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PROFESSIONAL PERSPECTIVES

Understanding and Helping People with Hallucinations Based on the Theory of Negative Legacy Emotions

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This article applies the new concept of negative legacy emotions to understanding and helping people suffering with psychosis and hallucinations. The theory of negative legacy emotions proposes that guilt, shame, and anxiety result from biological evolution, specifically to inhibit human self-assertion, willfulness, and aggression in personal and family relationships. Because human beings are so violent, the species would have destroyed itself if natural selection had not favored individual humans with inhibitory or restraining emotional reactions in personal relationships. Unfortunately, negative legacy emotions are crude responses that can worsen aggression and fail to provide adequate guidelines for ethical adult living.

Hallucinations share many qualities with guilt, shame, and anxiety, including a seemingly involuntary hold over individuals, making them compliant with them. Painful or disabling hallucinations are driven by guilt, shame, or anxiety. Rather than viewing hallucinations as essentially pathological or abnormal, this article examines them as a natural part of a continuum of the human creative imagination that are especially vulnerable to being overwhelmed by traumatic experiences and the resultant amplification of negative legacy emotions. These insights can help to liberate individuals from their psychotic and hallucinatory experiences to live by more rational and loving approaches.

Hallucinations have been a source of fascination for scientists and the public alike. They have a quality about them that seems both creative and primal. Psychoanalysts have suggested that hallucinations are, in fact, throwbacks to ''primitive mental states'' (Caper, 1998, p. 539). Clinically, psychoanalysts often mean *infantile* when they designate states as primitive; but there is also an underlying theory expressed in Freud's (1913/1990) *Totem and Taboo* that primitive peoples and ''neurotics'' possess similarly primitive states of mind. In psychoanalytic theory, these primitive states also share qualities with fantasies and especially with dreaming.

In a somewhat similar vein, Julian Jaynes (2000) proposed in his theory of the bicameral mind that primitive peoples experienced the world in a manner similar to that of modern

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individuals diagnosed with schizophrenia or psychosis. Instead of relying on conscious reasoning processes when facing new challenges, he argued that prehistoric people would receive advice, direction, or commands from hallucinated voices.

I find little evidence that prehistoric people relied on hallucinations for making important decisions, or that they existed in a mental state similar to infants. Native Americans, although living a Stone Age existence, were the intellectual equals of the arriving Europeans, displaying wisdom and leadership, organization skills, and learning to write eloquently in European languages and to participate effectively in unfamiliar Western societies (Josephy, 1994; Spence, 1914/1989).

There are obvious comparisons between hallucinations, hypnogogic experiences, and dream states. There are also comparisons between hallucinations and creative processes. Although lost to modern biological psychiatry, the idea that hallucinations are part of a normal spectrum of human experience is not new. Writing in 1890, psychologist and philosopher William James found that normal perception, dreams, illusion, and hallucinations are closely related. He pointed out the relationship between inner voices or talking to oneself and hearing voices coming from the outside. In addition, he related the potential for visual hallucinations to the strength of individual visualizing powers (James, 1890/1950).

I have compared people diagnosed with schizophrenia to wounded or broken poets who speak in metaphors that often reflect the abuse they have endured in childhood and young adulthood (Breggin, 1991, 21–46). Neglect and abuse in infancy and childhood has rendered into tatters their capacity for social relationships (Bowlby, 1998) and hence for connecting to others in a trusting, empathic fashion. In a state I described as *psychospiritual overwhelm* (Breggin, 1991), they lapse into helpless with fragmented thinking and communicating. In this study, I relate their hallucinatory "broken poetry" to my new theory of *negative legacy emotions* (Breggin, 2014). I show that their poetic metaphors and illusions in the form of painful or self-destructive hallucinations are expressions of guilt, shame, and anxiety, emotions that do have primitive origins in biological evolution and early childhood, and that this understanding can help in their recovery from self-defeating, disabling emotions.

THE THEORY OF NEGATIVE LEGACY EMOTIONS

The following sections summarize concepts that I recently presented and elaborated at much greater length in book form (Breggin, 2014).

The Need for Guilt, Shame, and Anxiety

For hundreds of thousands of years or more, humans have displayed a great capacity for violence, including the ability to band together to kill enormous animals while armed with little or nothing more than pointed sticks (Stiner, Barkai, & Gopher, 2009; Wenban-Smith et al., 2006). Even mankind's nearest ancestors, the chimpanzees, have the capacity for gang-like or war-like aggression (de Wall, 2005; Goodall, 1999). However, chimpanzees do not come close to displaying the unbridled ferocity against their own species that human beings have inflicted upon each other throughout known history, including modern times (Masson, 2014).

In addition to their immense capacity to unleash aggression, for hundreds of thousands, and probably millions, of years humans have been the most social creatures on Earth. The capacity to

band together for hunting and the emotional drive to bring back meat to the family and clan indicate a basic social, as well as a violent, nature. These hunting feats epitomized humanity's dual, conflicting nature—the capacity for social cooperation (Adler, 1927/2009) or "mutual aid" (Kropotkin, 1914) and the capacity for willful violence. As both the most violent and the most social creature on Earth, humans were likely to destroy themselves in their closest family and clan relationships unless they developed innate controls to inhibit the expression of willfulness and violence. As a result, natural selection favored those individuals who would respond with inhibitory or restraining emotions when in personal conflict within the family or clan.

Guilt, Shame, and Anxiety as Built-in Biological Reactions

Shame and anxiety have existed in every known society. Although some observers believe that early nonindividualistic societies may have not suffered from guilt, it too is found in some form in nearly all literature from the *Aeneid* to the Hebrew Bible, in nearly all known primitive cultures, and in all modern cultures (Scheff & Retzinger, 1991). In modern societies, all normal children will develop guilt, shame, and anxiety at an early age.

In addition, anxiety and shame have easily recognizable bodily manifestations, including autonomic nervous system arousal in anxiety and blushing in shame. The association between the specific emotion of shame or anxiety and the bodily reaction confirms that the capacity for these emotions was built in, biologically, to every individual before birth and then inevitably triggered or stimulated in childhood. Guilt also manifests itself physically, for example, in fatigue and gastrointestinal changes in many people, but these signs are less specific than those associated with anxiety and shame. Whether guilt is, itself, a basic biological reaction, or whether it is a derivative of shame as Scheff and Retzinger (1991) suggest, does not contradict its ultimate biological roots.

