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FROM *SYMPTOM* TO *DIFFERENCE*:
“HEARING VOICES” AND EXCEPTIONAL EXPERIENCES

By RENAUD EVRARD

ABSTRACT

Traditionally considered psychopathological auditory-verbal hallucinations, the voices heard by patients, but also by many people from the general population, are currently the subject of much attention from researchers, clinicians and public authorities. One might think that voice hearing is a psychopathological experience that has little to do with parapsychological phenomenology, except when information is ostensibly acquired paranormally under the form of a voice. But paranormal and spiritual interpretations of voices are ubiquitous in many studies of voice hearing, and even are outstanding examples of salutogenic appraisals of psychotic-like experiences. The research on the type of appraisal along the axes of internal / external or personal / impersonal provides direct guidance on clinical intervention strategies. No longer focusing on the 'what' but rather on the 'how' of these experiences helps to avoid some biases relative to the assessment of beliefs — especially unusual beliefs — in the clinical setting. In this paper, I first describe the genesis of the Hearing Voices Movement, as presented by the Dutch psychiatrist Marius Romme, and then selected research is reviewed on these anomalous experiences. I argue that parapsychology has much to learn from the Hearing Voices Movement, and *vice versa*. The change of perspective on voice hearing — from a *symptom* to an individual *difference* — may be generalized for all exceptional experiences, as the late Rhea White had begun to establish with her Exceptional Human Experiences Network. This leads us to consider how parapsychological research is used by people searching for meaning due to their exceptional experiences, and conversely how researchers attempt to normalize these experiences. How to maintain a clinical approach of exceptional experiences when facing a discourse that disqualifies their psychopathological approach? As the figurehead of the broader movement of “recovery,” the Hearing Voices Movement offers a *competitive clinical practice*, but failed to provide a true *differential clinical practice* starting from a neutral name referring to several psychopathological pathways that need to be distinguished.

INTRODUCTION

According to West (1948, p. 191), in the 1890 Census of Hallucinations by the SPR, 25.6 % (493 of 1,684 people with hallucinations) of the surveyed “hallucinations” were auditory (vocal) (Sidgwick et al., 1894). In West's “mass-observation” survey, this percentage increased to 31.7 % but with a smaller sample (102 of 217 people with hallucinations). In another collection of cases, 10% of spontaneous psi experiences submitted to the Duke University Parapsychology Laboratory were sensory hallucinations; the most common hallucination found was auditory (Rhine, 1953). But these data don't help to discriminate between “auditory-verbal hallucinations” and “auditory psi experience” (Rhine, 1963). West (1948, p. 194) suggested that:

Strictly speaking, hallucinations come into the domain of psychical research only when they convey information unknown to the percipient. So far as is known this so-called veridical variety is in every respect the same as an ordinary hallucination, except that the ideas in the percipient's mind which form the basis of the phantasms are obtained by paranormal cognition.

In this paper, I will argue that hallucinations enter the field of psychical research long before any objective evidence of paranormality is obtained. From the moment a person interprets his/her hallucinations as falling within the realm of the paranormal, psychical research is implicated, at least in its mental health role. The acceptance of this role has led to the creation of a clinical practice with exceptional experiences (ExE),¹ which is rapidly developing worldwide:

- We find more and more clinical settings for people who are concerned by their ExEs. Both the Institut für Grenzgebiete der Psychologie und Psychohygiene (IGPP) and the wissenschaftliche Gesellschaft zur Förderung der Parapsychologie (WGFP)'s counselling services in Germany handle more than 3,000 requests for information or help each year (see Belz, 2009; von Lucadou & Wagner, 2012).
- There is a growing amount of academic work on ExEs (Cardena, Lynn & Krippner, 2000; Murray, 2012), including dissertation theses (e.g., Evrard, 2012; Goulding, 2004; Rabeyron, 2010; Schaefer, 2013; Simmonds-Moore, 2003), publications in mainstream journals (e.g., Dein, 2012b; Fach, 2011; Fach et al., 2013), and conference proceedings (Coly & McMahon, 1993; Kramer, Bauer & Hövelmann, 2012; Simmonds-Moore, 2012).
- The popular reception of ExE improved, as seen in the increasing interest in near-death experiences, spiritual experiences and many other "extraordinary" experiences. People claiming these experiences can organize themselves in networks, using a passionate rhetoric which aims to demystify and depathologize these experiences, as exemplified in France by the Institut de Recherche sur les Expériences Extraordinaires (INREES; see Allix & Bernstein, 2009).

Beyond these concrete achievements, much remains to be done before ExEs will be accepted as fully-fledged human experiences, neutral in terms of mental health, and potentially beneficial, as they were described initially by Rhea White (1994) under the term "exceptional human experiences". Most often, these experiences are classified as psychopathological symptoms (Evrard, 2013), or as a consequence of illusion, error or fraud (Shermer, 2002; Wiseman, 2012).

This change of perspective on a commonly shared but unusual experience is already occurring for the experience of hearing voices when there is no auditory stimulus.

¹ Exceptional Experiences are usually understood as "deviations from what might be referred to as ordinary experiences, i.e. experiences consistent with typical "reality models" that individuals develop to cope with their socio-cultural environment" (Fach et al., 2013, p. 1).

