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# Auditory Verbal Hallucinations in Schizophrenia, Part II

## *Phenomenological Qualities and Evolution*

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**Abstract:** Hallucination is defined in the diagnostic systems as an experience resembling true perception without causal stimulus. In this second report from an in-depth phenomenological study of schizophrenia patients experiencing auditory verbal hallucinations (AVHs), we focused on the phenomenological qualities of AVHs. We found that a substantial proportion of patients could not clearly distinguish between thinking and hallucinating. The emotional tone of the voices increased in negativity. AVHs became more complex. Spatial localization was ambiguous and only 10% experienced only external hallucinations. There was an overlap with passivity phenomena in one third of the cases. The patients occasionally acted upon the content of AVHs. In the discussion section, we criticize the perceptual model of AVHs. We conclude that the definition of AVH in schizophrenia is misleading and exerts negative consequences on the clinical work and empirical research.

**Key Words:** Auditory verbal hallucination, schizophrenia, phenomenology, perceptual model, diagnostic criteria

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Auditory verbal hallucinations (AVHs) constitute a major psychiatric symptom and index the diagnosis of a psychotic disorder. Hallucination is considered to be a perception-like experience without causal stimulus. This generic definition applies to AVH in schizophrenia according to *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*, and ICD-10 and 11. The status of AVH with respect to mode of presentation, diagnostic significance, and pathogenetic issues is still a matter of ongoing debate and research. Recent reviews of the literature have uniformly emphasized the need for qualitative studies that focus on a comprehensive picture of psychopathology associated with AVH (Larøi et al., 2012; McCarthy-Jones et al., 2013; Waters and Fernyhough, 2017; Woods et al., 2014). It is important to emphasize that many of the crucial issues concerning AVH have been addressed in German and especially, French psychopathology. These sources are largely unknown to the contemporary reader (Parnas and Urfer-Parnas, 2017).

In a previous report, we have described the mode of onset of AVHs and their duration before disclosure and associated psychopathology in 20 mainly readmitted patients suffering from schizophrenia (Yttri et al., 2020).

Our orientation is phenomenological in the sense of continental phenomenological psychopathology initiated by Karl Jaspers (1997) (for the distinctions between uses of this term, see Parnas and Zahavi,

2002). The goal is to obtain a faithful description of the patient's contents and modes or forms of experience. Such an approach presupposes a face-to-face interaction between the psychiatrist and the patient, a semistructured narrative, or conversational conduct of the interview, which allows for spontaneous self-descriptions. Moreover, the interviewer needs to be highly trained and knowledgeable (Nordgaard et al., 2013; Parnas and Sass, 2008; Parnas et al., 2013).

In this second report from our sample of 20 patients with schizophrenia, we try to examine the following domains of AVH:

- 1) From thoughts to voices
- 2) Change in AVHs over time
- 3) Spatial localization of AVHs
- 4) Acting on the commands of AVHs
- 5) Overlap between AVHs and influence phenomena

In the *Discussion* section, we will articulate some basic phenomenological generalities on the nature of ordinary perception and of the AVH in schizophrenia, which do not support the current definition of AVH as a variant of perception.

## METHOD

The methodology is described in Yttri et al. (2020). In brief, we recruited 20 patients (mean age, 32 years; range, 18–53 years; eight men) who all suffered from paranoid schizophrenia. They were diagnosed according to ICD-10 and accepted the invitation to participate in the interview study. Sixteen patients were rehospitalized, 2 patients were admitted for the first time, and 2 patients were in outpatient treatment but had been hospitalized before. All patients reported hearing voices. We selected patients who could tolerate lengthy interviews. Additional exclusion criteria comprised organic brain disorder, clinically significant alcohol or drug abuse, aggressive and hostile behavior, and forensic status. The relevant ethic committee accepted this study. All the patients were interviewed by J.-E. Y., an experienced psychiatrist and a consultant at the Psychiatric Center Glostrup. The interviews were conversational, aiming at a self-description of the patient's experience, and were semistructured in the sense that the interviewer was obligated to ask the questions concerning the target domains listed in the introduction. In that sense, the approach was top-down. However, the last domain (overlap with influence phenomena) was articulated on the basis of the transcripts. The interviews were taped and transcribed verbatim. The material was independently evaluated by all the authors (research experienced clinical psychiatrist in a position of consultant), and consensus discussions were used among the investigators to divide the transcripts into the target domains of the study and detect possible additional topics (bottom-up).