Implications for Existential Psychology

Although this formulation raises doubts about the existential *origins* of guilt, shame, and anxiety, it leaves considerable room for existential factors such the self-awareness, consciousness, the creation of values, and the awareness of death. Like every human drive that is biologically or instinctually based, including hunger and sex, the expressions of guilt, shame, and anxiety vary greatly among individuals, families, and cultures, and can be modified by both environment and individual choice; but they remain biologically based and are universal. However, in my own clinical experience (Breggin 1991, 1997, 2014), and probably that of most therapists, incapacitating human emotions are driven by early childhood trauma and stress, often compounded by losses or abuses in adulthood, and do not originate or emanate from considerations of our place in the universe or mortality. To the contrary, we tend to struggle with existential issues such as the meaning of life after becoming helpless in the face of guilt, shame, and anxiety, and consequent deterioration of our social relationships. Although psychiatrist R. D. Laing is associated with existentialism, his seminal book with Aaron Esterson (Liang & Esterson, 1964/1978), *Sanity, Madness and the Family*, documents the roots of so-called schizophrenic processes within the confusing, contradictory communications and attitudes within the family of the identified patient.

How Guilt, Shame, and Anxiety Function

As noted, the theory of negative legacy emotions begins with the observation that human beings have extraordinary capacities for both willfulness and violence, and for sociability and love. It tries to answer the question, "How can such a violent creature live in intimate relationships without destroying them?" A reasonable conclusion is that natural selection favored individuals who would experience these negative emotions in their family life and close relationships, but not necessarily in relation to people outside the family or clan against whom violence might be pro-survival.

The theory postulates that guilt, shame, and anxiety serve an interrelated function, and that they biologically evolved over millions years for the specific purpose of inhibiting willfulness and aggression within personal and family relationships (Breggin, 2014). In short, natural selection favored the development of guilt, shame, and anxiety as a built-in means for managing the problem created by two potentially conflicting human qualities: willfulness and violence versus sociability, empathy, and cooperativeness. Negative legacy emotions are a form of innate anger management.

Frustration, stresses, and trauma in infancy and childhood invariably trigger guilt, shame, and anxiety in the infant or child, usually surrounding experiences of conflict in relationships with caregivers and siblings. As a result, these emotions tend to be aroused later in life in response to self-assertion in general, often without regard for the ethical soundness or necessity for being self-assertive at the time.

Guilt tends to suppress assertiveness, willfulness, or aggression by directing blame and anger inward in a self-punitive fashion. Shame suppresses it by making the individual feel too impotent, ineffective or inconsequential openly to express or act upon anger. Although blame and anger are directed outward in shame, the individual typically withdraws, while running the risk of breaking out in anger. Anxiety disperses assertiveness so that no one or nothing is typically blamed, rendering the individual relatively helpless to act.

As described and documented in *Guilt, Shame and Anxiety* (Breggin, 2014), biological evolution has been working toward solving the problem over several million years by increasing the survival and reproduction of individuals who suffer from guilt, shame, and anxiety in the context of personal conflicts. People who inhibited their willfulness and aggression in personal relationships survived and reproduced better than those who did not. Unfortunately, there are also huge drawbacks to these biologically evolved emotional reactions, including their disruption of self-assertion, reason, and sound ethics.

The Negative Qualities of Guilt, Shame, and Anxiety

I have called guilt, shame, and anxiety *negative legacy* emotions. They are *negative* because they ultimately have a self-destructive influence on mature adult decision-making. They are *legacies* because every human being inherits them from the combined influences of biological evolution and childhood experiences. Guilt, shame, and anxiety are a basic part of the human fabric. They ultimately function by rendering the individual emotionally or subjectively helpless in the face of personal conflict, and hence unable to express willfulness and to inflict violence (Breggin, 2014).

Negative legacy emotions are primitive in that the capacity for them evolved biologically over thousands and millions of years and were probably in full expression by the Stone Age and the development of *Homo sapiens*. Guilt, shame, and anxiety are literally Stone-Age

emotions. They are also primitive in being uncomplicated enough to be embedded in our genes, built into people's bodies, and triggered in early childhood before children are old enough to understand what is happening.

Negative legacy emotions are also prehistoric in two senses. Most obviously, they are prehistoric because they biologically evolved as human capacities long before *Homo sapiens* came on the scene 50,000–150,000 years ago. They are also prehistoric because they are stimulated, elicited, or triggered in childhood before people can understand their impact, verbally describe them to themselves, or even recall most of the incidents that amplified or directed them.

Guilt, Shame, and Anxiety Are Impersonal

Negative legacy emotions feel like they are very personal. When one feels guilty, one believes oneself to be bad. When one feels ashamed, one thinks himself or herself to be worthless or to deserve rejection. When one feels anxious, one believes, for that moment, that one is helpless or even doomed. As I describe in *Guilt, Shame and Anxiety* (Breggin, 2014), none of this is true. Because these emotions were built in by biological evolution and then stimulated and shaped in childhood before the age of reason or even recollection, they can be viewed as having little or nothing to do with who one really is, and in particular, with one's positive capacities for reason, creativity, and love.

Psychotherapists sometimes encourage their clients to own these emotions and even to look for something they may have done to stimulate their guilt or shame. The theory of negative legacy emotions suggests that this approach in therapy is misguided and harmful. It is far more liberating and empowering to view these emotions as primitive, prehistoric relics of humanity's evolutionary and childhood past that should be seen as alien and of no worth in people's mature lives. While working on rejecting them, people can triumph over and transcend them with positive values including rational personal responsibility and a joyful approach to life.

