# Auditory Verbal Hallucinations and their Phenomenological Context

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## Introduction

Auditory verbal hallucinations (hereafter, AVHs) are frequently associated with schizophrenia diagnoses but also occur in several other psychiatric conditions, as well as in the non-clinical population. In order to investigate how they are caused and how they might be treated (if they require treatment), it is essential to get the phenomenology right. Otherwise, there is a risk of failing to distinguish different experiences that need to be explained in different ways or even seeking to explain the wrong thing entirely, a point that applies equally to treatment. This is not to suggest that we need rely *exclusively* on phenomenological research in order to pin down the nature of AVHs. We can also draw on non-phenomenological findings in order to corroborate, clarify, or challenge phenomenological claims. For example, suppose it is assumed that AVHs are much like veridical auditory experiences, but it then turns out that patterns of brain activity associated with audition are entirely absent. In such a scenario, non-phenomenological findings would prompt us to a reconsider the phenomenology.

However, where AVHs are concerned, one might think that the required phenomenological work is easily done. The term 'auditory verbal hallucination' already says it all: a *hallucination* is an experience that resembles perception in one or another sensory modality, but which occurs in the absence of an appropriate external stimulus. By implication, an *auditory verbal hallucination* is an experience of hearing someone speak, which occurs in the absence of a speaker. Such definitions are commonplace in the literature. For example:

> Voices are defined as a sensory perception that has a compelling sense of reality, but which occurs without external stimulation of the sensory organ. (Hayward, Berry and Ashton, 2011, p.1314)

> Auditory hallucinations (AHs) are auditory experiences that occur in the absence of a corresponding external stimulation and which resemble a veridical perception. (Waters et al., 2012, p.683)

> Auditory verbal hallucinations (AVHs) are a sensory experience that takes place in the absence of any external stimulation whilst in a fully conscious state. (de Leede-Smith and Barkus, 2013, p.1)

This understanding is consistent with the (remarkably cursory) description of AVHs supplied by DSM-5: "Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual's own thoughts" (American Psychiatric Association, 2013, p.87). The only further qualification offered here is that cases where someone is falling asleep or waking up should be excluded. But again, it might seem that the relevant experiences are easy enough to comprehend: they are just like hearing someone speak. If that is right, then cursory definitions and descriptions are unproblematic. It is obvious what the relevant phenomenology consists of and so the phenomenological preliminaries can be dispensed with quickly.

This chapter will show that matters are considerably more complicated. The kinds of experience routinely labeled as 'AVHs' are diverse, and many of them are not at all like hearing someone speak. Furthermore, in the context of severe psychiatric illness, AVHs are generally not circumscribed perceptual anomalies. They are embedded in much wider-ranging phenomenological disturbances, of a kind that are difficult to describe. It is debatable whether and to what extent these disturbances correspond to established diagnostic categories. Hence, if AVH experiences are to be adequately characterized and differentiated, in-depth phenomenological research is needed, of a kind that is able to acknowledge, describe, and distinguish profound disturbances in the overall structure or *form* of experience. Current phenomenological psychopathology acknowledges that AVHs are often unlike mundane perceptual experience and that they arise within the context of more encompassing experiential changes. Nevertheless, it offers what is at best an incomplete account, one that is questionable in several respects.

**Interpreting Voices**

Talk of 'hearing a voice' can mean different things in different circumstances, as exemplified by utterances such as 'okay, I hear what you're saying', 'I hear you loud and clear', and 'I hear you', which can convey understanding, endorsement, or both, rather than merely registering the receipt of a verbal communication. Potentially different connotations should also be kept in mind

when interpreting first-person reports of 'voice-hearing' in psychiatric illness. The need for interpretive caution is recognized by Sarbin (1967, p.363), who takes it as given that the relevant experiences are 'imaginings' of one kind or another, but does not assume that they resemble veridical perceptual experiences. It is the clinician, and perhaps not the patient, who construes them as such:

> *What are the antecedent and concurrent conditions that lead a person publicly to report his imaginings in such a way as to lead a psychologist, psychiatrist, or other professional to designate the described imagining as an hallucination*? (Sarbin, 1967, p.363)[1]

A clinician's interpretation may be influenced by factors that have no bearing on the nature of the experience. For instance, whether a person says 'I hear a voice' or 'it is *as if* I hear a voice' is determined, in part, by age, linguistic ability, and whether or not she is a native language speaker. Drawing on J. L. Austin (1962), Sarbin adds that talk of things seeming 'real' also poses considerable interpretive challenges. Hence, even where someone explicitly refers to 'hearing' one or more 'voices', it should not simply be assumed that she has an auditory experience of speech when nobody is present.