Traditionally considered as psychopathological auditory-verbal hallucinations, the voices heard by patients, but also by people from the general population, are currently the subject of much attention from researchers, clinicians and public authorities. This fact owes much to the organization of a network of voice hearers, which has brought together researchers and those who hear voices, thus putting into dialogue scientific and experiential knowledge. This dialogue has too long been rendered impossible by a scientific attitude of elitist authoritarianism, of “Great Divide” between scientific expertise and popular knowledge (Latour, 1991). It is precisely this attitude that was criticized by Rhea White (1994) and which led her to change her approach of parapsychology to develop a network focused on ExEs with the aim of exploring the “meaning” that was often neglected in scientific assessments of these experiences.

In this paper I will present the somewhat symbolic genesis of the Hearing Voices Movement, then give an overview of the research that created debate about the treatment of auditory-verbal hallucinations. One might think that voice hearing is a psychopathological experience that has little to do with parapsychological phenomenology. But, much to the embarrassment of academic scholars and clinicians who are addressing this issue, paranormal and spiritual interpretations of voices are ubiquitous in the populations studied and contributed sometimes to a better mental health. Since the beginning of the Hearing Voices Movement, parapsychology has been implicated in the exchanges, but in a biased or perverted form. I believe that parapsychology has much to learn from the Hearing Voices Movement, and *vice versa*.

GENESIS OF A MOVEMENT

Auditory-verbal hallucinations are the most studied hallucinations (e.g., Freeman & Garety, 2003); this could be because they didn't fully fit in the canonical definition of "perception without object", a model where the hallucinatory perception should be auto-generated only from a drive. As noted by Pommier (2003), some hallucinations speak! How to explain through this simplistic instinctual model?

Since the 1980s, a new wave of studies focuses on an aspect of auditory hallucinations: anomalous voice hearing in the general population. This research has been combined with a social protest movement by individuals — often mental health services users — who are living with these hallucinations, sometimes in a mono-symptomatic and adaptive way. The paranormal interpretation of voices is very common and relatively well accepted, as well as other non-classical interpretations such as messages from religious or spiritual entities, from the collective unconscious, etc.). The combination of these data constitutes a theoretical and therapeutic paradigm for understanding acoustic-verbal hallucinations in the general population, which is preparing to integrate visual hallucinations (Oorschot, Thewissen, van Os, Myin-Germeys, 2010) and potentially all dimensional psychiatric symptoms.

Marius Romme reported (Romme & Escher, 1993) that one of his patients, Patsy Hage, who was suffering from verbal hallucinations that were encouraging her to attempt suicide despite psychiatric treatment and suppressant medication, was greatly

helped by reading Julian Jaynes's book (1976) which proposes an alternative theory of verbal hallucinations but also of telepathic hallucinations (Le Maléfan, 2008). In a few words, Jaynes' theory claimed that the human mind was a *bicameral* mind: one cerebral hemisphere "talked" and decided what to do in stressful situations, the other hemisphere listened it and obeyed. Even if the human mind evolved beyond this stage, verbal and *telepathic* hallucinations are supposed to be resurgences of this bicameral mind, as a natural mechanism which helped to regulate mental activities, as are supposed to exemplify the Greek heroes inspired by their ancient deities. Therefore, Patsy Hage claimed that her brain could have been naturally wired for hearing voices and that it was rather a latent ability that humanity had forgotten.

Because of the apparently positive effects of this alternative knowledge, Romme began to take seriously his patient's worldview and changed his psychiatric approach, ceasing to see patients' interactions with voices only as a morbid process. He relativized the place of beliefs in the assessment of psychotic-like experiences, as "normal" beliefs (e.g., the Christian God, or dysfunction of the dopaminergic system) may become negative and even persecutory; conversely, "marginal" or "alternative" beliefs are sometimes useful, if we place ourselves in a "pragmatic" clinical practice. For example, the spiritualist belief in a dead ancestor who gives tips, as during its lifetime, can help to accommodate comfortably voices (Roxburgh & Roe, 2014). Romme has accepted this challenge to medical knowledge and power, and articulated it with the general renewed interest in so-called psychotic experiences from the perspective of those who live with them.

The appeal to "voice hearers"

Beyond this somewhat symbolic genesis, the virtuous dynamic of Hearing Voices Movement was to have one foot in a politicized social action to normalise voices and one foot in the best journals on schizophrenia (e.g., *Schizophrenia Bulletin* or *British Journal of Psychiatry*). Both even become indistinguishable.

Romme introduced Hage to another voice hearer and observed the beneficial effect of this meeting: this meeting help them to see they were not alone in their attempt to cope with voices. Then, they went together on a popular TV show in the Netherlands and made an appeal to "voice hearers" to contact them. More than 700 people responded to the invitation, among whom 450 heard voices, including 150 who remained highly functional. Romme submitted a questionnaire to these 150 people and subsequently conducted in-depth interviews with 20 of them to better understand their strategies to cope with their voices. This was the subject of the first scientific publication on voice hearing in the prestigious *Schizophrenia Bulletin* (Romme & Escher, 1989), and also led to their first book which has been translated into many languages (Romme & Escher, 1993).

The interaction with these people didn't stop there: Romme and Escher organized, in 1987, the first congress on voice hearing where the speakers included the 20 interviewees who described their spontaneously developed strategies to live healthily

with their voices. The organization of this congress symbolized the movement of knowledge from a supposedly closed psychiatry to a community including both health practitioners and users, in a process of empowerment and self-management in mental health.