Negative Legacy Emotions Are Poor Guides for Ethical Living

Because they are so primitive, negative legacy emotions are very poor guides for adult decision-making. They are indiscriminately demoralizing and self-defeating. Because they are primitive and prehistoric, the theory proposes that guilt, shame, and anxiety have no place in mature ethics or decision-making (Breggin, 2014). My clinical and forensic work, and broader studies as well, confirm that murder and violence in general are often driven by shame (Scheff & Retzinger, 1991). In doing so, shame breaks through ethical restraints, rather than enhancing them. Often the perpetrators feel no guilt whatsoever over harming anyone whom they blame for feeling disrespected or humiliated. Yet other people, based on different childhood experiences, may feel so much guilt, shame, or anxiety at the mere thought of being angry that they cannot protect themselves from aggression, even when it is ethically justified and might be life-saving. This lack of correspondence between negative legacy emotions and sound ethics is especially poignant in respect to victims of child abuse who feel guilt, shame, and anxiety about their traumatic childhood experiences, and who irrationally blame themselves instead of their perpetrators.

Guilt, shame, and anxiety are built into human nature and then elicited and shaped through childhood experiences and adult trauma that make people feel helpless and unable to act on their own rational choices and principles. Consistent with many teachings from Buddha and Christ to

Martin Buber and Martin Luther King, Jr., reason and love, and not on guilt, shame, and anxiety, should provide the basis for sound ethics.

Because they are crudely derived from biological evolution and childhood experiences, negative legacy emotions are relatively ineffective and flawed in performing their task of suppressing willfulness and anger or violence. When negative legacy emotions feel overwhelming to the individual, they can backfire. They can lead to the unintended effect of causing so much frustration that the emotionally suppressed individual becomes increasingly willful and violent in resistance to them. This is especially true in respect to shame, which drives most personal violence (Scheff & Retzinger, 1991).

THE THEORY APPLIED TO HALLUCINATIONS

Psychosocial Versus Biological Origins for Hallucinations

Criticism of psychiatry's compulsive drive to reduce psychospiritual to meaningless chemical aberrations has a long history and has met stiff criticism in the past. In lectures delivered in1901–1902, William James (1902/1929, p. 12) criticized ''medical materialism'' for dismissing religious visions as rooted in epilepsy. Anton Boisen (1971), who was involuntarily treated in a state hospital, in 1936 eloquently expressed the meaning he found within his psychosis. Neither James nor Boisen, however, had the benefit of being able to relate these experiences to the negative emotions which, as I suggested earlier, underlie these experiences before they become more elaborated as existential in nature.

In this article, I further an examination that I began in my book *Guilt, Shame and Anxiety* (Breggin, 2014) concerning the relationship between negative legacy emotions and potentially severe emotional problems, in particular hallucinations. Nearly all nonorganic hallucinations (not caused by a brain disorder and presumably psychogenic) are demoralizing and emotionally self-defeating, and are understandable as extreme expressions of guilt, shame and/or anxiety.

Psychiatrists routinely interpreted hallucinations as a sign of a mental disorder or a diseased condition. It is true that visual hallucinations, in particular, can result from organic brain disorders, for example, when alcoholics in withdrawal delirium see bugs crawling on the walls or when individuals taking hallucinogens such as LSD or marijuana see faces take on grotesque shapes. However, in the vast majority of cases, people with hallucinations show no evidence whatsoever of suffering from a physical or chemical disorder. They have no objective signs of brain malfunction, such as abnormal neurological functioning or impairments of intelligence, short-term memory function, or orientation. They do not develop cognitive impairments, delirium, or dementia.

Although most people associate hallucinations with schizophrenia, a review of the American Psychiatric Association (2014) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, confirms that they appear in many other psychiatric diagnoses, including brief psychotic disorder, posttraumatic stress disorder, major depressive disorder, and bipolar disorder. None of these psychiatric diagnoses are proven to be caused by malfunctioning of the brain or so-called biochemical imbalances (Breggin, 1983, 1991, 2008, 2013; Lacasse & Leo, 2005; Moncrieff, 2008; Pies, 2011).

There is a marked difference between hallucinations that are caused by brain dysfunction and injury, and those that are psychosocial or functional in origin. These clinical distinctions were

routinely made in psychiatry before it decided to promote the idea that all mental disturbances are biological in origin. When hallucinations are physical in origin, they generally lack meaning. That is, they cannot be understood in terms of the individual's internal conflicts and psychological state. Alcoholics, for example, see little things moving about the room; they attach no special meaning to them other than fear or loathing. Alzheimer's patients will see colored animals or faces in a curtain, but they will not attach meaning to them. It requires an intact brain to create meaning. When the brain is damaged by accident, disease, or intentionally with psychiatric drugs, electroshock treatment, or lobotomy, hallucinations tend to lose their vitality and meaning (Breggin, 1983, 1991, 2008). The exception to this occurs at times with hallucinogenic drugs such as LSD or marijuana, which can produce hallucinations that do reflect the individual's internal psychological life. They probably can do this because they are not inflicting sufficient brain dysfunction to render the person unable to create meaning.

The hallucinations discussed in this article relate to the creation of meaning, including the kinds of experiences psychiatrists diagnose as post-traumatic stress disorder, schizophrenia or mania.

60 Minutes Unwittingly Dramatizes Psychospirituality

On July 27, 1986, the TV program *60 Minutes* produced a show entitled "Schizophrenia" that promoted biopsychiatric theories. Speaking of schizophrenia, one of their experts declared, "We know it's a brain disease now. It's like multiple sclerosis, Alzheimer's Disease." Patients uttering supposed nonsense were put on display to impress the TV audience with the random, bizarre, and meaningless quality of their communications.[1]

The first *60 Minutes* patient, Brugo, identified himself with spirituality, as well as religion, and declared he was "not extinct."

> And I'm Croatian Hebrew, which is Adam and Eve's kin. And I have been Croatian Hebrew for centuries and cent—upon centuries. And I'm a Herto-erectus man, and I'm also part Neanderthal, and I mean to keep that heritage, 'cause I'm not extinct.

Packed into these few remarks were symbolic references to his desperate need for personal value and dignity, and his identification with religion and humanity. He also may be alluding to his awareness of primitive impulses stirring inside himself, as well as his fear of personal psychosocial extinction. Here is more than enough material to stimulate anyone's desire to communicate with him. Indeed, he seems to be skirting metaphorically around the edge of his biological evolutionary emotional heritage as a human being, much as I have tried to formulate more scientifically and rationally in my theory of negative legacy emotions.