What is at least clear from first-person reports is that the various experiences labeled as AVHs are diverse. As Jaspers remarks in *General Psychopathology*:

> ….we often find 'voices' as well, the 'invisible' people who shout all kinds of things at the patient, ask him questions and abuse him or order him about. As to content, this may consist of single words or whole sentences; there may be a single voice or a whole jumble of voices; it may be an orderly conversation between the voices themselves or between them and the patient. They may be women's, children's or men's voices, the voices of acquaintances or unknown people, or quite undefinable human voices. Curses may be uttered, actions of the patient may be commented on or there may be meaningless words, empty repetitions. Sometimes the patient hears his own thoughts spoken aloud. (Jaspers, 1963, p.73).

[1] Over time, it may be that the patient adopts some of the language that healthcare professionals employ to describe her condition. Hence a clear distinction can no longer be drawn between her own narrative and one that labels her experiences as 'hallucinations'. This makes interpretation even more challenging.

More recent studies have identified several dimensions of variation, including whether the voice addresses the subject in the second-person or refers to her in the third-person, whether its experienced origin is internal or external to the subject, the number of voices heard, the degree to which voices are personified, the thematic content of utterances, how elaborate the content is, whether or not there are hallucinations in other modalities, degree of control over voices, and degree of distress caused (e.g. Nayani and David, 1996). Nevertheless, it remains unclear which differences are superficial and which more profound. In fact, it is not even clear which criteria should be employed to distinguish degrees of profundity or to classify AVHs into subtypes for one or another purpose. One thing that does become apparent, however, is that many so-called 'AVHs', most likely the majority, are quite unlike hearing someone speak. Nayani and David (1996) report that 49% of their subjects heard voices "through their ears as external stimuli", while 38% experienced them as occurring in "in internal space", and 12% experienced both, while Leudar et al. (1997, pp.888-9) state that 71% of their subjects heard only internal voices, 18% heard voices "through their ears", and 11% heard both. Internal voices are often described as lacking some or all auditory characteristics. This is perhaps best exemplified by the reports of congenitally deaf 'voice-hearers', who often express bemusement when asked whether their voices have one or another auditory property (Atkinson, 2006). But many others similarly report voices that originate in an internal location, often 'in the head', and that lack some or all auditory qualities. These experiences may also be described in terms of receiving a communication from elsewhere, reading in the absence of a text, having a perception-like experience of something that remains somehow thought-like, or as *like* telepathy. That they differ substantially from other AVHs, which are experienced as audition-like and as originating in an external location, is clear from the testimonies of those who experience both types and contrast them, sometimes explicitly stating that they use the term 'voice' to refer to two different kinds of experience (Ratcliffe and Wilkinson, 2015; Ratcliffe, 2017).

Phenomenologically inspired approaches to AVHs recognize that the relevant experience is often quite unlike hearing someone speak. For instance, Henriksen, Raballo, and Parnas (2015, p.167) take it to be more a "sort of direct inner intuition" than a "sensory experience". In support of that interpretation, they quote first-person accounts such as the following:

> "…often, I cannot tell if I have a thought, if it's the voice, or if it's a feeling I have."