In the aftermath of the conference, the Resonance Foundation (*Weerklank*) was created in the Netherlands in 1988. It was followed by a second congress of voice hearers, jointly organized by the department of social psychiatry of the University of Limburg and the voice hearers of this foundation. This congress was an opportunity for mental health professionals to hear the views of those who were directly affected by this phenomenon. The approach advocated by Romme's team and the Resonance Foundation has fostered the development of a partnership between voice hearers and their allied professionals. The verbal hallucination itself was no longer considered as the problem to be addressed or eradicated: rather, it was an individual's inability to "cope" with their voices that determined their healthy or unhealthy status.

An international movement

In 1988, the first support group for voice hearers was founded in Manchester, England, and, in 1990, a network of similar groups (Hearing Voices Network) was also founded. Today, there are over 180 of these support groups spread throughout the country, offering support to people who hear voices, their families and professionals in the field of mental health (www.hearingvoices.org). Since 1989, several national and international conferences have been held, and September 14 even has been declared "World Hearing Voices Day".

In recent years, one has witnessed the development of a support network and international movement of voice hearers, first in Northern Europe, and then expanded to several countries. The International Network for Training, Education and Research into Hearing Voices (www.intervoiceonline.org), co-founded by Professor Romme and based in England, became a non-governmental organization involving psychiatrists, psychologists, nurses and voice hearers; its mission is to coordinate hundreds of local groups in many countries.

The Hearing Voices Movement considers itself as a post-psychiatric organization, outside the realm of mental health strictly speaking, because it recognizes that voices are an aspect of individual differences, rather than a mental health problem. Members of this movement do not hesitate to quote the model of the depathologization of homosexuality, or to invoke the former stigma on left-handed people (Romme & Escher, 1993) as analogous to the voice-hearer's plight.

The success of this movement made it the figurehead of the broader movement of "recovery" (Romme, Escher, Dillon, Morris, & Corstens, 2009), which is challenging the authority of the psychiatric profession in order to substitute it with other forms of management of mental health. In 2009, The World Health Organization and the European Commission launched a joint project to encourage the "empowerment" of mental health service users, encouraging alternatives to nosography (classifications of

diseases). Insidiously, this policy converges to the ideal of self-treatment and, thus, deinstitutionalization, which is also the objective of current economic policies of reducing costs in mental health.

Practices based on recovery are opposed to the idea of a predetermined and linear career of patient, and conceived “relapses” are normal occurrences in the course of recovery. The subjective assessment of psychopathology replaces the alleged capacity to objectively define it. Medical discourse and power are relativized or explicitly challenged because they are not inherently superior to knowledge established “from the inside”. Thus, instead of striving for *healing*, one works towards *acceptance and assimilation of the disease*, of the learning of the “life with”, a regained independence and a greater experienced satisfaction in life. Finally, abuses and coercions of drug-based psychiatry are put on the same level as the abuses that have generated the trauma that led to the development of symptoms.

This contestation-relativization of psychiatric power is not fully comparable with previous anti-psychiatric discourse (Crossley & Crossley, 2001). The recovery movement criticizes bad psychiatry but does not reject it as a whole, having some alliances with some respected mental health professionals and public authorities. Indeed, public authorities have less embarrassment when supporting mental health policies in favour of “empowerment” of the users. All reasons — human rights, democracy, scientific falsifiability, courts, tolerating atheism, etc. — are combined to give a different weight to these voices. However, this discourse which often uses the psychopathology of psychoses as a foil, could be *a minima* described as “anti-psychopathological” since it is systematically in opposition to the psychopathological interpretations. Instead of the figure of the hallucinated patient, the movement opposes the image of the hearing voices citizen. These competing visions sign the introduction of a *competitive clinical practice* (promoting an alternative view), which is not a true *differential clinical practice* (promoting a view with alternatives) starting from a neutral name referring to several psychopathological pathways that need to be distinguished. Indeed, some authors claimed that, in the Hearing Voices Movement, psychotic-like experiences are treated as neurotic episodes, without a good understanding of hallucinations, delusions, and dissociative states (Evrard & Le Maléfan, 2013a, 2013b).

VERBAL HALLUCINATIONS, VOICE HEARING AND EXCEPTIONAL EXPERIENCES

Renaming verbal hallucinations under the term “voice hearing” is not a trivial process. This terminological change is directly aimed at reducing stigma. And the effect is immediate as a whole population that didn’t recognize itself as ‘verbal hallucinators’, did recognize itself as ‘voice hearers’. This vocabulary — more neutral on the psychopathological side — is accompanied by other revolutions: voice hearers who will ‘use’ the medico-psychological services to finally accept their voices without being ‘destroyed by the system’ are renamed ‘survivors’; or, from ‘victims’, they became ‘victors’ (Coleman & Smith, 1997). Such language innovations participate in the shaping of social minorities who challenge the stigmatizing representations that seem to affect

them. Harrowing testimonies — vulnerable to typical deformations of personal stories (reconstructive memory, expectancy bias, self-serving bias, etc.) — and scientific arguments converge. These minorities unite around a common language and imagery posed as alternatives denouncing a master played by a steamrolling nosography (Romme et al., 2009).