The *60 Minutes* interviewer then dismisses the communications of the second patient, Jim, because Jim is "convinced he was shot to death when he was a baby." Yet his brief remarks seem like unmistakable metaphors for child sexual abuse by a male perpetrator:

> I had my head blown off with a shotgun when I was two years old. And—and before that, things happened in my crib. I remember all these things and stuff, but I just remember, you know. I remember all this stuff.

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[1]This section is modified from Breggin (1991, pp. 23–24).

Jim is almost certainly describing his memories of a series of child abuse experiences. Patients of mine have begun with similar anguished fragments of memory before discovering the agony of their childhood torment and torture.

Another *60 Minutes* patient, Ronnie, is struggling with his own identity and his separateness or isolation from people. He also talks in psychospiritual terms, again with undertones of sexual abuse:

> I thought everybody's bodies was connected to mine, and their—their spirits—were—I was—I was laying in bed and I played—you know how we live, where, you know, like you're smashing some air for yourself? Well, like, I was smashing every spirit next to me, and the—all kind of bad things were happening.

Still another patient, Lynn, identifies herself with God and with being "different," and tells viewers that her "wisdom" is more than she can handle. Lynn is practically inviting viewers to ask her about the inner knowledge of child abuse that she cannot bear:

> I've got the wisdom of God in me, and I have to learn how to cope with it. Nobody seems to think you're supposed to survive when you're different. [Crying] But I know—as—like the words in Job said, all I can say was, "Have pity on me, my friends. I've been touched by the hand of God."

Even in a carefully orchestrated attempt to show the meaninglessness of schizophrenic communications, one finds these words laced with meaning and references to abuse.

"Hearing Things" as a Natural Process

Auditory hallucinations are probably the most common, and they frequently occur in people who do not meet establishment criteria for mental disorders. Barrett and Etheridge (1992) found that 30–40% of individuals from the general population experienced hearing voices. Posey and Losch (1983–1984) summarized the results from surveying 375 college students:

> Overall, 71 percent of the sample reported some experience with brief, auditory hallucinations of the voice type in wakeful situations. Hypnagogic and hypnopompic hallucinations[2] were also reported. The most frequent incidents were hearing a voice call one's name aloud when alone (36%) and hearing one's thoughts as if spoken aloud (39%). Interviews and MMPI results obtained from twenty selected subjects suggested that these reports of hearing voices were not related to pathology. Further findings [include] a significant relationship between high rates of auditory hallucinations and the extent to which subjects reported skills in music, art, and poetry. (p. 99)

Posey and Losch confirm several points about auditory hallucinations: (a) They commonly occur as a natural or routine part of life; (b) they are not necessarily associated with emotional distress, trauma, mental disorders, or psychiatric diagnoses; and (c) they correlate with creative "skills" or an enhanced capacity for artistic creativity.

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[2]Hypnogogic images are in transition from awake to sleep and hypnopompic images in transition from sleep to awake.

The Continuum of Auditory Hallucinations

Auditory hallucinations are perhaps the easiest to grasp intuitively because they seem so obviously an extension of processes that people consider normal or natural and familiar. Most people have experienced "talking to myself" or conducting internal dialogues. Sometimes they are in response to stress, for example, in replaying how they wished they could have reacted during an argument. At other times, however, they are part of routine thinking about things of interest to them, including rehearsing how people want to communicate something in the future. The clarity with which people experience these internal voices varies enormously, so that some have only a vague sense of the actual sound of voices while others have a vivid experience that approaches or surpasses the clarity of real voices heard outside one's head in normal conversation.

Individual variability in hearing internal voices compares to the more familiar variability of hearing music within one's head. Many people are capable of hearing music inside their minds with the clarity of listening to speakers or a live concert. Musicians frequently write down what they are hearing inside their heads. Beethoven was deaf when he heard and completed his Ninth Symphony inside his head and wrote it down for others to enjoy. From talking with singers and musicians, it is apparent that many if not most have a lively interior experience of hearing music. Some can hear a song once or twice and then recall it in the privacy of their minds before singing it spontaneously in tune. I have seen birders accomplish something similar with bird songs.

In marked contrast, other people hardly hear anything inside their heads, and certainly not music. This "deficit" can hamper playing musical instruments or singing on tune. Those numerous people who hear music inside their heads can find it hard to believe that the experience is outside the realm of many other people. Not hearing things strikes them as abnormal.

People who easily hear things inside their heads can find it distracting. Tunes can become stuck inside their consciousness in any annoying or disruptive fashion. The hearing of music feels involuntary and they have to exert effort or wait for the passage of time to stop the music. Although entirely natural or normal, and indeed a gift, the involuntary hearing of music inside one's head begins to crossover into the arena of hallucinations that are involuntarily heard coming from the outside.

"Seeing Things" as a Natural Process

William James (1890/1950) pointed out that people differ widely in the power or availability of their visual *memories*. To illustrate whether people are visual or not, James suggested asking them to recall what they had eaten for breakfast. Some people, he pointed out, will see the breakfast table in their mind as if it were still in front of them; others will have to think about it while trying to remember cooking or tasting the food.

Hypnagogic images, which usually occur in the twilight zone between wakefulness and sleep, are very close to what are called hallucinations (Mavromatis, 1987), although informed mental health professionals are likely to view them as normal. These vivid visual experiences, usually occurring in transition to sleep, can feel completely real. However, the individual is likely eventually to realize he or she is or has been in a dream-like state. In his monumental study, Mavromatis not only views all hallucinatory-like human experiences as essentially normal, he also questions the distinctions between reality and nonreality routinely made in discussing these phenomena.

I have found that people vary enormously in their capacity to create new visual experiences, much as they do in respect to creating internal musical experiences. Decades ago in my practice as a therapist and psychiatrist, a woman complained that she saw things she was thinking about so vividly that they would interfere with her driving a car. Sometimes the images were emotionally impactful, such as recalling a childhood trauma that had come up in therapy; but at other times they were visualizing of routine thoughts or ideas. On occasion, she had felt the need to pull her car off the road to avoid hazardous driving when the visualizations were blocking her view of the road.