This study took place in 2018 in the catchment area of Psychiatric Center Glostrup, servicing 300,000 inhabitants of the greater Copenhagen area.

## RESULTS

Before we proceed with the presentation of the specific results of the study, we will briefly summarize the findings reported previously from the same sample (Yttri et al., 2020). The most striking result

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The study was conducted according to research standards, including obtaining informed consent from the study subjects. The study has received the local ethics approval.

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was a long delay between the beginning of AVHs and their disclosure to the psychiatric personnel. The mean age of beginning of AVHs was 16 years, and the mean duration of AVHs at the time of first examination was 6.5 years. Second, the naming of the AVHs as “voices” typically happened during the contact with psychiatric treatment facilities with the help of a psychiatrist. None of the patients considered their voices as a sign of illness comparable to a medical condition and many patients saw their experiences as being reflective of a special contact with a hidden dimension of reality. Finally, the experience of AVHs was embedded in a plethora of anomalies of subjective experiences, currently called “self-disorders.” Importantly, many patients experienced a diminished sense of self-presence and an experiential distance between the sense of self and their thinking, often resulting in hearing thoughts being spoken (*Gedankenlautwerden*).

Here, we report the qualitative and developmental findings from our current analysis.

## From Thoughts to Voices

At the start of the experience of AVHs, most patients had difficulty to distinguishing between thoughts and voices. Many of these patients continued with this insecurity at the time of examination.

Some patients described that the articulation of voices was preceded by the interruption of the stream of consciousness. Certain thoughts acquired a phenomenal salience by a disconnection to the main theme of thinking, diminished sense of mineness (“it is not me”), and a surprising content. The patient started to attend to the apparent messages emerging in the midst of their thinking. The experience was uncontrollable, and the quality of the experience was mostly described as voices in the head. The patients who were able to make the distinction between thoughts and voices based this distinction on the novelty, strangeness, and the alien character of the experiences. Those who could not initially separate AVHs from thoughts acquired such ability after a period.

Case 18: “In the beginning, I didn't know if it was my own thoughts, or if it was the voices. I mixed them together a lot.”

Case 8: “It is really difficult to separate thoughts and voices, because it is kind of the same.”

Case 3: “It's really hard to separate. Because sometimes I have thought pressure, and then I get in doubt if it is the voices, I can hear. Other times the voices pretend to be thoughts, because they do not want me to take medication. But it is as if I have learnt that my thoughts are not so violent and dramatic as the stuff my voices want me to do.”

Case 4: “In the beginning, I thought it was my own thoughts that was being read louder and louder. But when it became very loud, I figured out that it was voices.”

Case 9: “I could hear that it was not my own voice. It was as if it was a radio that scattered a bit, or as if one speaks through the radio. I could hear that it was not myself. I don't know how, but I just sensed that it was not me. Because something was said that I usually did not think. Like ‘it is your fault.’”

Case 6: “It was something new. I could clearly feel the difference between what I think and what I hear.”

Often, the same patient provided internally discrepant description, for example, “loud and clear as normal voices” and “did not know what was what.” It was as if the normal experience of a voice and an AVH were in two different dimensions of reality. One patient explained that she “registered” the voices instead of hearing them. Some patients also described that they could feel the presence of the voices even when

they could not hear them or that they could sense that the voices were talking negatively about them without being able to hear them.

Case 10: “I hear voices all the time. I register them, but it is as if... If you imagine a room where the floor is dry. That is a person without voices. And then there is only that person inside that room. But I imagine when I am inside that room hearing voices, that the floor is wet. And when walking around inside the room I hear splashing. And it is simply as if I register it as if there is someone inside the room making a sound other than me.” [...] “It is as if you sit there and think a thought, and then it appears in my head. And then I register it, but the sound is different, not as it used to be.”

Case 1: “There is sound on my thoughts. There has always been sound on my thoughts. It is as if I think with my own voice. And my male voices, they are my voices, and my voice is my thoughts. I separate voices from thoughts in that way. [...] In the good periods it is as if I can feel that they are there, but I cannot hear them.”

Case 4: “When the voices are ongoing, I almost feel as if I am in another world, where there are no other people but me, and where I only hear voices.”