How to rename hallucinations

This revolutionary terminology is not without controversy because its implications for the mainstream psychopathological discourse are huge. There is a switch from a taxonomy to a folksonomy (a taxonomy made by and for the users) which is the mirror of social pressures on public policies in mental health area. In continuation of this process, any psychiatric term could be unnamed to provide more valorizing taglines: e.g., visual hallucinators can become “visionaries”, as they were described in the original definition of hallucination by Esquirol in 1817, with this ambiguous meaning referring to the seers.

Psychiatrist and parapsychologist Ian Stevenson (1983) has even suggested the term “idiophany”, instead of “hallucination” to describe “unshared sensorial experiences” in the general population, although this more neutral term does not affect the underlying conceptions. Some researchers from Quebec propose the term “extraordinary experiences” instead of “verbal hallucinations” (St. Onge, Charpentier, Ouellet, 2005); I will opt for a similar solution, but with a clearer reference to the paranormal. Research on voice hearers indicate that hallucinatory and paranormal experiences can be grouped into a single entity, *anomalous* or *exceptional* experiences (Belz, 2009), as was the case in the *Varieties of Anomalous Experiences*, published by the American Psychological Association (Cardeña, Lynn & Krippner, 2000). This transition allows integration of the perspective of those who live the experience by shifting from a premature and unjustified psychopathological stance, and without falling into anti-psychiatry.

Leudar and Thomas (2000, p. 14) prefer to speak of an “unusual form of private speech”. Nevertheless, it remains difficult to span the gap between the expression of private locution and spontaneous, uncontrollable and xenopathic verbal hallucinations (i.e. hallucinations with a quality similar to that of objects existing in the extracorporeal world). But the conventional medical designation is difficult to assimilate for voice hearers. The speaking voice would be nobody’s voice; and its meaning is not considered important (Leudar & Thomas, 2000, p. 91). This explanation does not take into account one difficulty of the experient who cannot completely reject the voice as “non-self”, nor fully accept it as “self”, as William James (1891) pointed out in his analysis of the phenomenon. It is therefore not surprising that the hearers seek accounts other than medical discourse to support their experiences. Work seems possible around these transitional areas, in which parapsychology is involved.

The transitional area of parapsychology

It is quite surprising that, of the seven cases selected by Romme and Escher (1993, p. 59-87) to illustrate the hearers who managed to adjust to their voice without going through the mental health services, all had adopted a paranormal or spiritual interpretation of the communications. This kind of interpretation becomes commonplace and is no longer fingered as delusional. From their 1987 survey, Romme and Escher (2000, p. 98) found a predominance of paranormal interpretations over biomedical ones (neurochemical imbalance, perceptual and cognitive failures, etc.).² The significant presence of paranormal and spiritual interpretations comes from the fact, according to Heery (1989), that they constitute an intermediate zone between the classical pathological perspective and the traditional religious perspective. These intermediate resources provide enough flexibility so that everyone can seize it to find a meaning that suited to its strange experiences, compiling elements from several models without having to follow fixed dogmas, without incurring the limitations of conventional perspectives. "Neither saints nor psychotics" seems the watchword, according to Heery.

Researchers working with voice hearers are accustomed to being confronted with paranormal interpretations of these experiences. Here, the presence of something paranormal does not aggravate the diagnosis or fundamentally alter the possible clinical work. This dovetails perfectly with the cognitive hypothesis that hallucinations are attribution errors about the source of certain events (Bentall, 2000a). Bentall's model includes a cultural factor which stipulates that the hallucination will use "culturally pre-structured" externalist assumptions (telepathy, disincarnate spirits, collective unconscious, etc.) to describe the nature of the sources causing hallucinations. Even if we can initially encourage the individual to reassign his or her experience to an internal source, the externalist "colourations" of the interpretations are valued when they seem to help the hearer's coping strategy (Schofield & Claridge, 2007). In cases where the individual is attached to a system of interpretation that causes harm, cognitive-behavioural therapy is always a possible strategy to "restructure beliefs" (Bentall, Haddock, Slade, 1994).

Surprisingly, this valorisation of externalist assumptions even passes by the invitation of "experts" of each interpretation. In publications and conferences on voice hearing, experts are asked to detail how each more or less exotic theory gives meaning to the hallucinatory experiences. The psychopathological approach is thus strongly relativized as psychiatry and psychology do not provide the "appropriate technology for dealing with the problems posed by the experience of voice hearing" (Leudar & Thomas, 2000, p. 129). For instance, in his clinical practice, Philip Thomas used a non-judgmental discussion of hallucinations. He will not even address the explanatory framework of the voice hearer "because we believe that the explanatory framework is in

² It seems, however, that these paranormal interpretations are less likely to be communicated when hearers adapt themselves to traditional care and / or when they perceive researchers as members of a medical team supposedly closed to these interpretations. Thus, in the qualitative study of Fenekou & Georgaca (2010), even the participants interpreting their voices as paranormal phenomena finally line up to biological explanations of the origin of their voices.

itself related to, or symbolic of, the voice hearer's life" (Leudar & Thomas, 2000, p. 131).