> "….the voice seems partly real, but at the same time distorted. It can also appear as a face or a text. I cannot really describe the sound." (quoted by Henriksen, Raballo, and Parnas, 2015, p.167)

Such experiences are not usually mistaken for veridical auditory communications, and are instead distinguished from them with ease (although this is not to deny that confusion can occur). As noted by J. H. van den Berg (1982, p.105), psychiatric patients often know "full well the difference in nature between their hallucinations and their perceptions". They may even give their voices a "special name", to indicate that they have a "recognizable character of their own which distinguishes them from *perception* and also from *imagination*". So a person might refer to *hearing voices* and insist that she *really does hear voices*, while at the same time speaking and acting in a way that implies recognition of their distinctness from mundane auditory perceptions. This is consistent with the wider phenomenon of double-bookkeeping, where a person's words and actions indicate an equivocal attitude towards delusions and perceptions; they are perception- and belief-like in certain respects but at the same time set apart from mundane perceptions and beliefs (e.g. Sass, 1994). Phenomenological approaches have tended to focus on AVH experiences of this kind, and have sought to develop accounts of more enveloping phenomenological disturbances that they depend upon.

**AVHs as Symptoms of Self-Disorder**

A consistent theme in phenomenological psychopathology is that AVHs are largely attributable to global changes in the *form* of experience - not *what* is experienced but *how*. So they are not isolated 'hallucinations', which occur against a backdrop of otherwise unproblematic experience. The emphasis of discussion has been on AVHs in schizophrenia. The earliest descriptions of dementia praecox / schizophrenia, by Emil Kraepelin and Eugen Bleuler, identify profound disturbances in the experience of *self*, involving pervasive changes in perception, emotion, thought, and agency. Kraepelin (1919, p.3) writes that there is a "peculiar destruction of the internal connections of the psychic personality", while Bleuler (1950, p.9) refers to a "splitting of the psychic functions", where "the personality loses its unity". The theme of *self-disturbance* or *self-disorder* in schizophrenia has been further developed by subsequent phenomenological

psychopathology. Several recent discussions have adopted the term 'minimal self'.[2] As described in detail by Zahavi (2014), minimal self is not an *object* of reflective or pre-reflective experience; it is not an isolable *quale* or *feeling* of any kind; it is not a transcendental condition for the possibility of experience that lies *behind* the relevant experiences; and it is not a mere abstraction from experience. Rather, it is an indispensable structural condition for experience, which is integral to all experiences. As such, it is an inextricable aspect of experience, as opposed to an isolable component. Zahavi (2014, p.22) thus refers to it as a sense of "mineness" that is inseparable from the "distinct manner, or *how*, of experiencing".

The concept of minimal self has been applied, in slightly different ways, to the phenomenology of schizophrenia by Thomas Fuchs, Josef Parnas, Louis Sass, and others. It is proposed that AVHs presuppose wider-ranging phenomenological disturbances, which arise before the onset of specific symptoms such as hallucinations and delusions. These disturbances centrally implicate the most basic experience of selfhood, the minimal self. For example, Sass (2014, pp.5-6) states that schizophrenia involves a "disturbance of minimal- or core-self experience" or "ipseity", the "sense of existing as a vital and self-identical *subject* of experience or *agent* of action". Parnas et al. (2005, p.244) refer to the erosion of a "basic self-awareness (ipseity)", something that more usually operates as a "*medium* or a *mode* in which specific intentional experiences, such as perception, thinking, or imagination, articulate themselves" (p.244). Fuchs (2013, p.248) likewise emphasizes the disruption of a "first-person perspective" that "inhabits all modes of intentionality and imbues them with a sense of mineness".

Disturbances of minimal self envelop all aspects of the structure of experience - the sense of being immersed in a world, how one experiences and relates to other people in general, the sense of time, bodily experience, and experiences of agency, perception, thought, and emotion. Although the emphasis of discussion varies somewhat, it is consistently maintained that a profound alteration in the overall *structure* or *form* of experience takes hold in the prodromal stages of schizophrenia, and precedes more specific symptoms (Parnas and Sass, 2001). It is further claimed that seemingly localized symptoms, including AVHs, are only *intelligible* in the context of a subtle and hard-to-describe alteration in the global structure of experience. Hence they are not "atomistic, self-sufficient, thing-like symptoms". Rather, they are "meaningfully

[2] For references to complementary themes in earlier phenomenological writings, see, for example, Sass (2001) and Fuchs (2012).

interrelated facets of a more comprehensive and characteristic gestalt change in the patient's experience (field of consciousness) and existence" (Larøi, de Haan, Jones, and Raballo, 2010, p.235).

