

Command Hallucinations and Criminality: A Clinical Quandary

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Clinical literature on the role of command hallucinations in producing antisocial behavior is sparse and fragmented. This article reviews exploratory models of auditory hallucinations and the prevalence of command hallucinations in clinical and forensic settings. In addition, clinical guidelines are offered for assessing the authenticity of command hallucinations and their relevance to criminal behavior within the context of forensic evaluations.

Controversy on the relationship of command hallucinations to criminal behavior was highlighted in the recent United States Supreme Court case of *Colorado v. Connelly*.^{1,2} Boldly entering into this foray, the American Psychological Association (APA)³ stated that it found “no studies or reports concluding that persons who obeyed *command hallucinations* were chronically impaired” (p. 20). The APA suggested that less than one percent of individuals receiving command hallucinations obeyed them, arguing that this was statistical evidence that command hallucinations are not coercive.

An entirely separate issue of forensic concern is establishing the veracity of reported command hallucinations. As noted by Resnick,⁴ simulated auditory

hallucinations are a common form of malingering used by criminal defendants. Indeed, command hallucinations represent an intraindividual phenomenon that may provide mitigation or exculpation in a criminal trial.^{5,6} The “compelling” nature of command hallucinations is one of many factors used in arguments against volitional incapacity.^{7,8}

The present article will review the literature on command hallucinations in relation to criminal behavior. In addition, command hallucinations will be addressed as a clinical issue in examining their authenticity and influence on criminal behavior. Clinical guidelines will be offered for the assessment of criminal defendants who report command hallucinations.

Etiology and Prevalence

Explanatory models of auditory hallucinations abound, suggesting both the complexity of these phenomena and the weakness of our etiological explanations.

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Slade,⁹⁻¹¹ for example, posits a four-factor model comprised of increased psychological stress, genetic or other predispositional factors, decreases in external stimulation, and a positive feedback loop to reduce dysphoria. More recently, psychophysiological explanations of auditory hallucinations have been stressed (see Asaad and Shapiro¹²) with hypothesized brain deficit as described by West's^{13,14} perceptual release theory and Marrazzi's neurophysiological dissociation theory.¹⁵⁻¹⁷ Perhaps the most compelling approach is the information-processing model propounded by Horowitz.^{18,19} According to Horowitz, hallucinating patients manifest differences in imaging, increasing distortion of perception, erroneous appraisal of information, and intrusions of unwanted images. Intrusive images may occur in

response to highly stressful perceptions, warded-off ideas, or unacceptable feelings. From this perspective, command hallucinations would represent extreme intrusiveness with externalized and disowned images assuming authority for the individual. However, no specific etiological explanations have been delineated for command hallucinations.

Studies of command hallucinations vary widely with respect both to their samples and to clinical characteristics studies (see Table 1). Although the majority of studies have addressed psychiatric inpatients, inclusion criteria range from a sequential sample of inpatients (e.g., Hellerstein *et al.*²⁰) to specific studies of hallucinating patients.^{21,22} In addition, two studies have reported on forensic populations: the first on pretrial defendants assessed for insanity⁶ and the

Table 1
Epidemiological Review of Command Hallucinations and Criminality*

Study	Sample	Hallucinations	Command Hallucinations	Commands Obeyed	Antisocial Commands	Antisocial Commands Obeyed
Kemph ²⁴	259 13-15 year old psychotic patients	47.5	-	-	7.7†	-
Lowe ²²	60 hallucinating inpatients	100.0	-	10	-	-
Rogers ⁶	385 insanity evaluatees	13.5	-	-	11.2	5.8‡
Taylor ²³	121 psychotic inmates	-	-	-	-	1.7
Goodwin <i>et al.</i> ²¹	116 hallucinating inpatients	100.0	33.6	-	-	0
Depp ²⁵	60 assaultive inpatients	-	-	-	-	15.0§
Hellerstein <i>et al.</i> ²⁰	789 inpatients	19.1	7.4	-	-	-

* All values are percentages. -, unknown. Criteria vary somewhat from study to study: † Probably an underestimate since it includes only serious offenses. ‡ Controlling hallucinations that were the basis of actual criminal behavior. § Active hallucinations just prior to the psychotically-based assault.