Researchers justify quite effectively why they rely on users' beliefs and their representatives, rather than going against them and strengthen the censorship imposed on these experiences (Romme & Escher, 2000, p. 109); this is why the basic books edited by Romme and Escher include chapters on alternative intervention models and theories. However, like a kind of transcultural psychiatry, they accept these beliefs without giving them a full status of scientific truths. They admit their protective or compensatory functions, functions also held by clinicians' own beliefs (Romme & Escher, 2000, p. 108). But the metaphysical beliefs of the patient are seemingly based on still heterodox research (e.g., beliefs in supernatural or extraterrestrial entities, assimilated to the products of science fiction) and "for therapists to adopt such a premise would be contrary to their professional training" (Romme & Escher, 2000, p. 103). The distribution of beliefs is not yet egalitarian because it does not leave the "Great Divide" requiring more rationalism from qualified professionals than from disturbed users.

However, even within this clinical tolerance, parapsychology was awarded a status superior to other alternative models. It would be, just as transpersonal psychology, a 'stepdaughter' science of traditional psychiatry and psychology (Romme & Escher, 2000, p. 107-108). In the "toolkit" of Coleman and Smith (1997), which is highly recommended by Romme and Escher, voice experience is organized according to three models of beliefs: pathological, psychological, and *telepathic*. The hearers are even encouraged to read books on all paranormal experiences.

Nevertheless, the role attributed to parapsychology is quite special; it is not to highlight scientific research in parapsychology pointing to the existence of genuine paranormal phenomena. Under the guise of 'parapsychology', these authors refer to a practical knowledge of how to handle paranormal experiences which is not one that usually occupies researchers. This 'practical parapsychology' (e.g., Boutboul, 2007; Réant, 1988) implies a gift or a sensitivity derived from a subtle level of consciousness. This gift might be exercised and developed for the benefit of others through clairvoyance and mediumship (Romme & Escher, 1993, p. 24). It implies also a control on the external sensory inputs through the building of psychic barriers, i.e. shields closing the ego to psi (Romme & Escher, 1993, p. 53). The know-how of 'parapsychologists' to regulate the flow of the hetero-psychic information, to settle 'feelers' to 'on' or 'off', is considered a cognitive intervention (Romme & Escher, 2000, p. 107).

However, there is no trace of this practical knowledge in the scientific research in parapsychology (Irwin & Watt, 2007); this is problematic because the welcome of alternative knowledge to make sense of hallucinations is not impervious to pseudo-knowledges adorning themselves with scientific attributes. Escher is quite aware of that as she observed the damage caused by certain consultations of psychics and mediums on the hard journey of voice hearers (Romme & Escher, 1993, p. 53). It seems that the

role of parapsychology still need to be established precisely, and, to do this, experts in parapsychology have to become familiar with the debate on voice hearing.

THE DEBATE ON VOICE HEARING

This section is only a brief crossing into the vast debate surrounding the movement of "voice hearers" (McCarthy, 2012), in order to show how the clinical approach to ExE can find overlap between psychical research and a related mainstream field of study. I address first the answer to some classical arguments to justify the refusal to listen to patients' voices. Then I discuss studies in the wake of Romme and Escher, to highlight what they teach us about the (clinical) listening of hallucinations.

Classical arguments

In their review of literature on the classical view of auditory hallucinations, Romme and Escher (2000) show that voices remained described as a psychiatric symptom. In this psychiatric context, the clinician should not pay attention to the content of the voices, however it could exacerbate patient's disconnection with reality. Against this traditional statement, researchers oppose three arguments:

1. The first argument comes from epidemiological data showing, since Sidgwick et al. (1894) to Tien (1991), that 2-4% of the general population have experienced auditory hallucinations, only a third of whom are mental health services users. Posey and Losch (1983) wanted to test Jaynes' (1976) theory by checking whether verbal hallucinations manifested in everyone. With 375 students tested, they found that 70% of them showed brief verbal hallucinations when fully awake, 39% said they had heard their own thoughts as if they were spoken aloud (a symptom of the first rank in psychosis, according to Schneider's classification), 36% heard a voice calling them by their name when they were alone. A replication of this study with a large sample from the same university found similar results (Barrett & Etheridge, 1992), and subsequently compared hallucinators and non-hallucinators on tendencies toward psychopathology. They used the Minnesota Multiphasic Personality Inventory (MMPI) for the ten standard clinical scales (Graham, 1987). Results revealed no significant difference between two groups.

After the first major study by Posey and Losch, further studies with university students between 1992 and 2005 found that 11 to 37% of respondents admitted to having heard a voice saying their thoughts out loud (Aleman & Larøi, 2008, p. 63-64), and likelihood of responding affirmatively was not related to social conformity, substance use or other indicators of psychopathology. A recent internet survey confirms that the experience of verbal hallucination follows a continuum in the general population without being systematically related to distress (Lawrence, Jones & Cooper, 2010). The prevalence of auditory hallucinations doubles in children and adolescents (Aleman & Larøi, 2008, pp. 69-71). All these data reinforce the important issue of differential diagnosis between psychotic symptoms and normal human experiences.

2. A second argument is the trans-nosological aspect of verbal hallucinations, since these particular symptoms can occur in many psychiatric and non-psychiatric disorders, but are also common in healthy subjects, and can be induced in laboratory conditions (Bentall, 2000a). "Hallucinations can occur in many different clinical conditions and, therefore, lack of diagnostic specificity" (Aleman & Larøi, 2008, p. 88). The categorical association of hallucination with psychosis is thus undermined.