More specific, and largely complementary, accounts have also been offered of *how* changes in the sense of self (and, by implication, in the overall structure of experience) give rise to AVHs. The common theme is that one becomes estranged from one's own thought processes, which are experienced as increasingly alien, as somehow object-like. Sass (e.g. 1992; 1994; 2003; 2007; 2014) offers an influential account, which emphasizes what he calls "hyperreflexivity": a largely involuntary attentiveness to aspects of experience that are more usually unproblematic and inconspicuous. In his words, it is "a condition in which phenomena that would normally be inhabited, and in this sense experienced as part of the self, come instead to be objects of focal or objectifying awareness" (Sass, 2003, p.153). AVHs and other kinds of anomalous experience are thus attributable, at least in part, to a kind of alienating self-awareness (e.g. Sass, 1992, pp.226-235). Thoughts are no longer integral to a medium *through which* one engages with the world and instead appear curiously conspicuous and alien. Along with this, there is a more general sense of practical disengagement from the world as a whole and from other people, as well as a pervasive detachment from one's thoughts, perceptions, and activities.

Others similarly suggest that AVHs involve thought becoming somehow object-like. Henriksen, Raballo, and Parnas (2015, p.172) refer to the "morbid objectification of inner speech" as an "essential" precursor to the formation of AVHs, whereby a medium of awareness, *through* which one experiences and engages with one's surroundings, gradually becomes an object of awareness. There is, they say, a kind of "dissociation" between the "sense of self" or "ipseity" and the "flow of consciousness". This is presupposed be the intelligibility of AVHs; such experiences involve a quasi-perceptual sense of alienation from one's own thoughts, of a kind that could not arise against the backdrop of a more mundane experience of the self and its surroundings.[3]

[3] On one interpretation, AVHs of this type are indistinguishable from experiences of thought insertion (TI). If TI is taken to involve an experience of alienation from thought *content*, rather than from the *process* of thinking, then it could equally be described as a perception-like experience of thought content, which is exactly how Henriksen et al. (2016) conceive of AVHs. For a more detailed defence of the view that TI is to be identified with (a certain kind of) AVH, see Ratcliffe and Wilkinson (2015); Ratcliffe (2017). For an attempt to retain the AVH/TI distinction in such cases, see Humpston and Broome (2016).

Proponents of this view tend to maintain that the phenomenological "gestalt" within which AVHs crystallize is specific to schizophrenia: self-disturbance in schizophrenia is uniquely pronounced, and also qualitatively distinctive from other kinds of self-disorder. It has been further proposed that self-disorder is detectable before the onset of clinically significant levels of disturbance (Raballo and Parnas, 2011, p.1018; Cermolacce, Naudin, and Parnas, 2007). This raises the possibility of employing phenomenologically inspired methods for the purposes of early detection and thus early intervention. To this end, Parnas and colleagues have developed the Examination of Anomalous Self Experience (EASE), a detailed checklist for a semi-structured, phenomenological interview, the principal aim of which is to reliably detect disorders of minimal self-awareness that are specific to the schizophrenia spectrum (Parnas et al., 2005). So, to summarize, the overall picture is that AVHs, or at least certain kinds of AVH, are preceded by and depend upon a distinctive disturbance of the overall structure of experience, of a kind that is specific to schizophrenia. This disturbance alienates the subject from her own thoughts (or, more specifically, inner speech), to such an extent that she eventually comes to experience some of them in a quasi-perceptual, object-like way.

**An Incomplete Story**

It is plausible to insist that many AVHs are not like hearing a voice, and also that such experiences tend to arise against a backdrop of wider-ranging phenomenological disturbances. Even so, the explanatory power of the self-disorder account is currently rather limited. Furthermore, certain aspects of the account are unclear, and others questionable. For one thing, why AVHs are experienced only episodically remains unexplained. If there is an all-enveloping phenomenological change that renders thought somehow perception-like, then surely all thoughts, or at least all thoughts of a certain type (for instance, those that take the form of inner speech) would be experienced in this way. One might respond that the relevant change is temporally inconsistent, and therefore disrupts some thoughts to a greater extent than others. While this might accommodate the sporadic nature of the experiences, it leaves their content-specificity unaccounted for. AVHs in severe psychiatric illness tend to have consistent and often quite specific thematic contents. For instance, voices are often abusive; over 50% of those voice-hearers with psychiatric illness diagnoses report critical, hostile, abusive voices (Nayani and David, 1996; Leudar et al., 1997). Until the self-disorder approach can show why global changes

in the structure of experience lead to sporadic, content-specific experiences, it remains importantly incomplete.