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second on psychotic inmates.²³ In reviewing Table 1, differences in sampling appear to account for the marked differences in the frequency of command hallucinations.

Despite the paucity of data, several observations can be distilled from Table 1. First, an examination of the Goodwin *et al.*²¹ and Hellerstein *et al.*²⁰ studies would suggest that roughly onethird of hallucinating patients experience command hallucinations. Second, a small but significant proportion (0.7% to 11.2%) of the samples received command hallucinations instructing them to commit antisocial acts. Third, the frequency with which command hallucinations are obeyed has not yet been established, although it clearly exceeds the very conservative estimate made in the APA brief.³

Other studies that include command hallucinations are difficult to classify. Several investigators have noted the prominence of command hallucinations during the active phase of schizophrenic disorders but do not provide any precise detail on the content of these hallucinations or their influence on the patients' behavior.²⁶⁻²⁸ Instead, case studies have focused on the role of command hallucinations in self-mutilation^{29, 30} or as a prominent feature in combat-related posttraumatic disorder³¹ or have addressed the effectiveness of behavioral treatment for command hallucinations. Behavioral strategies have varied from aversive conditioning³² and covert punishment³³ to self-monitoring³⁴ and satiation.³⁵ In each case reported, treatment was effective at reducing com-

mand hallucinations; the results, given the handful of case reports, merely suggest the potential effectiveness of behavioral approaches in the treatment of command hallucinations.

Clinical Issues

The clinical assessment of command hallucinations is complicated by an absence of precise inclusion criteria for delineating this psychotic presentation. However, the hallmark of command hallucinations is the presence of instructions or nonnegotiable demands placed on the patient by the hallucination. The evaluation of command hallucinations must therefore include the actual content of the hallucination, the patient's interpretation of the content, and the perceived authority of the auditory hallucination. As an example, a recent Ontario case involved a defendant with a nonforensic history of command hallucinations spanning a 17-year period. The voice of his deceased grandmother served as an oracle of God and, from the patient's perspective, spoke with absolute authority and transmitted messages with unquestionable clarity. The actual content of these hallucinations consisted of the commands, "save your mother," and "do it now," which others might view as ambiguous but which were perceived clearly by the patient as divine instructions to save his mother from the forces of evil by causing her death. After his arrest, he heard his mother calling his name affectionately and knew unquestionably that she was with God and pleased with his actions. This case illustrates the need to assess

carefully the patient's interpretation of command hallucinations and what authority he or she ascribes to it.

Resnick^{4,5} has discussed in detail the assessment of malingered hallucinations. Citing the research of Goodwin *et al.*²¹ he indicated that auditory hallucinations are typically heard outside of the patient's head and frequently stop following a change in activities. With reference to command hallucinations, Resnick has suggested that clinicians should have a high index of suspicion when forensic patients either state that they automatically obey these "voices" or report only circumscribed symptoms (e.g., command hallucinations only) at the time of the offense. In investigating the authenticity of auditory hallucinations, Resnick recommended the following: the clinician should (1) collect a full and unstructured account of the hallucinations and their relationship to the criminal behavior; (2) question closely the nature of these hallucinations including their gender, voice characteristics, duration, and content of speech; and (3) compare a patient's account with records as well as with the patient's self-report.

Rogers³⁶ has developed a structured interview approach to the assessment of malingering. Initial research on the Structured Interview of Reported Symptoms suggests that clinical probes may be useful in distinguishing malingered from authentic hallucinations.³⁷ For example, clinicians may wish to make bizarre and improbable inquiries (e.g., "Do these voices ever sing to you in a foreign language?" or "Does this voice

echo or vibrate throughout your entire body?"). Alternatively, inquiries could suggest unrealistic precision (e.g., "Does this voice occur only on cloudy days?") or an unusual combination with other symptoms (e.g., "Have you noticed that when you lose weight you also lose these voices?"). Clinicians should devise their own clinical probes for the assessment of auditory hallucinations and their veracity.