3. The third argument is the fact that highly valued intellectual or religious characters have experienced verbal hallucinations, which comes to show, by playing a sort of authority argument, the compatibility between the acceptance of voice and a high level of intellectual functioning or great achievements. *Vice* becomes *virtue* through a change of perspective. The argument of the "great hearers" is not a scientific or clinical argument as well structured as the others, but is rather a background referential consolidating an imaginary identity. In the literature on voice hearers, it is common to read statements such as "Pythagoras was a voice hearer, and Socrates heard a demon nobody else could hear, and this demon guided his actions" (Leudar & Thomas, 2000, p. 1). Joan of Arc, as the paradigmatic example of this argument, is even on the cover of Romme and Escher's major books (1993, 2000). Researchers working with voice hearers are led to revisit some classic debates of nineteenth or early twentieth century psychiatry, with more or less success. Religious voices and visions still raise considerable controversy in the mental health field (Dein, 2012a; Dein & Littlewood, 2007; Gumper & Rausky, 2013).

In fact, Joan of Arc was described as a "sad monomaniac" by Brierre de Boismont (1861a, 1861b), but many are reluctant to reduce her character to her hallucinations. It is certain that she left her mark on History, and, although it remains enigmatic, her voices could be regarded as having delivered truthful information she would not have known otherwise.³ But, as Brémaud's analysis (2008) shows, using the psychoanalyst Maleval's reading grid, this heroine seems to have had a psychotic structure regardless of whether she heard voices that enabled her to fulfil her political and spiritual quest. But is Joan of Arc therefore a good example for voice hearers? Wasn't the idea to show that auditory hallucinations are not systematically associated with psychosis?

Paradoxes carried by these key characters of verbal hallucinations raise the question of the over-pathologization of this phenomenon. In any case, this use of authority characters does not advance the clinical debate because, without an analysis of the appraisals of these hallucinations, no differential criterion can really emerge (Brett, Peters, Johns, Tabraham, Valmaggia & McGuire, 2007). The evocation of great hearers participates, nevertheless, to the de-stigmatization of the phenomenon. This shows that

³ Although he remained cautious, Michelet (1853) accurately recounted the psychic experiences of Joan of Arc: she recognized at first sight King Charles VII in a crowd, despite the precautions taken to hide him (p. 32); she founded the sword of St. Catherine behind the hotel of Sainte-Catherine de Fierbois, ostensibly because the voices informed her of this secret; she predicted her injury (p. 50); she saw the man who sold her (p. 78); she predicted the day of the release of Compiègne (p. 96), etc.

our society has not always had the same relationship to these experiences, and thus could change it again.

In the same vein, shamans, mediums, and psychics often claim to have extra-sensory perceptions through various kinds of voices, and this claim is less and less interpreted as a clear sign of madness. For instance, there is a growing body of research conducted with mediums who claim to hear voices of the deceased (cf. Taylor & Murray, 2012; Temple & Harper, 2009) but do not seek support from mental health services, and actually appear to have better psychological wellbeing than comparable others (cf. Roxburgh & Roe, 2011).

Research initiated by Romme and Escher

Research in the wake of Romme and Escher offer new arguments in the clinical debate on hearing voices (and on ExEs by extension). Based on a survey of 450 people who responded to the appeal on TV, Romme and Escher (1989) argued that there was a process of *adaptation* to hallucinations than I will now describe in greater detail. Many implemented coping strategies were often custom, but people crossed the same phases:

- a) Surprise phase: an usually sudden onset first lived with fear.
- b) Organization phase: a process of selection and communication with the voices.
- c) Stabilization phase: a period during which most consistent means to cope with voices in the long course are developed.

A second argument emphasizes the importance of *individual differences*. Approximately two-thirds of respondents described themselves as having difficulties coping with their voices, while a third described themselves as supporting well their voices (Romme & Escher, 1989). Differences in attitudes and beliefs could be detected between groups of voice hearers with positive and negative after-effects: having a higher self-esteem; an ability to set limits with the voices, to listen selectively, to communicate more often; having an explanatory model, more social and supportive connections; and being more inclined to discuss voices with others. Gradually, the work of Romme and Escher argued for individuals to able to cope naturally with their psychotic experiences, which has sparked the curiosity of many researchers.

In another study, Pennings and Romme (1996) compared three groups: hallucinating patients, patients with dissociative disorders, and a last group of people who heard voices but did not meet the formal criteria for mental illness (American Psychiatric Association, 2013). Remarkably few differences were recorded in the phenomenology of hallucinations experienced by the three groups: they all heard both positive and negative voices, but the proportion of positive verbal experiences was higher among non-patients, and a much greater percentage of patients than non-patients felt they could control their voices and were able to refuse to obey their orders.

The many forms of *relationship* hearers have with their voices have been the subject of much research (Chin, Hayward, & Drinnan, 2009; Jackson, Hayward, & Cooke, 2011; Sorrell, Hayward, & Meddings, 2010; Vaughan & Fowler, 2004), paving the way towards an open dialogue with the voices, against the grain of the usual

psychotherapeutic recommendations (Corstens, Longden, & May, 2012; Seikkula, 2011).