Puzzled by my client's experiences, I consulted a highly respected, humanistic and open-minded psychiatrist who told me that I should prescribe her antipsychotic drugs. Fortunately, I had already abandoned the medical model, and I instead suggested to her that she had amazing visual powers that she might put to good use. Within a short time, she had bought a motion picture camera, taken a course in filmmaking, and was enjoying her uncommon visual capacities by making films of her own. Although her great capacity to visualize continued, at times, to interfere with other activities, she now recognized it as a creative power that was in no way embarrassing or abnormal, and instead something to be proud of.

Since then, I have found that a number of friends and clients have similar powers of visualization that are, at times, difficult for them to manage. They rarely experience any grave risk or difficulty from the power to visualize. The most common problem occurs when driving a car while simultaneously talking with a passenger about something that abruptly stimulates visualizations, such as designing a web site, planning a menu, or figuring out a new arrangement of furniture in the home or office. Some find that thinking geometrically or mathematically automatically brings up visual images, whether they want them or not at the time.

On the other hand, much like people who cannot hear things inside their heads, there are those who have almost no visual capacity (Kosslyn, 2004; Pylyshyn, 2003). Face-blindness is a specific deficit in recognizing faces, but difficulty visualizing or having mental image pictures in general can lead to similar unfortunate consequences. At a conference, someone who is a poor visualizer might eat dinner with you the night before and fail to recognize you at breakfast. When visualization is broadly missing or undeveloped, these individuals cannot call up a picture of anyone or anything in their mind's eye and can only recognize friends whom they have repeatedly seen. Even then, they can easily become confused if they meet their friends out of context. Lacking visualization, they are likely to be poor spellers of English and to have a poor sense of direction. There is a surprisingly lack of research into people who lack visualization. However, a quick Google search will disclose that individuals are talking about it on the Internet, some remarking how that it took them by surprise to learn that other people do in fact see mental image pictures.

Like those who hear music in their heads, good visualizers find it hard to believe that anyone could lack the ability. Not seeing things strikes them as abnormal. In short, there is a broad range of auditory and visualization experiences in human beings, from almost none at all to being able to hear music in one's head and to create vivid pictures in front of one's face, and ultimately to hallucinate.

What Does this Variation Tell Us?

When a person has hallucinations—sees things that are not perceived by anyone else—they differ from strong visualizers largely in their nearly immutable belief that what they are seeing

is real, regardless of how bizarre or irrational it seems to others. Often these hallucinations are unpleasant or even demoralizing, traumatic in origin, and lead to being psychiatrically diagnosed.

Soldiers returning from combat will have flashbacks like waking nightmares in which they are once again in combat, terrified, and surrounded the by sights, sounds, smells and even tastes of battle. However, unlike typical hallucinations, when the flashback is over, and with the passage of a few minutes or more, these individuals no longer think the experience is real. They no longer believe that they are in combat.

Hallucinations can also result from traumatic losses. After losing a loved one, a man might see her in a restaurant or walking down the street, when it clearly is not her. For a moment, he feels elated, certain he has seen her; and then reality sets in, followed by disappointment.

Individuals who were emotionally, physically, or sexually abused in childhood frequently have flashbacks. However, they can also develop full-blow hallucinations in which they interpret and experience their visual or auditory experiences as undeniably real. In my clinical experience, individuals who have undergone intensive or ritualized sexual abuse in childhood may see and hear, and even physically feel, the presence of someone or something intrusive that relates to the abuse. Dark figures wearing masks can come through walls and grab them at night, driving them in terror to hide in a closet. Shadows can become terrifying shapes with glaring eyes that say threatening things that are similar to what they heard in childhood, such as ''Don't you dare tell anyone about me'' or ''You will be killed for resisting me.''

How do these apparitions differ from more routine visualizations? They are involuntary; but so are other visualizations, including hypnagogic images and the examples of people whose visualizations interfered with their driving. Most of the time (but not always), visual hallucinations are terrifying, and in this they do differ from people who routinely have nonhallucinogenic visualizations. Finally, the individual with hallucinations believes that the visualizations are actually occurring in the real world, when they are not. This lack of correspondence with reality is the hallmark of what are called hallucinations.

From this, one can conclude that visual hallucinations are visualizations that are usually terrifying, always seem beyond the individual's control, and most importantly appear to them as undeniably real. Although they are usually the product of suffering and induce emotional pain, they are the expression of an underlying capacity for visualization that is in no way abnormal but instead can indicate a valuable capacity to visualize.

Child Abuse and Hallucinations

Child abuse amplifies and shapes negative legacy emotions. The capacity for guilt, shame, and anxiety is built-in and even instinctual (Breggin, 2014), but the emotions are triggered and influenced by experiences in childhood. Great extremes of abuse result in great extremes of guilt, shame, and anxiety. Similarly, child abuse produces hallucinatory experiences, sometimes in proportion to the intensity of the abuse. Krippner, Pitchford, and Davies (2012) described how traumatized children reexperience the flashbacks as if they are real—that is, disconnected from any past experience: ''It is important to note that children have difficulty disassociating the experience of trauma to previous encounters. Rather, the re-experiencing takes the form of a constant, continuous, present threat'' (p. 21).

In my clinical experience, adults severely abused as children can experience hallucinations that similarly present to them a "constant, continuous, present threat." Like the children described by Krippner and his colleagues (2012), the hallucinations relate in content to abuse experiences but the children are unable to make the connection. When encouraged to recognize that they are hallucinating abuse, they can become terrified of the consequences. Abused children are invariably taught (brainwashed) that there will be dire consequences for communicating about their abuse, or even for believing that it really happened (Smith, 1993).

The relationship between childhood abuse and later psychotic experiences is thoroughly documented. Hammersley et al. (2003) confirmed: "There is evidence of a specific association between childhood sexual abuse and positive symptoms, particularly hallucinations, in patient samples, community samples, and also in surveys of schizotypal traits in ordinary people" (p. 543; citations deleted).