## Change in AVH Over Time

In all patients, we observed a qualitative change in the character of voices over time. During the first episode of AVH, 5 patients heard their name or a single word, 10 patients experienced at the onset second-person AVHs, whereas only 5 patients started with voices commenting or discussing in the third person. At the time of the interview, most ( $n = 14$ ) experienced voices discussing, whereas the remainder, 6 patients, experienced second-person hallucinations. The developmental change was a gradual process that happened over months to years. In all cases, the content of voices was self-referential. The voices could comment on other people's behavior, which was related to the patient, for example, “they are looking at you.” With time, the content of the voices became increasingly negative and destructive. At the interview, all patients experienced negative content. In certain cases, the content could oscillate among negative, neutral, and positive. At the time of the assessment, 13 patients experienced voices urging them to commit suicide. Only two patients never experienced such command, whereas five patients did not address this issue explicitly, but only hinted to the suicidal content.

Case 1: She was 11 when she first heard an unknown male voice. The voice asked her questions like “what have you been doing today” and “how are you.” During the next month, more male voices emerged. They started commenting her thoughts and actions and discussing her in third person. “Why is she eating so much?” “It is probably the reason why she is fat.” They became more and more negative, encouraging her to commit suicide and self-harm.

Case 2: He was 27 when he started hearing an unknown, male voice calling his name. Some months later, when he was at work, the same voice started commenting his actions. “Now he is driving” and “now he is drinking coffee.” Within the next weeks to months, the voice became more and more intense and negative, encouraging him to commit suicide or become violent.

Case 3: She was 3 years old when she started hearing voices. It was two female voices telling her to hurt a boy that was teasing her. “Take that spade and hit him.” It has been the same two voices all the years. Now they discuss her in third person; “look, she is not listening” “now she is making trouble again.”

Nineteen patients ascribed sex to their voices. Only one patient did not ascribe sex to the voices but said that they had a male

expression. Another patient explained that he heard both a male voice and voices without sex or identity. One patient also ascribed color to the voices.

### Spatial Localization of AVH

Nine patients could not localize voices as being “inside or outside the head.” They experienced AVHs as diffusely everywhere or changing from inside to outside. Nine patients experienced AVHs only from inside the head and two only from outside the head. In many cases, it seems to us that the ascription of localization in terms of an objective space was in fact devoid of meaning for the patient. Furthermore, some descriptions could indicate an experience of some sort of foreign body penetrating the patient and even possessing multisensorial characteristics.

Case 10: “The voice came from outside the left ear, about 20 cm outside from me. And then it went into my head, through my head, and through the other ear. It felt as if it was going through me.”

Case 4: “It is hard to say if they are inside my head, or if they for example come from that corner over there.”

Case 11: “If I go into my room, it is as if I can hear them from the garden.”

Case 8: “I feel it is inside my head, but I hear them right now, and now it feels as if they come from the outside. The black voice come from 1 m outside the left ear. The green and yellow voices come from further away than the black voice. But the green voice fills more than the yellow voice and comes from a meter further ahead. It can sometimes fill so much that my ear burns, but that is mostly the black voice. Sometimes, there can be so many voices that it feels like being to a concert or party, and then the voices can be anywhere.”

Several patients experienced limited space in the head and, thereby, difficulties to contain both thoughts and voices simultaneously. Similarly, many patients were able to spatially localize their thoughts.

Case 8: “Sometimes, I get headache because there are so many thoughts moving around. And then they are localized here, in the forehead. At other times, when there are many voices, they (the thoughts) are also located in the back of the head.”

Case 1: “The thoughts are mostly placed in the frontal part of the head. It is as if they move in the front. They move in front, and if I do it right, it is as if they nudge the voices back.”

Case 10: “And then they (the voices) simply did that, that they took everything in the back of my head and closed it off, and the only place I had left to think was my forehead. I could think in my frontal lobe. (...) I did not have the possibility to think, I could not finish a thought, because there was no space to finish the thought. Because they (the voices) had taken all space.”

### Acting on the Commands of AVHs

Fourteen patients had acted upon the commands of their AVHs at least once. In these cases, the AVHs were compelling and intrusive. There was a strong attraction (proximity) between the voice and the sense of self. The patient felt invaded without possibilities to escape and thereby forced to listen. It was almost impossible to resist acting on the commands of the AVHs. For some patients, acting on the commands of the voices was a way of getting temporarily peace from the voices. In other cases, it seems that acting upon voices was correlated with the overall severity of the psychotic state.