The individual differences would lie in the *appraisal* of the experience: for example, interpretations that most decreased anxiety were psychodynamic (e.g., voices being understood as manifestations of Jungian archetypes), mystics (the voice reflected a spiritual development, a widening of consciousness), and psychic (a sensitivity or a gift that we must learn to control). From thirty observations, Heery (1989) suggested a correlation between psychic or spiritual interpretations of voices and greater wellbeing. The less effective interpretations promoted an external locus of control for voices (e.g., biomedical or demoniacal interpretations). The “appraisal” factor soon became a more relevant variable than the simple observation of presence or absence of voices.

To understand better the various forms of integration of these hallucinatory experiences in the general population, researchers analyzed their correlates in different periods of life, particularly during childhood and adolescence (Pearson, Burrow, FitzGerald, Green, Lee & Wise, 2001). Escher et al. (2002a, 2002b, 2003, 2004) followed 80 voice-hearing adolescents over 3 years to establish more precisely the factors that predict the cessation of hallucinations (which occurred in 60% of cases) which were the interpretations of voices as more positive, less intrusive and less omnipotent. If the subject developed a very defensive and passive coping strategy, it was a sign that he was overwhelmed by his or her voice and would have a higher chance of developing depression. Thus, the interaction with the voice experience is more important than the voice experience itself in what motivates the demand for care. It would be a better indicator for the clinical treatment than criteria such as frequency or content (which are typically used to establish a diagnosis).

A criterion as xenopathy (assimilating all feelings attributed to an external source to a psychotic symptom) would have remained insensitive to these differences since all adolescents included in Escher et al.’s studies perceived the voice as outside themselves, especially through paranormal interpretations: paranormal gift (39%), ghost (20%), or message from other worlds (18%). While these adolescents received usual treatments (such as psychotherapy or drugs), only 3% of them gave credit to the psychopathological explanation of the voice. It may be noted, however, that these adolescents were less interested in explaining their experiences than their parents, who often resorted to parapsychological interpretations by setting the “gift” of their child within a specific psycho-spiritual path (See for example this trend in the indigo children movement: Evrard & Le Maléfan, 2010a).

A fourth argument came from the relationship between voices and various *traumas*. The externalist interpretation can be linked to the event after which the voices appeared, which in 75% of cases proved to be a traumatic experience associated with a sense of helplessness and loss of control (Escher et al., 2004). Two recent studies confirm that trauma influences the occurrence of ExEs without directly influencing the emergence of psychotic disorders associated with a demand for care (Andrew, Gray & Snowden, 2008; Lovatt, Mason, Brett & Peters, 2010). Appraisals of ExEs would play a central role as a mediator between trauma and psychosis (Lovatt et al., 2010, p. 818).

A similar number appears with an adult population: 70% of them say they started hearing voices after a "traumatic event" (in an extremely broad definition including, for example, death of a family member, divorce, moving, or sex abuse), which had often occurred in childhood (Romme & Escher, 2000). This is an aspect on which many researchers insist, as to reinforce empathy and radically change the image of the hearers from 'crazy' to 'victims'. The voices are then understood as messages on the hearer's problems, not as a frightening problem in itself. The presence of well identifiable triggers of voices is even among the factors that predict on average how long the voice will last (Escher et al., 2002a, 2002b). The persistence of voices is correlated with the perseverance of other psycho-social problems that reinforce the feeling of helplessness of the individual.

Another study (De Loore et al., 2011) found a higher discontinuation rate of voices than Escher et al. with nearly 2,000 adolescents from Maastricht, in the Netherlands. Of these respondents, 5% recognized hearing voices. After two years, the voices were maintained in only 27% of these adolescents. But these researchers show that, although verbal hallucination is common and mostly transient in adolescents, it should not be trivialized. In this study, verbal hallucinations are associated with more depressed mood and various psychopathologies, and those which remain aggravate this condition while fostering the development of delusional ideation. Then perseverance is major source of worry than only presence of hallucinatory experiences (De Loore et al., 2011, p. 252; Escher et al., 2003). Despite that, why don't a majority of hallucinating teenagers suffer deleterious effects over time?

Several psychological models attempt to account for the fact that the type of appraisal of voices is a better predictor of the level of distress than, for example, the frequency of occurrence of these voices or their content, which is not different from auditory hallucinations of patients with a diagnosis of schizophrenia (Aleman & Larøi, 2008, p. 78-80). Thus, Garety et al. (2001) proposed that an interpretation assigning an external origin to the voice caused more anxiety than assigning it to an internal cause. Actually, there is some evidence that the perceived location of hallucinations (inside, outside, or both) has no relationship with demographic, clinical or other factors (Copolov, Trauer & Mackinnon, 2004). For Brett et al. (2007), it is *impersonalization* rather than *externalization* which is the most stressful factor: for example, a neurochemical explanation of the voice does not necessarily make sense to the individual, even if it refers to an internal cause, while some appraisals in terms of voice messages from deities or spirits often produce comforting arrangements or effective locums.