Out of 100 consecutive psychiatric admissions, Read and Argyle (1999) studied 22 patients with a history of either physical or sexual childhood abuse and then examined the data for the frequency and content of positive psychotic symptoms of hallucinations, delusions, and thought disorder. (*Positive* psychotic symptoms mainly include hallucinations and delusions, as well as disorganized and abnormal thinking.) They found:

> Seventeen of the 22 patients exhibited one or more of the three symptoms. Half of the symptoms for which content was recorded appeared to be related to the abuse. An analysis of the relationships between types of abuse and specific symptoms suggested that hallucinations may be more common than delusions or thought disorder among patients who have been sexually abused, particularly among those who have experienced incest, and that delusions may be more related to having been physically abused. (p. 1467)

According to Alemany et al. (2011):

> Psychological stress occurring during either childhood or adulthood has been related to psychosis. Childhood adversity as a form of psychological stress has been shown to be a risk factor for the development of psychotic symptoms in clinical samples and psychotic-like experiences in individuals from the general population. (p. 38, citations deleted)

In their own study of 533 individuals from the general population, Alemany et al. (2011) found "a specific relationship between childhood abuse and positive psychotic-like experiences in the general population" (p. 41). "The resulting prevalence rate indicated that psychotic-like experiences were quite frequent. Specifically, 40.7% of the sample often or almost always experienced at least one positive psychotic-like experience" (p. 39).[3]

That most hallucinations are demoralizing, dreadful, or terrifying provides a key to their origin. They are usually driven by the negative legacy emotions of guilt, shame, and anxiety. Almost every hallucination has an element of guilt, shame, or anxiety, and most of them are direct expressions of what I have called "emotional overwhelm" (Breggin, 1991, p. 21).

How do these hallucinations come about? They seem imprinted from childhood, much like traumatic flashbacks, but so deeply embedded that they persist and blend into reality.

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[3]The authors did not find an association between child *neglect* and hallucinations or psychosis.

In my clinical experience, reassuring or even happy hallucinations also begin in childhood and occasionally persist into adulthood. Children with ordinary childhoods develop imaginary friends and companions that seem real to them. They can also become lost in books, videos, or movies that, temporarily at least, become real to them. Abused children can hang onto these childhood capacities and then create hallucinated companions in adulthood. Again in my experience, individuals can more easily recognize these happier hallucinations as unreal. In clinical work, a person who sees both frightening and reassuring hallucinations may more readily realize and admit that the comforting rabbit that they see in the room might possibly be a creation of their imagination. They are not afraid that the rabbit will retaliate against being disclosed.

Common Qualities of Hallucinations and Negative Legacy Emotions

Hallucinations can be auditory, visual, tactile, gustatory (taste), or olfactory (smell). People with hallucinations experience them as entirely real and, when pressed, will argue strongly for their existence, despite their obvious unreality. The individual retains the subjective experience and the conviction of reality even when confronted with the seeming impossibility of the hallucinations being real, for example, a complex visual and auditory hallucination of a flock of birds that follows the person everywhere including into the confines of the therapist's office. In an empathic therapy setting, where trust is built, individuals can learn that their hallucinations are not real, but it is with great effort and frequent relapses along the way.

Individuals experiencing guilt, shame, and anxiety will often act in a similar fashion to people who are hallucinating. In therapy, for example, they will act as if guilt, shame, and anxiety have a reality of their own that is valid and that must be obeyed. When feeling guilty, they will argue that they deserve it; when feeling ashamed, they will argue that they must feel that way, given how they have been treated; and when feeling anxious, they will say that there is no other way to feel under the circumstances. They are compliant with their punishing, self-defeating emotions the way people feel driven to be compliant with their hallucinations. Once again, this demonstrates that guilt, shame and anxiety are not reliable guides to adult ethical decision-making.

Hallucinations are dominating and domineering in a way that makes their victims feel helpless to resist them. The same is true of guilt, shame, and anxiety, the underlying function of which, as negative legacy emotions, is to render the individual too helpless to assert himself or herself. When dealing with hallucinations or with guilt, shame, and anxiety, the therapist will often run into an abject refusal to face the emotional experiences and their childhood origins in order to overcome them (Breggin, 1991, 1997). These individuals feel genuinely helpless in the face of their emotions, much as others feel helpless in the face of their hallucinations. Hallucinations, like guilt, shame, and anxiety, are self-defeating experiences that tend to disrupt mature adult decision-making.

Hallucinations and Creativity

It is a mistake, I believe, to think of painful hallucinations as creations of the individual's imagination. If a therapist tells clients, "There are creations of your own imagination," they are likely to feel baffled and resentful. Why in the world would they want to imagine someone threatening or chasing them with a knife? In my therapeutic work, I find that distressing or

demoralizing hallucinations are not products of the individual's choice, although their existence or vividness does reflect a creative imagination. They are more like flashbacks impressed upon the child or young adult's brain and mind, stamped there in a seemingly indelible fashion by the horrors experienced. Nor are hallucinations best viewed as unconscious defense mechanisms. They are simply involuntary impressions, much as someone might see a horror movie and have difficulty shaking off the dreadful images. This is very much the sense of the quotes from schizophrenics cited from the *60 Minutes* show; the individuals are reporting and describing inexpressibly horrible experiences.

From a more positive perspective, it requires considerable visual ability to experience hallucinations. In that sense, the individual's creative powers make possible the hallucinations without causing them. Akin to people who have difficulty getting a musical tune out of their head, these people have visualization so deeply impressed upon them that they cannot shake them. If they lacked visual ability, they would not be able to experience the hallucinations. Because they have greater visualization ability than others, they may experience them more vividly. Nonetheless, they are not the result of conscious choice. However, conscious determination and self-understanding, as well as supportive and caring relationship, can provide the basis for people to learn to manage and even reject their hallucinations (Breggin 1991, 1997).

Overcoming Hallucinations Driven by Negative Legacy Emotions

Guilt, shame, and anxiety are the fundamental negative legacy emotions. They inhibit, mute, or redirect willfulness and aggression away from the people with whom one is in conflict. Negative legacy emotions are the result of natural selection enabling the survival and reproduction of people who have internal reflexive reactions that inhibit their willful and aggressive responses; but they simply do not work well, especially after childhood, and guilt, shame and anxiety become irrational burdens on adult rational decision making.