In addition, the claim that self disturbance culminates in an *object-like* experience of thought is not wholly clear, and may involve a degree of equivocation over the term 'object'. On one reading, 'object' refers to an *object of experience*. In other words, it pertains to *whatever it is that we experience*, as distinct from any qualities attached to the *act of experiencing*. So one could say that, while our thoughts ordinarily have objects, they are not themselves objects. Nevertheless, even if it is accepted that thoughts are not ordinary objects of experience, it seems plausible to maintain that we can be reflectively (and perhaps unreflectively) aware of our own thoughts in this way without feeling alienated from them. And the claim that thought becomes object-like is intended to convey something more specific than this. Thoughts become somehow akin to a type of object of perception: an inanimate entity that is external to the self. But in what respect? Sometimes, it seems as though the answer is that they acquire sensory properties that are ordinarily attributed certain entities and occurrences in the external environment but not to thoughts. Consistent with this, Parnas et al. (2005, p.241) refer to a "perceptualization of inner speech or thought", stating that inner speech takes on "*acoustic* and in more severe states *auditory* qualities". There are also descriptions of inner speech becoming "more pronounced" before the onset of voices, with "subtle pre-psychotic distortions of the stream of consciousness – such as abnormal sonorization of inner dialogue and / or perceptualization of thought" (Raballo and Larøi, 2011, p.163). With this, thought ceases to be part of the medium *through which* we experience and engage with our surroundings and instead becomes something separate from ourselves, something we confront. However, the appeal to sensory properties is in tension with the admission that AVHs are quite unlike auditory perceptual experiences. Furthermore, much the same contrast between alienated and non-alienated experiential contents arguably applies to perception as well. For example, in *Autobiography of a Schizophrenic Girl*, Renee describes her experiences of previously familiar objects as follows:

> Objects are stage trappings, placed here are there, geometric cubes without meaning….When, for example, I looked at a chair or a jug, I thought not of their use or function – a jug not as something to hold water and milk, a chair not as something to sit in – but as having lost their names, their functions and meanings; they became 'things' and began to take on life, to exist." (Sechehaye, ed, 1970, p.44, pp.55-6)

In the case of an AVH, the claim is not that inner speech is experienced as akin to a mundane auditory perception. A more appropriate comparison would be with the kind of alienated perceptual experience described by Renee. However, that being the case, it is inaccurate to say that thought becomes perception-like, given that thought is experienced as *alien* in a way that can equally be contrasted with mundane, non-alienated perceptual experiences of 'objects'. The relevant sense of alienation should therefore be distinguished from the adoption of perceptual characteristics. It does not require such characteristics and, even if they are present, they do not account for it. Talk of "objectification" thus refers to a sense of alienation that requires further clarification, something that differs from both ordinary thought and ordinary perception.

But perhaps the most substantial problem with the minimal self account of AVHs is the widespread insistence that self-disorder, of the relevant kind, is schizophrenia-specific. That position is explicit in the writings of Parnas and some of his collaborators, although others are less committal.[4] Current applications of the label 'schizophrenia' most likely accommodate a far wider range of experiences. So the self-disorder proposal is presumably intended to be revisionary, at least to some extent. By identifying schizophrenia with a certain type of self-disorder, the intention is to apply the diagnosis in a more principled, discerning, and restrictive way. Let us accept, for the sake of argument, that the self-disorder account of schizophrenia is right. The problem we then face is that schizophrenia-specific self-disorder does not seem to be necessary for AVHs, including those AVHs that involve perception-like experiences of alienated thought content. It is widely acknowledged that AVHs can occur in non-clinical, healthy subjects as well, although their frequency in the non-clinical population is debated (e.g. Aleman and Larøi, 2008, Chapter 3; Watkins, 2008; McCarthy-Jones, 2012, Chapter 7). Some further maintain that the AVH experiences of healthy and clinical subjects are much the same. For instance, Romme and Escher (e.g. 2006) suggest that what distinguishes the two populations is not their experiences *per se* but how they react to those experiences. In clinical subjects, voices and the like are a source of considerable distress, nurturing a pervasive feeling of disempowerment and helplessness.