Case 1: “The voices told me to sit in my bed, because I ought to die, and it had to be now. So, I put fire to my bed. And the apartment burned down.”

Case 14: “I took a lot of pills because someone told me to do it.”

Case 11: “I feel there is this unbalance inside of me, making it difficult to feel myself. Where I look at the mirror and feel... it is me or it is someone else thought-wise. As if I am controlled to do something I do not want to do. It can be to hurt myself, but also to hurt others.”

Case 2: “This Sunday the voice told me to go berserk. That I should throw things and hit someone.” “Did you do it?” “Yes.”

### Overlap Between AVHs and External Influence

In many cases, the description of voices contains an element of foreign agency. In one third, there was an explicit overlap between AVHs and external influence. Some patients consider voices as a telepathic phenomenon.

Case 10: Those who talk to me, those who puts thoughts into my head (...) Sometimes she virtually controls me. Then it is as if she controls my body and decides what I should do (...) “Now I raise your arm.”

Case 12: “I have always felt that there was a woman controlling me and talking to me, telling me what to do.”

Case 11: “Sometimes I have heard it as if my own thoughts have become loud in my head, and then I get in doubt if it is my own thoughts. Or if they are thoughts that come from the outside.”

Case 9: “Sometimes it (the voice) takes over my body and makes me walk. I was hospitalized, and then it was as if he (the voice) took control over my body. I could see that I was walking, but I could not stop it.”

Case 3: “When I was a child, I felt that someone had stolen the remote control to my body. And was controlling me. Because even when I did not want to hurt people, the voices wanted me to do it, and then it ended with me doing it, just to get some peace.”

## DISCUSSION

This qualitative study responds to the call for detailed phenomenological accounts of AVHs, including contextual issues and concomitant psychopathology (Larøi et al., 2012; McCarthy-Jones et al., 2013; Uptegrove et al., 2016; Waters and Fernyhough, 2017). We will first address the limitations of the study, followed by a discussion of the presented results. Finally, we will discuss the phenomenological issue of perception and AVHs in general terms, based on our own and other's empirical and clinical phenomenological studies.

### Limitations

The sample size is limited because of the qualitative nature of the study and thus a resource demanding conduct and analysis of the interview. The sample consists of rehospitalized patients, which probably resemble rehospitalized patients with schizophrenia. It is well known that patients with schizophrenia become hospitalized several times during their lifetime (Bleuler et al., 1976; Ciompi, 1980; Huber, 1997). Thus, we cannot provide an epidemiological generalization, but we believe that our qualitative results apply to most patients with schizophrenia, which is consistent with our clinical experience and studies of the literature (see below).

## Current Results

Our study points to a clear developmental nature of AVHs. Such nature is primarily manifest in the long temporal duration and evolution of AVHs before disclosure. The mean temporal interval between the first emergence of anomalous experiences and a full articulation of AVH was 6.5 years. Thus, in 10 of our cases, the hallucinatory experiences began in childhood or adolescence (Yttri et al., 2020). This finding is concordant with the results of the birth-cohort studies reporting that hallucinations at ages 11 and 14, respectively, were highly predictive of adult nonaffective psychosis (Cannon et al., 2002; Welham et al., 2009).

Another developmental feature consisted in an increasing complexification of voices. The voices typically started as single words and ended in two thirds of the cases with the Schneiderian phenomena of voices discussing or commenting. On the level of pure content and emotional tone, the development was characterized by increasing negativity and solicitation to suicide. Importantly, the content was always about the subject herself and no other issues.

Many patients were continuously in doubt whether their experiences merited the name of voices or merely thoughts. In fact, in most cases, the original anomalous experiences were considered by the patients to be “thoughts” or “thought-like.”

With respect to the localization and the nature of the hallucinatory space, several participants were not able to determine whether voices were “internal” or “external.” Nearly half of the patients experienced internal voices only, and only 10% exclusively external voices. This finding is similar to that of Jones and Luhmann (2016), who found only external voices in 17% of their patients. In many cases, the description of the experience of external voices contained a subjectivized view of the space, which did not correspond to the nature of objective social space (e.g., hearing at a distance), incompatible with the laws of acoustics such as hearing voices being diffusively everywhere. In other words, the issue of localization seems to be quite ambiguous, without a clear significance for the patients, and reflective of the subjective nature of the hallucinatory space. These findings testify to the fragile nature of the spatial dimension of the experience; in fact, the voices seem “to come from nowhere” (Gennart, 2011, p. 486).