To recap, guilt accomplishes this inhibition by turning the blame and the anger inward. Shame enforces the inhibition by making individuals feel too impotent or inconsequential to assert themselves aggressively. Shame directs blame outward, but the individual tries to suppress feelings of anger out of feelings of helplessness. However, the feelings of humiliation can become so intolerable that the desire to retaliate overcomes the sense of powerlessness with the unleashing of violence. Anxiety befuddles individuals, dispersing their anger, and rendering them too helpless to take willful, aggressive actions.[4]

When people are feeling profoundly depressed, their hallucinations are likely to be guilt-driven. They feel that they are bad or even evil, and that is what the voices tell them. "You are bad," "You are no good," "You bring it all on yourself," "You've got no one to blame but yourself," "You're always hurting people," "Look what you've done to your mother," "Just your being there hurts your children," "You don't deserve to live," and "Everyone will be better off if you were dead." Their sense of being evil may be so great that they hallucinate an evil stench emanating from their body.

[4]This conception of how negative legacy emotions manage anger and yet can cause anger is elaborated in Breggin (2014).

In my clinical experience, individuals diagnosed with major depressive disorder are usually suffering from enormous, paralyzing guilt, often related to child abuse (Breggin, 1991). If they have hallucinations or delusions, they the hallucinations are likely to be guilt-driven; but they can also be mixed with shame and anxiety.

One of my hospital patients during my training heard a voice telling her things like "do the laundry" and "wash the dishes." We were able to identify the voice as that of her mother during her childhood, and she was able to gain some control over the voices by standing up and declaring, "Mom, stop nagging me. I'm a grown up."

I am very much in agreement with the Voice Hearers Network (Romme and Escher, 2000) who believe that most people usual hear voices in response to earlier trauma and abuse. They too point out that the content of the voices often relates to hateful, threatening remarks made to the victim by childhood perpetrators. Voice hearers reject psychiatric diagnoses and drugs, and instead seek self-empowerment through new ways of relating to their voices, from making friends with them to talking back to them.

Most hallucinations are shaming (Breggin, 1991, 2014). Voices say things like, "You are worthless," "Nobody would love you," "I'm all you've got," "Who do you think you are?", "You have no chance of getting anywhere," "Stop acting like you're somebody special," and "You'll blow it if you try." If the individual is asked in therapy to talk about the hallucinations, the voices will take over and harangue the victim: "Nobody will believe you," "People will think you are crazy" or "You'll just look stupid." All of these hallucinations closely parallel the brainwashing described by Margaret Smith (1993) in her book about ritual sexual abuse. Although not usually in such a systematic fashion, in nonritual sexual abuse the perpetrators also make the children feel guilty, ashamed, and anxious about standing up for themselves or about reporting their tormentors.

People who are diagnosed as schizophrenic are commonly experiencing overwhelming shame reactions (Breggin, 1991, 2014) and their hallucinations are usually humiliating. In addition, these individuals are frequently overcome with anxiety, in which case the hallucinations are profoundly threatening.

People with anxiety-driven hallucinations will hear threatening voices, often related to making sure that the victim does not talk about the hallucinations or the underlying child abuse. The voices may say, "You'll wish you were dead," "You're better off killing yourself," "You are going to die in the worst way," and "You'll be screaming but no one will hear you." They may also issue commands for the individual to kill himself or herself to end the torment. Especially in response to extreme, ritualized abuse, the individual may see threatening figures, and even feel their grasp. Especially at night, dark figures or bizarre shapes may seem to come out of the wall with such reality that the victim flees into a closet to hide like a terrorized child.

Therapists, psychiatrists, and other people can be with individuals without realizing that they are undergoing bombardment with visual and auditory hallucinations. You may see them blink, cover their eyes momentarily, or flinch for a split second. At a moment when the therapist anticipates that the patient or client will be pleased by a warm exchange, encouragement, or a happy occurrence, the individual beleaguered by hallucinations may become silent and grim. He or she may hunch over, twitch, glance away, or look at something in the corner, as the hallucinations threaten to retaliate for any flickering sign of daring to become assertive enough to wish for a moment of happiness or even peace.

Negative legacy emotions of guilt, shame, and anxiety are typically elicited during childhood at exactly the moment a child attempts to be self-expressive, assertive, or demanding. Because hallucinations are driven by negative legacy emotions—guilt, shame, and anxiety, with underlying emotional helplessness—they are likely to rear up with special vigor when the individual thinks about expressing any willfulness or aggression. For individuals who have been abused, even a glimmer of hope or to wish for some small measure of happiness may bring down fear of the childhood abusers in the form of humiliating, hateful hallucinations.

In working with people who have painful or demoralizing hallucinations, it can be helpful for them to realize that their hallucinations originated in child abuse. They can be encouraged to see them as tied to negative legacy emotions that they can learn to manage and even to get rid of. Ultimately, they can replace the guilt, shame, and anxiety, and painful hallucinations, with conscious positive visualizations and with positive principles of living, including sound ethics and love (Breggin, 2014).

Many people who hallucinate have extraordinary auditory and visual capacities. Otherwise, they would not be able to hear and to see things so vividly that their reality becomes indisputable to them. After they grasp that their hallucinations are not real but result from early abuse, they can learn to create more life-enhancing auditory and visual experiences. They can also become empowered by the realization that the creation of elaborate, meaningful hallucinations may be beyond the capacity of other people. They may feel encouraged to explore and to express their creativity. No good will come from diagnosing them and treating them with drugs (Breggin, 1983, 1991, 2008, 2013). However, they can learn to experience their power as individuals and to create better lives for themselves through a variety of therapeutic approaches based on empathy and healing family conflict and emotional strife (Breggin, 1991, 2008, 2013; Whitaker 2002, 2010).

Many people can find relief in understanding that their guilt, shame, and anxiety—including their distressing hallucinations—are not something that they deserve or must comply with and obey. Impersonal and beyond their control, these negative legacies were built in by biological evolution, triggered in childhood, and amplified by trauma and abuse. Seeing that guilt, shame, and anxiety are *impersonal*—that they are primitive, prehistoric, negative legacy emotions—can help people to reject these self-defeating emotional reactions in favor of more life-enhancing feelings, attitudes, and values (Breggin, 2014).

