level of consciousness of a sort that need not necessarily be classed as morbid and which we may for the present purpose regard as normal. Thus we may consider subjective sensory experiences as having either a morbid or a normal (i.e. a non-morbid) origin.

From the psychiatric view, the experience of a sensation is less important than the way in which the subject interprets it. Broadly, we may say that, irrespective of the type of sensation, the interpretation may be either normal or morbid. In distinguishing these interpretations the same test may be applied as that commonly used to assess delusional ideas. A normal interpretation is then one which is appropriate to the subject's cultural and educational status; a morbid interpretation is one which would be commonly judged by his peers as erroneous but on which the subject remains, during a relevant period of time, incorrigible. Thus we may classify subjective sensory experiences into four groups according to their origin or interpretation being normal or morbid. Let us consider each group in turn.

(1) Normal subjective sensory experience with normal interpretation. We should note here that a period of time must elapse between an experience and its interpretation by the subject. Freud recounts that once when he was alone in a railway carriage he stood up and saw in the mirror the unpleasing face of a stranger. It was some seconds before he recognized the face as his own. In the same class is the common experience of a recently bereaved person who hears his name, or some other words, spoken by the deceased relative; usually only a moment or two elapses before he realizes his error. In such cases the initial interpretations, though erroneous, are not essentially morbid and are self-corrected after a short interval of time during which the subject gains more awareness of the situation or has an opportunity to reflect. These experiences may therefore be classed as of normal origin with normal interpretations. The same may be said of instances where the misinterpretation lasts longer, as in dreams, in the hypnagogic state, in hypnosis, or in the case of explorers who have related that during a long and dangerous journey each *sensed* the constant presence of a kind of guardian angel as a seemingly real and additional member of their team.

(2) The association of a normal subjective sensory experience with a morbid interpretation, while possible, would never be easy to demonstrate. A persistent morbid interpretation would probably indicate a psychiatric disturbance, and this would make doubtful the subject's credibility in reporting a normal subjective experience. If a person claimed that he saw a vision of his recently dead father, whose expression he interpreted as a command to kill his adulterous stepfather, and if he continued to feel that he must obey this command, we would conclude either that he was looking for an excuse to commit murder or that the vision was part and parcel of an already existing psychotic state.

(3) Subjective sensory experiences of morbid organic origin but with normal interpretation are common. They include tinnitus, the fortification spectrum of migraine and the epileptic aura. Most subjects have, or quickly acquire, insight into these experiences—that is to say, they interpret them normally. The same is probably true for the sensory experiences induced by drugs such as mescalin, LSD and amphetamine, which do not substantially alter consciousness. Morbid interpretations may of course be made—a person may believe that his tinnitus is caused by people operating a machine to annoy him—but these are rare. Where the level of consciousness is much altered by the organic factor, as in delirious and toxic states, a morbid interpretation during the delirium is

* I have avoided the word *perception* because in the present context it has the disadvantage of confounding a person's awareness (or experience) of a sensation with the interpretation he then puts on it.

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common, but tends rapidly to be self-corrected as the delirium subsides. However, we must note that insight does not always return rapidly, and in some cases (e.g. the persistent hallucinatory states of chronic alcoholism) may never return.

(4) Subjective sensory experiences occurring in the clear consciousness of a functional psychiatric disorder are commonly given a morbid interpretation. Thus, in schizophrenia the patient usually believes the voices he hears are those of other persons, even if he believes they are coming from inside his head. The characteristic of these morbid interpretations is that during the course of a more or less prolonged illness they are not subject either to self-correction or to correction by friends or medical attendants. On the other hand there are cases of evident psychiatric disorder where the patient describes similar experiences yet interprets them, or seems prepared to interpret them, in a more normal way: that is to say, he will state, or agree, that the experiences are part of his illness or the outcome of his mental state.

To consider how the concept of pseudo-hallucination can best be applied to this classification of subjective sensory experience, we must first define a hallucination. A common definition, as given by Fish, states that a hallucination is a perception in the absence of an external stimulus. If we take perception to mean both the experience and the interpretation of a sensation, then this definition covers all types and interpretations of subjective sensory experience and leaves no room for any concept of pseudo-hallucination. Let us instead define a hallucination as a subjective sensory experience which is of morbid origin and interpreted in a morbid way. Such a definition—which perhaps corresponds with Jaspers' 'hallucination proper'—will include the 'projected' voices of schizophrenia and the frightening visions and tactile misinterpretations of delirium tremens. Not included in this definition will be all those subjective sensory experiences which either have a normal origin or are given a normal interpretation. It is from these groups that we must decide which, if any, are usefully to be called pseudo-hallucinations.