[4] For instance, Sass (2014, p.5) is more generally cautious account the schizophrenia construct. He suggests that, although flawed, it does at least appear seem to suggest "some subtle but underlying factor at the core of a psychiatric condition that is perhaps best conceived of as a syndrome (and probably represents a final common pathway with diverse etiological origins)".

One response on behalf of the self disorder view is to reject the claim that the experiences are relevantly similar. It might initially seem that they are, but only because of a failure to explore the comparative phenomenology in sufficient depth. Stanghellini at al. (2012) note that the relevant studies are seldom sufficiently receptive to potential phenomenological differences, and argue that detailed first-person descriptions in fact point to quite different experiences. Henriksen, Raballo and Parnas (2015) also emphasize various differences between AVHs in schizophrenia and in healthy subjects. Hence distinguishing between AVHs in healthy subjects and in those with schizophrenia diagnoses may not be so much of a problem. Nevertheless, the same cannot be said of AVHs in schizophrenia and in other types of psychiatric illness. AVHs are associated with several other conditions, including posttraumatic stress disorder, psychotic depression, bipolar disorder, and borderline personality disorder. For example, Upthegrove et al. (2016) quote frequencies of 70% in schizophrenia, 23% in bipolar disorder, and 46% in borderline personality disorder. First-person accounts of abusive, insulting, or threatening voices in these populations have much in common. Now, it could be that certain experiences are more common in schizophrenia than elsewhere, such as "running commentary or arguing voices" (Henriksen, Raballo, and Parnas, 2015, p.178). But even Romme and Escher (2006, p.167) are happy to concede that voices commenting in the third-person are more common in those with schizophrenia diagnoses. What remains the case is that all sorts of other AVH experiences do not seem to be schizophrenia-specific, and are common to several diagnostic categories. Claims for the schizophrenia-specificity of a certain type of AVH tend to contrast AVHs in schizophrenia with AVHs in non-clinical populations (e.g. Henriksen, Raballo, and Parnas, 2015). However, not enough work has been done to support the claim that they are equally distinguishable from AVHs in other clinical populations. And, in the absence of any evidence to the contrary, the default assumption should be that these experiences have much in common.

A related problem for the self-disorder account is that not all AVHs in severe psychiatric illness are quite so different from veridical auditory experiences. While some involve encountering thought or inner speech in a perception-like way (the nature of which needs to be spelled out more clearly), others are more like hearing someone speak. Wu (2012) thus proposes that many AVHs are exactly as the term would suggest: non-veridical auditory perceptual experiences of voices. In a clinical context, Dodgson and Gordon (2009) make a more specific case for what they call "hypervigilance hallucinations", which are to be distinguished from inner

speech AVHs. The former arise due to pervasive anxious anticipation, of a kind that is commonplace in psychiatric illness and diagnostically non-specific. Because the subject is always on the alert, anticipating self-directed communications with negative thematic contents, there is an increased disposition towards false positives, where ambiguous sensory information is interpreted (and also *experienced*) in terms of voices. Even without recourse to a principled taxonomy of AVH-subtypes, it is clear that an anomalous experience of inner speech is very different from an over-interpretation of perceptual stimuli, and it is equally clear that the two experiences come about in different ways.[5] Both kinds of experience are associated with schizophrenia diagnoses. And, if they are both to be explained in terms of self-disorder, the relevant explanation needs to distinguish the ways in which a common, underlying self-disorder gives rise to two very different types of experience.