The research on the type of appraisal along the axes internal-external or personal-impersonal provide direct guidance on clinical intervention strategies: rationalization, normalization, tolerance to paranormality, etc. If therapy can target the positive development of the individual and the stopping of voices, it should be more effective with a closer attention to the emotions involved in these experiences and more support for coping strategies rather than attempts to remove voices. However, there is currently too much diversity in definitions and measures of appraisal; and cognitive-behavioural

therapies focused on the changing of the (negative) appraisal of voices to reduce the associated distress have not yet yielded the expected results, probably because other factors may be involved (Mawson, Cohen & Berry, 2010).

An ideal recovery — noticeable since the early interventions of Romme where he invited his hearers voice patients to heal themselves by becoming spokespeople for their own cause — is that the voice hearer, after passing through this ordeal, becomes a clinician himself or herself helping other voice hearers, in the manner of the *creative neurosis* of shamans (Ellenberger, 1970). Does this mean that the Hearing Voices Movement offers a "cultural ready-to-wear" disease, a socially accepted way of being crazy, a frame designed for a neurotic sublimation of desire?

CONCLUSION AND CLOSING REMARKS

There is an overlap between some ExEs in which a message is perceived through a voice and 'conventional' voice hearing, but we also see that this overlap is larger because voice hearers of the latter type develop an arsenal of paranormal and spiritual interpretations of their experiences. But this rapprochement raises a fundamental question: Should all ExEs be addressed as hallucinations requiring a differential clinical practice? The standard book *Varieties of Anomalous Experiences* includes a chapter on "hallucinations" and voice hearing by leading researcher Richard Bentall (2000a). The latter has even explicitly link his research and paranormal experiences (Bentall, 2000b). It is clear that parapsychologists face data similar to those on auditory-verbal hallucinations. These are experiences:

- known in all cultures at all times;
- Whose prevalence is very high in the general population;
- Which can have negative but also positive effects;
- Which are considered as belonging to the extended phenotype of psychosis because they exceed the generally accepted reality;
- And which are the subject of a socio-cultural controversy on their nature and their place in the clinical knowledge.

In some ways, ExEs seem to follow the same path as auditory-verbal hallucinations:

- a) The process of *renaming* "ExE" some variously categorized experiences already occurred, but there is still no strong consensus on the best terminology. Some researchers argued for the use of a relativistic definition of ExE, because the paranormal/anomalous is not the same for all! Then, this is called "exceptional" an experience that goes beyond the available cognitive and emotional schemas of an individual (Belz, 2009). The use of a phenomenological model of ExE (Fach et al., 2013) also helps to get closer to what people really describe, avoiding the socio-cultural thematic categories that distort these experiences (such as "Near-Death" Experiences, "Alien Abduction" Experiences, and "Mystical" Experiences).

- b) Here too, the presence of *paranormal interpretations* does not aggravate the diagnosis or fundamentally alter the possible clinical work. But clinicians do not have enough tolerance with non-parapsychological interpretations that *externalize* but still *personalize* the source of the ExE.
- c) To strengthen the position where ExE are *neutral regarding mental health* (Goulding, 2004), we need more studies showing that paranormal interpretations and other alternative appraisals may be adaptive (Brett et al., 2007; Schofield & Claridge, 2007), that is to say more studies of “paranormal solutions” (Rabeyron, 2012). Rather than continually emphasize the positive and transformative aspects of ExE, we need a more balanced approach that doesn’t disqualify either ExE or psychopathology itself, such a *clinical differential practice* of ExE. We need, for example, more studies on the links between trauma, dissociation, negative life events and ExE.

In the end, we can say that the Hearing Voices Movement is focused on one type of ExE, but the triggered process could lead us to reconsider a wider range of unconventional experiences. Will we ever see the creation of an “Exceptional Experiencers Movement”? Several indicators suggest that its foundations are laid. Stanislas Grof’s Spiritual Emergency Network, Rhea White’s Exceptional Human Experiences Network, and John Mack’s Program for Extraordinary Experience Research had an epistemology very similar to the Hearing Voices Movement. In France, the INREES manages alliances with researchers, clinicians and public figures that support the claims of people living exceptional experiences who try to escape from a psychopathological destiny (Allix & Bernstein, 2009). This lucrative company succeeds in communicating on these topics in all media, but, for the moment, without any impact on public authorities. However, the example of the category of religious and spiritual problems in the Diagnostic and Statistical Manual of Mental Disorders – 4th edition (DSM-IV), after a form of lobbying by transpersonal psychologists (Evrard & Le Maléfan, 2010b), shows that the current paradigm is not totally impervious to these claims (On this continuing debate, see Peteet, Lu & Narrow, 2011).

It is quite possible that an “ecological niche” (Hacking, 2002) is now mature enough for the emergence of an “Exceptional Experiencers Movement.” Scientists and clinicians interested in these experiences are involved – *whether they like it or not* – in the development of this niche. For example, those who try to prove that psi is genuine provide support to those who claim that their ExE were objective and have to be interpreted through parapsychology. By other means, Moreira-Almeida and Cardeña (2011), based on data from the “psychosis continuum” and other more specific data, argue for a de-pathologization of paranormal and spiritual experiences in the next revision of the International Classification of Diseases by World Health Organization. One can imagine that, if such a category is created, ExE will gain in attractiveness. Instead of the taboo and the automatic fear of “going crazy” that usually accompany these experiences (Schetsche, 2003), a form of alternative socialization may emerge

allowing these experiencers to occupy a more rewarding place in our Western societies, like shamans, seers and mystics in other cultures and other times.

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