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REFERENCES

Adler, A. (2009). *Understanding human nature*. London, England: Oneworld. (Original work published 1927)

Alemany, S., Arias, B., Aguilera, M., Villa, H., Moya, J., Ibáñez, M. I., ... Fañanás, L. (2011). Psychotic-like experiences, childhood abuse, the BDNF-Val66Met polymorphism and adult psychosis. *British Journal of Psychiatry, 199*, 38–42.

American Psychiatric Association. (2014). *Diagnostic and statistical manual of mental disorder, fifth edition.* Washington, DC: American Psychiatric Association.

Barrett, T. E., & Etheridge, J. B. (1992). Verbal hallucinations in normals. I: people who hear voices. *Applied Cognitive Psychology, 6,* 379–387.

Boisen, A. (1971). *The exploration of the inner world.* Philadelphia, PA: University of Pennsylvania Press. (Original work published 1936)

Bowlby, J. (1998). *A secure base: Parent-child attachment and healthy human development.* New York, NY: Basic Books.

Breggin, P. R. (1983). *Psychiatric drugs: Hazards to the brain.* New York, NY: Springer.

Breggin, P. R. (1991). *Toxic psychiatry: Why empathy, therapy and love must replace the drugs, electroshock and biochemical theories of the "new psychiatry."* New York, NY: St. Martin's Press.

Breggin, P. R. (1997). *The heart of being helpful: Empathy and the creation of a healing presence.* New York, NY: Springer.

Breggin, P. R. (2008). *Brain-disabling treatments in psychiatry: Drugs, electroshock and the psychopharmaceutical complex, second edition.* New York, NY: Springer.

Breggin, P. R. (2013). *Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families.* New York, NY: Springer.

Breggin, P. R. (2014). *Guilt, shame and anxiety: Understanding and overcoming our negative emotions.* Amherst, NY: Prometheus Books.

Caper, R. (1998). Psychopathology and primitive mental states. *International Journal of Psychoanalysis, 79* (Pt 3), 539–551.

de Waal, Frans B. M. (2005). A century of getting to know the chimpanzee. *Nature, 437,* 56–59. doi:10.1038/nature03999

Freud, S. (1990). *Totem and taboo: Resemblances between the psychic lives of savages and neurotics.* New York: W. W. Norton & Company (Original work published 1913).

Goodall, J. (1999). *Jane Goodall: 40 years at Gombe.* New York, NY: Stewart, Tabori & Chang.

Hammersley, P., Dias, A., Todd, G., Bowen-Jones, K., Reilly, B., & Bentall, R. (2003). Childhood trauma and hallucinations in bipolar affective disorder: preliminary investigation. *British Journal of Psychiatry, 182,* 543–547. doi:

James, W. (1929). *Varieties of religious experience.* New York, NY: Modern Library. (Original work published 1902)

James, W. (1950). *Principles of psychology,* volumes I & II. New York, NY: Henry Holt. (Original work published 1890)

Jaynes, J. (2000). *The origin of consciousness in the breakdown of the bicameral mind.* New York, NY: Houghton Mifflin.

Josephy, A., Jr. (1994). *500 nations.* New York, NY: Alfred A. Knopf.

Kosslyn, S. T. (2004). Mental images and the brain. *Cognitive Neuropsychology, 22*(3), 333–347. doi:10.1080/02643290442000130

Krippner, S., Pitchford, D. B., & Davies, J. (2012). *Post-traumatic stress disorder.* Westport, CT: Greenwood.

Kropotkin, P. (1914). *Mutual aid: A factor of evolution.* Boston, MA: Porter Sargent.

Lacasse, J. R., & Leo, J. (2005). Serotonin and depression: A disconnect between the advertisements and the scientific literature. *PLoS Medicine, 2*(12): e392. doi:10.1371/journal.-pmed.0020392.

Laing, R. D., & Esterson, A. (1978). *Sanity, madness and the family.* New York, NY: Penguin Books. (Original work published 1964)

Masson, Jeffrey Moussaieff. (2014). *Beasts: What animals can teach us about the origins of good and evil.* New York, NY: Bloomsbury.

Mavromatis, A. (1987). *Hypnagogia: the unique state of consciousness between wakefulness and sleep.* London, England: Routledge and Kegan Paul.

Moncrieff, J. (2008). *Myth of the chemical cure: A critique of psychiatric drug treatment.* New York, NY: Palgrave Macmillan.

Pies, Ronald. (2011, June 11). Psychiatry's new brain-mind and the legend of the "chemical imbalance." *Psychiatric Times,* p. 1.

Posey, T. B., & Losch, M. E. (1983–1984). Auditory hallucinations of hearing voices in 375 normal subjects. *Imagination, Cognition and Personality, 3,* 99–113.

Pylyshyn, Z. (2003). Return of the mental image. Are there really pictures in the brain? *Trends in Cognitive Science, 7*(3), 113–118. doi:10.1016/S1364-6613(03)00003-2

Read, J., & Argyle, N. (1999). Hallucinations, delusions, and thought disorder among adult psychiatric inpatients with a history of child abuse. *Psychiatric Services, 50*, 1467–1472.

Romme, M., & Escher, S. (2000). *Making Sense of Voices: A Guide for Mental Health Professionals Working with Voice-Hearers*. London: MIND.

Scheff, T. J., & Retzinger, S. M. (1991). *Emotions and violence: Shame and rage in destructive conflict*. Lanham, MD: Lexington Press.

Smith, M. (1993). *Ritual abuse*. San Francisco, CA: HarperSanFrancisco.

Spence, L. (1989). *The myths of North American Indians*. New York, NY: Dover. (Original work published 1914)

Stiner, M. C., Barkai, R., & Gopher, A. (2009). Cooperative hunting and meat sharing 400–200 kya at Qesem Cave, Israel. *Proceedings of the National Academy of Science, 106*(32), 13207–13212.

Wenban-Smith, F. F., Allen, P., Bates, M. R., Parfitt, S. A., Preece, R. C., Stewart, J. R., ... Whittaker, J. E. (2006). The Clactonian elephant butchery site at Southfleet Road, Ebbsfleet, UK. *Journal of Quaternary Science, 21*, 471–483.

Whitaker, R. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. Cambridge, MA: Perseus.

Whitaker, R. (2010). *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York, NY: Crown.

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