Most patients occasionally acted upon the commands of the voices. Finally, there was a clear overlap between voices and passivity phenomena (influence phenomena) in one third of the cases. Moreover, several other patients described their voices in a way that implicitly indicated that the voices were imbued with the status of foreign agency.

## General Phenomenological Considerations

Now we will discuss AVHs from a general phenomenological perspective on the basis of our own and others' empirical and clinical phenomenological research (Charbonneau, 2001; Jones and Luhmann, 2016; Klosterkotter, 1988; Lagache, 1934). AVH is described in the contemporary diagnostic systems as a species of hallucination. The latter has been defined as perception-like experience with the clarity of a true perception without external stimulus. The research domain criteria defines AVH in the following way: “a conscious sensory experience that occurs in the absence of corresponding external stimulation of the relevant sense organ and has sufficient sense of reality to resemble a veridical perception” (Ford et al., 2014). Thus, the implicit definition of perception in those diagnostic systems involves a causal element (source-object) and a vaguely articulated descriptive element (clarity, “resembling veridical perception”). Because of this descriptive vagueness, we need to characterize more closely the phenomenological nature of perception. An essential feature of a perceived object is that the object is experientially given only partially, aspectually, or phrased differently, it is given through adumbrations (Merleau-Ponty, 2012). When we see a house, we see only a certain façade of the house. However, we say that we see the whole house and not just a façade. The unseen sides of the

house are cogiven in perception as its anticipatory horizons correlated to the subject's sensory motor action. Moreover, these horizons, although not accessible to me right now in my present position, are potentially open to others' perspectives. In sum, the perceptual object is given as a public object in a shared social space. Such an object invites further exploration, which is to say an unfolding of additional spatial aspects in a temporal stretch. For these reasons, the perceptual object appears “in person” so to say “in the flesh” as a corporeal presence, which constitutes its quality of reality (Leibhaftig) (Jaspers, 1997). The nature of perceptual experience, of perceptual object, and of perceptual space is essentially or intrinsically interrelated. Similarly, when I perceive an acoustic object, I hear it from a certain direction; the sound has a duration and indicates its physical source (Murata, 2015). When I hear a spoken sentence, the sentence refers to a spatiotemporally located speaker and is embedded in what has been said and the anticipation of what is going to be said. In other words, the acoustic object is given in a certain contextual horizon and is located, although more diffusely than a visual object in the shared social perceptual space. However, AVH fails on all these phenomenological dimensions. The patient's description of the origin of AVH as thought-like and the rarity and the vague nature of the purely external hallucinations jointly point to the fact that the hallucinatory object is in most cases not entirely as a typical acoustic object nor can be unproblematically considered as auditory. The patients are able to describe AVH as not entirely resembling “normally spoken voices.” What the patient experiences are lexical fragments as brief and typically abrupt interpellations, which are so to say thrown at the patient all at once without a temporal stretch: “In the hallucination, there is no unfolding and succession” (Charbonneau, 2001, p. 19). In the so-called “listening” attitude” (i.e., the auditory element), the patient is perhaps in a state of waiting receptivity and immersed in attending to and understanding the messages rather than just listening to the voices (Lagache, 1934, p. 129). We must emphasize that the hallucinatory space, originating in the patient's immanence of thinking, articulates itself as a sort of intrasubjective space that is not an objective social space, but a modification of the patient's immanence and linked to the instability of the self (Henriksen et al., 2015). Thus, hallucinations in schizophrenia “are not of this world” but rather in front of it (Merleau-Ponty, 2012). As an example of the breakdown of the objective space, the patient may hear voices that come from her working place or another continent.

The question is now how to describe the experience of voices in phenomenological terms. In trying to articulate this issue, it is important to point to the developmental nature of the patient's experience. A normal stream of consciousness consists of mutually interpenetrating perceptions, imaginations, thoughts, and sensations. Thinking itself consists of flashes of meaning often supported by imagistic or linguistic elements (Bennett and Hacker, 2003). This stream is unified into a single field of consciousness because it is self-saturated or pervaded by the first-person perspective as mine (Zahavi, 2005). There is no experiential distance between my thinking, its meaning, and my sense of subjecthood. I, so to say, inhabit my stream of consciousness. Even in the case of self-reflection, for example, when I think about my latest lecture, the self who is reflecting and the self reflected upon are experientially unified. I do not observe or listen to my thoughts. Apparently, the patient has originally an experience of certain thoughts that acquire an unusual salience attracting their attention (e.g., thought interference). This is to say that certain thoughts become autonomous and lose their interconnectedness with the stream of consciousness. This peculiar salience seems to be related to the diminished sense of mineness (ipseity). There emerges an increasing sense of experiential distance between the sense of subjecthood and the thought in question; a part of the subject (his/her thoughts) becomes an object of attention. Thus, a part of the subject converts into an object (Ey, 1973).