The prefix 'pseudo' generally means false, in the sense of deceiving a casual observer into believing that something appears to be what it is not. Pseudology, for example, is false speaking, i.e. the making of statements which seem true to the unwary but are really untrue; pseudo-dementia is a condition which, on first impression, seems to be dementia but is not. 'Pseudo-hallucination' would therefore seem to be a term best applied to a phenomenon which at first sight may be mistaken for a hallucination. Subjective sensory experiences of the type described above as of normal origin and normal interpretation will scarcely be mistaken for hallucinations in the restricted sense of that term which always implies a morbid state. We may further accept that subjective sensory experiences of normal origin and morbid interpretation cannot usefully be differentiated. This leaves those of morbid origin and normal interpretation. But it is evident that tinnitus or the migraine spectrum are very unlikely to be confused with true hallucinations, and the same holds for the experiences occurring in sensory deprivation which Ziskind called pseudo-hallucinations. We may conclude that the term pseudo-hallucination is most usefully and most logically restricted to those subjective sensory experiences which are the consequence of functional psychiatric disorder and which are interpreted in a non-morbid way by the patient—that is to say to those types of clinical observation mentioned at the beginning of this section.

Many factors complicate the simplicity of the above analysis. We may mention three of them. (1) The duration for which a morbid interpretation continues may be an important factor in an observer's decision whether or not to call the symptom a hallucination in the narrow sense (the same consideration applies to the assessment of a delusion). Where the duration is very short or very long there is no problem, but there are intermediate durations—after amphetamine intoxication, for example—where the decision as to morbidity of interpretation becomes somewhat arbitrary and will depend on how far the tenor of the patient's life is disturbed. It is in reference to this time factor that we must determine whether the voices heard by patients with Leonhard's shallow schizophrenia should

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be called hallucinations or pseudo-hallucinations; and perhaps also this is the context in which we should see Jaspers' statement that pseudo-hallucinations can change over into hallucinations. (2) Normality of interpretation is equivalent to insight and insight is a difficult concept. A person who is convinced against his will and 'of the same opinion still' may be said to have pseudo-insight, and the same may be said of a patient subjected to a too bothersome questioning on his experiences. Insight, moreover, is not an all-or-none category. Quite apart from evident alterations in the level of consciousness, insight may be partial and fluctuating. During recovery from an acute psychotic illness, for example, patients commonly pass through a stage of partial insight during which they may attempt to rationalize their earlier morbid interpretations. (3) A patient may more or less unconsciously simulate his experiences or his interpretation of them. Simulated hallucinations may properly claim to be called pseudo-hallucinations, just as simulated dementia is called pseudo-dementia. It is with simulation in mind that we may recall the frequency of pseudo-hallucations in Sedman's attention-seeking females and the 'vivid hallucinations' of Jaspers' hysterical patients. However, the fact that such reported experiences have been confidently classed as pseudo-hallucinations may reflect no more than the relative lack of sophistication in these histrionic patients. With greater sophistication a patient could of course describe experiences which it would be impossible to distinguish from true hallucinations on purely phenomenological grounds.

Conclusion

The difficulty in delimiting the term pseudo-hallucination springs partly from the clinical difficulty in eliciting shades of subjective experience in a mentally disturbed person, and partly from the different ways in which the term 'hallucination' is used. American textbooks use hallucination in its broad, lay sense, to cover dreams, hypnagogic experiences and other forms of 'imagery'. If hallucination is used in this broad sense, pseudo-hallucination can have no meaning except as a particular variety of hallucination. That would involve a confusing use of the prefix, not in accordance with its use in such terms as pseudo-dementia and pseudo-hypertrophy. If hallucination is used in the restricted sense, as defined above, then there is a proper place for pseudo-hallucination. In that event however no term is left to cover other subjective sensory experiences (tinnitus etc.) which are also interpreted normally. This absence of a term has been noted by Curran and Partridge, who say (page 65) that sensations due to a disturbance of the apparatus of sense (e.g. from a detached retina) should be distinguished from hallucinations and illusions. It is the absence of such a term that makes necessary the use of hallucination in its broad sense.

Some clinical value can be assigned to pseudo-hallucinations as defined above, principally in that they may help in the differential diagnosis from schizophrenia of depressive psychosis, obsessional states or histrionic behaviour. Against this, however, must be set the view that hallucinations are not of themselves a very important diagnostic sign of schizophrenia and become so only by virtue of their association with more fundamental symptoms (Slater and Roth, page 239). Morever, because of the fluctuating and partial nature of insight, it is often not possible to say with conviction that insight is fully present or absent. It might therefore be considered more profitable to think in terms of the *degree* of insight, as proposed by Freedman and Caplan (page 567). If that procedure is adopted, then the concept of pseudo-hallucination becomes largely superfluous.

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