Given these various concerns, it is clear that the self-disorder account of AVHs requires further refinement. As things stand, phenomenological approaches are not even close to showing that the majority of AVHs occurring in schizophrenia are diagnostically specific. Of course, it could be that schizophrenic self-disorder is one of many different phenomenological contexts in which these experiences can arise. But, if that is so, we would have to concede that, although self-disorder might be sufficient to bring about AVHs, it is not necessary for them. And this would involve abandoning strong claims about AVHs *only being intelligible* in the context of a distinctive phenomenological "gestalt", thus substantially weakening the position. Worse still, it would open up the possibility that self-disorder is not even sufficient for AVHs. If one accepts that it is not necessary, then one cannot simply assume that it has a role to play when it is present. Perhaps it is just an accompaniment, an associated symptom. Or, to really complicate matters, perhaps schizophrenia-specific self-disorder is necessary and sufficient for some types of AVHs, necessary but not sufficient for others, sufficient but not necessary for others, and neither necessary nor sufficient for others. All four possibilities remain open. An alternative option would be to concede that the degree and type of self-disorder required for AVHs of one or another type is not, after all, schizophrenia-specific. Whatever the case, the claim that AVHs are only intelligible in relation to a certain kind of profound phenomenological disturbance needs

[5] The possibility remains that the difference between other kinds of external, audition-like AVH and internal, thought-like experiences is more a matter of degrees, that there is a spectrum of experiences (Humpston and Broome, 2016).

more work. The types of AVH in question need to be specified more clearly, as does the kind of 'objectification' they involve. And the alleged specificity to schizophrenia needs to be reconciled with the much wider range of most, if not all, types of AVH experience.

**Trauma and Psychosis**

To conclude, I want to briefly contrast the self-disorder view with another, currently popular, way of thinking about AVHs. This alternative maintains that AVHs are not symptoms of schizophrenia. They are instead attributable to traumatic experiences and to an associated sense of alienation from other people, neither of which are consistently associated with one or another psychiatric diagnosis. Two prominent advocates of the view are Marius Romme and Sandra Escher, who insist that 'voices' originate in unresolved trauma and are essentially relational in nature. They propose that we reconceptualize "psychosis" as an "emotional crisis, of a kind that is essentially interpersonal in nature and also embedded in a wider sociocultural context. 'Voices', they maintain, should not be regarded as illness symptoms that are to be eliminated through treatment. Rather, we should seek to make sense of them, to grasp their emotional meanings and their relationships to life history. So the aim is not so much to get rid of them as to help the person come to terms with them and, in so doing, to reduce the distress they cause (e.g. Romme et al., 2009; Romme and Escher, eds, 2012).

Setting aside the specifics of Romme and Escher's approach, the view that AVHs are closely associated with trauma is a plausible one. There is a substantial literature pointing to strong correlations between childhood abuse, as well as other traumatic events at various life stages, and the later onset of psychosis. There are also correlations between types of abuse and specific symptoms. For instance, childhood sexual abuse is particularly strongly associated with AVHs. Some symptoms are most reliably associated with combinations of childhood and adulthood trauma, and there are also dose-response relationships. In the majority of cases, there is every reason to believe that first-person reports are accurate (e.g. Larkin and Morrison, eds, 2006). An emphasis on the relational nature of AVH experiences and on their interpersonal causes is in tension with claims made by Parnas and colleagues. While acknowledging that self-disorder inevitably implies profound changes in the interpersonal sphere, they insist that self-disorder comes first, both phenomenologically and causally. Instead of emphasizing the interpersonal and social, they seek to identify genetic causes. Raballo, Sæbye and Parnas (2009,

p.348) go so far as to state that the "primary relevance" of work on self-disorder in schizophrenia is to "etiological research into the genetic architecture of schizophrenia".[6]

The association with interpersonal trauma does at least serve to account for the content-specificity of AVHs, as well as the frequent negativity of content. It also accommodates varying degrees of personification. A voice, and the personality that comes to be associated with it, could resemble -to varying degrees and in different ways- a particular person, such as an abuser or perhaps a protector. That said, there is a lack of clarity here too. It is sometimes unclear whether the position is that AVHs are often incorrectly taken to be symptoms of schizophrenia or, alternatively, that the schizophrenia construct should be dismissed altogether. For instance, Longden, Madill and Waterman (2012) maintain that voices are attributable to dissociation rather than psychosis but at the same time reject the distinction between them (rejecting, by implication, a distinction between schizophrenia and affective disorders). But you can't have it both ways. It is also unclear which types of AVH are associated with trauma and which are not, or whether the relational contexts in which post-traumatic AVHs arise also amount to pervasive alterations in the overall form of experience, along the lines of what phenomenological psychopathology has sought to describe.