For this reason, the voices are felt as hyperproximate and do not allow any evasion because the subject cannot escape from himself/

herself. The subject in his/her hallucinatory space is completely exposed in a total passivity with no possibility of creating a distance (Gennart, 2011). The thoughts become progressively objectified, acquiring a sound-like quality without being a true acoustic voice (“thought loudness,” *Gedankenlautwerden*), perhaps repeated (thought-echo or written as a piece of text on an inner screen) (Rasmussen et al., 2018). Finally, the thoughts can be experienced as totally alien (“it thinks in me”; (Bleuler, 1950; Gruhle, 1929; Jansson and Parnas, 2020). The latter phenomenon constitutes a bridge to passivity or influences phenomena as illustrated in one third of our cases.

The acoustic conceptualization is often introduced or reinforced by the terminology of the psychiatrist interviewing the patient, the former operating with the framework of social perceptual space. We think that a better term in most cases would be “thought-voices,” a term used by many patients spontaneously.

The patient is convinced of the reality of his/her experience. However, this reality is not our shared social reality and the patient typically does not expect others to experience his/her voices. The patients' reality is of immanent nature and the veridicality of hallucinations may be epistemologically compared with veridicality of feeling a pain. It is characteristic that the patient lives in a simultaneous double reality (the phenomenon of double book-keeping). One reality is our shared social world, whereas the other with an apodictic epistemic status is a private reality ungoverned by the natural and conventional axioms of causality and time (Henriksen and Parnas, 2014; Parnas and Henriksen, 2016; Parnas et al., 2020).

## CONCLUSION AND IMPLICATIONS

In agreement with Jones and Luhrmann (2016), we believe that the current official definition of AVH is empirically (phenomenologically) incorrect in most cases of AVH in schizophrenia. In other words, AVH is not an experience similar to a veridical perception, but something that is much more ephemeral and private. A part of the problem is that the diagnostic systems define hallucinations at a generic level, which then applies to their variations in different disorders. We therefore think that it will be useful to describe AVH in schizophrenia not in terms of the generic definition but by articulating their phenomenological quality and contexts.

The current official definition has a profound and misleading impact on the training of psychiatrists. In a standard diagnostic situation, the psychiatrist tends to reify the phenomenon and is liable to consider only external AVH as true hallucination. As JM Henry pointed out: “The patient's difficulties to articulate the details of the nature of hallucinations is less a sign of the reticence on the part of the patient than an expression of the psychiatrist's insistence on framing the hallucination in the perceptual space to which it does not belong” (Charbonneau, 2001) (our translation in Charbonneau written by Jean Marc Henry, pp. 84–85).

Therefore, the assessment of a psychiatry-naïve patient is not sufficient if it is restricted to the typical question: “Do you hear voices?” Rather it is necessary to conduct an interview in which the patient is allowed to faithfully describe his/her experience and its evolution. We also think that the current view of AVH as a variant of perceptual experience has negative implications for pathogenetic research.

AVH itself is not a self-sufficient sign of mental disturbance unless it is an aspect of a profound change in the structure of consciousness (Charbonneau, 2001; Gennart, 2011; Jones and Luhrmann, 2016). This latter change is today described as self-disorders in schizophrenia (Henriksen et al., 2021; Raballo et al., 2021). Thus, it is only a concomitant grasp of self-disorders that imbues the AVH with a diagnostic specificity for schizophrenia. The self-disorders may inflict as much suffering as “hearing voices.”

Finally, with respect to treatment, it is important to adopt a personalized approach that takes into consideration all aspects of the patient's psychopathology and not just the AVH as the primary or exclusive target.

The voices and so on were not that important. I think that the enduring and pervasive feeling of being unreal is the disease itself. When I realized this condition of looking at myself as in a movie was permanent, I understood it would eventually destroy the core of my life (Møller and Husby, 2000).

## DISCLOSURE

The authors declare no conflict of interest.

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