Clinicians may wish to make structured inquiries regarding how the commands are communicated (e.g., "Do these commands ever appear to you visually, as a giant message written across the horizon?" or "Are the commands ever whispered to you from stone walls?"). In addition, clinicians may inquire regarding unusual sources of these commands (e.g., "Have you ever received commands from Jupiter or its moons?") or the consequences of *not obeying* them (e.g., "Did you ever have the thought that your body would turn to sand if you did not obey these commands?"). Although these clinical probes may appear too transparent, preliminary research on the Structured Interview of Reported Symptoms suggests that malingerers have considerable difficulty in distinguishing them from bona fide symptoms if they are embedded within a series of diagnostic questions. The point of the discussion is that clinicians, particularly in forensic evaluations, should begin to implement their own clinical probes for the evaluation of command hallucinations.

Beaber *et al.*³⁸ constructed the M test, a 33-item true-false scale to differentiate

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subjects simulating schizophrenic disorders from actual schizophrenics. A validation study conducted by Beaber, *et al.*³⁹ found that a discriminant analysis was able to differentiate university students, some of whom were instructed to answer questions honestly and others to malingering, from male schizophrenic inpatients. Although the study is of limited generalizability (see Rogers⁴⁰ for a review), forensic clinicians may wish to use the M test as a screening measure. This measure includes 15 items that represent rare or unusual psychotic symptoms (i.e., the M-scale). In an actual case of malingered command hallucinations, the authors found an overendorsement of these unusual psychotic symptoms.

The presence of command hallucinations has traditionally been seen as an important indicator of marked impairment. Spitzer and Endicott⁴¹ rated behavior that was considerably influenced by hallucinations in the severely impaired range (i.e., 21 to 30 on the Global Assessment Scale); a similar rating of impairment was recently adopted in the diagnostic nomenclature of DSM-III-R.⁴² However, Hellerstein *et al.*²⁰ found no significant differences between 58 patients with command hallucinations and a comparison group of inpatients with respect to length of hospitalization, assaultive behavior, or level of medication. On the basis of these data, they concluded that command hallucinations do not indicate a high risk for dangerous behavior and that most patients were able to ignore hallucinatory commands. These conclusions do not seem to be justified inasmuch as it is likely that the

hospital staff actively intervened with patients who were admitting to command hallucinations of a violent nature⁴³ and attempted to minimize their aggressive behavior.

Clinicians within forensic settings are left with the uncomfortable task of assessing command hallucinations with respect to issues of malingering, dangerousness, treatability, and criminal responsibility. In addition, it has been noted clinically that patients with command hallucinations are often reluctant to discuss them with hospital staff. Perhaps more than any other reported symptom, command hallucinations impose a heavy responsibility onto clinicians, given their potential for clinical and legal ramifications. Table 2 and the following discussion are presented as a preliminary framework for evaluating command hallucinations and their relationship to criminal behavior.

Five factors that should be considered in the forensic assessment of command hallucinations are premorbid criminal behavior, chronicity of command hallucinations, consistency of command hallucinations with the patient's wishes, the patient's relationship to the command hallucinations, and the patient's disregard for apprehension by police. These factors and representative clinical issues are summarized in Table 2. Within a forensic context, the clinician must be able to differentiate between psychotic and nonpsychotic motivation for criminal behavior. Thus, one emphasis of Table 2 is on the ability to distinguish factors, other than command hallucinations, that may be antecedents of

Table 2
Clinical Guidelines for the Assessment of
Command Hallucinations with Special
Reference to Criminal Behavior*