Regardless of the many gray areas, it at least appears that these two positions are opposed to each other. One of them attributes AVHs to self-disorders, which are responsible for disturbances of interpersonal relatedness, have a largely genetic origin, and are specific to schizophrenia. The other takes AVHs to be essentially interpersonal, relational phenomena, does not recognize the existence of pre-intersubjective self-disorder, insists that AVHs to have an interpersonal origin (in most cases), and rejects the association with schizophrenia. The contrast is an intriguing one, given that both positions are developed in detail, supported by substantial bodies of evidence, and in many respects plausible. As is evident from a brief scan of the sources they tend to cite, the two have, to date, proceeded in near-complete isolation from each other. Nevertheless, there is at least one author in the phenomenological tradition who comes close to combining them. Wolfgang Blankenburg (1969/2001; 1971/2012) describes altered experience

[6] See also Raballo and Parnas (2011). However, not all advocates of a self-disorder approach place so much emphasis on genetic causes. Borda and Sass (2015) and Sass and Borda (2015) acknowledge potential roles for various different biological and non-biological causes at different life-stages. They also emphasize the heterogeneity of schizophrenia and propose a broad distinction between two kinds of scenario. In one of these, onset is early, negative symptoms predominate, and self-disorder is a prominent cause. In the other, onset is acute, positive symptoms are more salient, and "secondary factors" may have a greater role to play than "primary" self-disorder.

of self, body, world, and other people, of the kind associated with schizophrenia, in terms of a pervasive loss of habitual, bodily, *commonsense*, or a loss of *natural self-evidence* (*Verlust der natürlichen Selbstverständlichkeit*). With this, a previously taken-for-granted, unthinking confidence is gone and everything seems strangely unfamiliar. Thus, as Sass similarly emphasizes, what once operated as an unthinking background to thought, experience, and activity is now oddly conspicuous. Blankenburg adds that this 'commonsense' is inextricable from how a person relates to others. It is, he says, "primarily related to an intersubjective world (*mitweltbezogen*)". To be more specific, it consists of a confidence that is inextricable from the ability to sustain a kind of habitual, pre-reflective 'trust' other people (*Vertrauenkönnen*). Furthermore, adverse events that occur during interpersonal development can either fail to nurture or derail the "basic trust" upon which a wider commonsense depends (1969/2001, p.307, p.310).

What we have here is an account that combines an emphasis on profound and wide-ranging phenomenological changes (involving a sense of alienation from the world, one's activities, one's body, and even one's own thoughts) with an acknowledgement of their inextricability from the interpersonal sphere and from patterns of interpersonal development. This points to various potential ways of bringing the two together.[7] Perhaps Blankenburg's loss of commonsense is to be identified with self-disorder, in which case the 'minimal self' would have to be conceived of as a 'relational self' too, something that depends for its integrity on a primitive sense of trust in others. Alternatively, it could be that loss of commonsense is sometimes or always preceded by a more fundamental disturbance of minimal self.[8] And, if a more primitive form of self-disturbance is sufficient for loss of commonsense but not necessary for it, we are then faced with the question of whether disruption of commonsense (of whatever degree) can fuel the development of one or another kind of AVH, even in the absence of underlying self-disorder. Last but not least, there is the issue of whether any types of AVHs, or any of the wider-ranging experiential disturbances that they depend upon, reliably track the diagnostic category 'schizophrenia', rather than severe psychiatric illness more generally. Perhaps they do but, as things stand, the jury is still out.

[7] For an attempt to develop such an approach in detail, see Ratcliffe (2017).

[8] Fuchs (2015) acknowledges and discusses in detail the kind of phenomenological change Blankenburg describes. He also recognizes its inextricability from interpersonal dynamics. Nevertheless, he continues to maintain that alteration of a "pre-reflective, embodied self" has priority and necessitates disruption of social relations.

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