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- A. Premorbid criminal behavior
1. Was there a pattern of criminal behavior before the first psychotic episode?
 2. Is the most recent criminal behavior different from prior offenses in terms of type, frequency, or expressed motivation?
- B. Chronicity of command hallucinations
1. If the command hallucinations are chronic (typically the case), what factors contributed to compliance at this particular point?
 2. If this is the first reported command hallucination that resulted in criminal activity, has malingering been ruled out?
 3. Longitudinally, has there been an expansion in the patient's compliance from non-criminal to criminal actions?
- C. Consistency with patient's wishes
1. Did the command hallucinations sanction the patient's own intentions or plans?
 2. Did the criminal behavior achieve anything for the patient, in addition to obedience to the command hallucinations?
 3. If compliance with command hallucinations is variable (typically the case), what motivated the patient to comply at this particular point?
 4. How specific were the commands? If they were vague to the patient, how did he or she decide on a course of action?
- D. Patient's relationship with the command hallucinations
1. What is the nature and extent of the patient's relationship to the command hallucinations? How has it changed over time?
 2. What were the patient's reasons (e.g., compliance with a higher authority, perceived threats, blind obedience) for following the command hallucinations?
 3. If motivated by compliance to a higher authority, did the patient make this relationship known to others?
 4. If motivated by a perceived threat, how did the patient expect to extricate himself or herself?
 5. If motivated only by "blind" or "automatic" obedience, has malingering been ruled out?
- E. Disregard for apprehension
1. Did the patient plan or expect to "get away with" the crime? Was this because of his or her actions, or because of promises made by the command hallucinations?
 2. What precautions were taken by the pa-

Table 2 (continued)

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- tient to minimize identification or arrest?
 3. What actions were taken following the crime (e.g., creating an alibi, destroying evidence, fleeing) to avoid arrest?
 4. Were precautions or postcriminal behavior directly in response to command hallucinations?
 5. When arrested, were the reported command hallucinations only volunteered after more rational accounts of the criminal behavior had been offered? If so, has malingering been ruled out?
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* Components of Table 2 were adopted from Rogers, 1986, 1987a.

antisocial activity. Naturally, the presence of an antisocial personality disorder offers no immunity to psychotic disorders or command hallucinations.

An additional emphasis of Table 2 is on the timing of the command hallucinations and subsequent compliance. The issue of "Why now?" is paramount in identifying precursors to dangerous behavior and establishing issues of criminal responsibility. If an identifiable pattern emerges (e.g., increasingly intrusive command hallucinations with a diminution in the patient's control that results in both noncriminal and criminal compliance) then the role of command hallucinations can be established either for the assessment of treatability⁴⁴ or of insanity.⁶ In cases in which no pattern or an improbable pattern exist, the clinician is confronted with the task of ruling out malingering and attempting to establish precursors both of the command hallucinations and of the patient's often complex motivation for complying.

Conclusion

The clinical literature on command hallucinations does not represent the entire spectrum in terms of either phenomenology or patient compliance. Case studies often have a dramatic or unusual content (e.g., autocastration in response to hallucinatory commands). In addition, retrospective studies that rely upon hospital records^{20, 24} represent the clinical management concerns of the treating staff; these data are likely to underrepresent nonviolent command hallucinations that are either ignored or obeyed by the patient. However, on the basis of the available studies, it would appear that approximately one third of psychiatric patients with auditory hallucinations experience command hallucinations. Research has varied widely on the prevalence of antisocial commands and what proportion of these commands are obeyed. Within forensic settings, Rogers⁶ found that nearly six percent of insanity evaluatees were directed by hallucinations, whereas Taylor²³ found only 1.7 percent in her study of mentally impaired prisoners. One explanation for this discrepancy is that Taylor's research would not have included patients found chronically unfit to stand trial or not guilty by reason of insanity. In light of these studies, command hallucinations seem to be a very real issue, for a small but important number of forensic patients.

The clinical assessment of command hallucinations rests largely on unstructured and structured interviews. Resnick⁵ offered useful guidelines for evaluating the authenticity and psycho-

legal relevance of command hallucinations. Similarly, this article provides a preliminary framework for assessing the complex relationship between command hallucinations and concomitant criminal behavior.

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