

***Commentary on Pseudohallucinations in an Adolescent:  
Considerations for Diagnosis and Treatment in the Case of "Kate"***

**Using Phenomenology To Understand Hallucinatory Experiences**

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**ABSTRACT**

This commentary responds to Shapiro, Bussing, and Nguyen's (2014) case study of "Kate," a 16-year-old adolescent female who required psychiatric hospitalization for auditory hallucinations with secondary delusional thinking. I continue their discussion about the conceptualization of hallucinatory experiences in the context of an individual case, and the significance of this conceptualization for diagnosis and treatment. In particular, this commentary summarizes contemporary research on the diverse manifestations of auditory verbal hallucinations (AVHs) and the difficulties with developing a meaningful classification system for these phenomena. It then investigates one approach to understanding AVHs, philosophical phenomenology, and argues for the relevance of this approach in clarifying the formal features of a symptom and relating these in a meaningful way to the overall structure of the underlying pathology. Finally, this commentary applies a phenomenological perspective to Kate's particular symptomatology, and discusses the implications of its findings for treatment approaches with Kate and others who experience various forms of AVHs.

*Key words:* hallucinations; pseudohallucinations; phenomenology; psychosis; case study; clinical case study

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**INTRODUCTION**

In their article "Pseudohallucinations in an adolescent: Considerations for diagnosis and treatment in the case of 'Kate,'" Shapiro, Bussing, and Nguyen (this issue; 2014) offer a thoughtful case study of an adolescent girl who experiences what the authors term "pseudohallucinations," and who is successfully treated with a combination of CBT and psychodynamic approaches. This paper raises interesting questions around the practice of diagnosing and the ways this may affect treatment and outcome. The authors focus on Kate's hallucinatory experiences, which she describes as multiple voices who variously tell her to behave in certain ways and who threaten or warn her about danger or threats, often in relation to her obedience or disobedience. They conceptualize these voices as manifestations of Kate's disowned anger and aggression, and their clinical interventions aim to prevent reinforcement of

the voices while supporting the healthy expression of Kate's affective experience, particularly in relation to developing a more mature and independent role in her family system.

In recent years, there has been a rise in interest in understanding the nature of hallucinatory experiences, including such groups as the International Consortium on Hallucination Research (Waters, Woods, & Fernyhough, 2014), the Hearing Voices Movement (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014), and the Hearing the Voice project (Woods et al., 2014). These projects have brought new energy to a phenomenon that is still poorly understood and have contributed to important new research and treatment efforts (Thomas et al., 2014). One feature that seems to be shared across these groups is their emphasis on the subjective experience, or phenomenology, of hallucinations, a trend that represents a departure from the traditional, symptom-based approach of mainstream psychiatry. By enquiring into individuals' own experience and interpretations of their hallucinations, these projects are increasing the awareness of the diversity of the phenomena that fall under this umbrella (see, e.g., Woods et al. (submitted)). Such research projects may therefore offer additional knowledge and insights to help further contextualize Shapiro et al.'s case.

This commentary aims, then, to elaborate upon the discussion begun by Shapiro et al. about the nature of hallucinations, and specifically auditory verbal hallucinations (AVHs), first by considering the varieties of hallucinatory experience, including the concept of pseudohallucinations or nonpsychotic hallucinations and their status in relation to other hallucinatory experiences. It will especially highlight recent research on the subjective experience or phenomenology of hallucinations as a means of refining the conceptualization of these phenomena. The paper will then return to the case of Kate, to consider how a phenomenological approach might further augment and enrich an already successful approach to working with this young woman. Finally, it will consider the implications of this thought-provoking and challenging case for therapeutic endeavors with others who experience AVHs.

## CONCEPTS OF HALLUCINATIONS

As Shapiro et al. point out, the notion of pseudohallucinations is a controversial one, and there has never been a lasting consensus on the phenomenon the term is meant to describe (Berrios & Dening, 1996). Van der Zwaard and Polak (2001) found that the term *pseudohallucination* was typically used to describe either a) a perceptual experience that is experienced as occurring in the mind (i.e., is not experienced as outside of the self, or b) a hallucination with intact reality testing (i.e., the person who experiences them knows they are not real). However, as van der Zwaard and Polak are careful to observe, these definitions are also applied to "true" hallucinations. The Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5; American Psychiatric Association, 2013), for example, does not specify whether "true" hallucinations must be experienced as external, or whether they need to be fully believed as real. Furthermore, research investigating the actual experience of hallucinations in schizophrenia and other psychotic conditions has found significant variation on these two points (Lowe, 1973; McCarthy-Jones, Trauer, et al., 2014; Nayani & David, 1996; Stéphane, Thuras, Nasrallah, & Georgopoulos, 2003). These findings call into question the widespread assumption that most hallucinatory phenomena in psychosis involve straightforward belief in the external

existence of the hallucinated object (see also Junginger & Frame, 1985). Furthermore, Berrios and Dening (1996) point out that the concept of pseudohallucinations appears to be used to try to set some clinical phenomena apart from the more pathological processes of hallucinations associated with psychotic disorders, but that this is problematic when the definition of hallucinations itself is unstable and wide-ranging. DSM-5 (American Psychiatric Association, 2013) provides little guidance either, mentioning “pseudohallucination” only once as a possible symptom of conversion disorder, but without providing a definition of the term.

As a result of this conceptual confusion, van der Zwaard and Polak (2001) suggest using the label “nonpsychotic hallucinations” to describe unreal perceptual experiences where insight (that the hallucination is unreal) is maintained. They also briefly list other possible ways to classify similar perceptual disturbances, including “internal imagery,” “partial hallucinations,” and “transient hallucinations,” though these terms do not receive much elaboration and it is unclear how the authors arrived at this particular classification system and whether it corresponds any more closely to actual experience.

So far, these efforts at classification appear as attempts to impose order over what is in reality a very muddy set of experiences with features that often overlap or shade into one another. McCarthy-Jones et al. (2014) point out that trying to classify different types of hallucinations without understanding their essential features has inevitably resulted in arbitrary and unhelpful categories. They recommend that an adequate classification or subtyping system should include: 1, operationalization and ability to assess phenomena in a clinical interview; 2, establishment of validity via external markers such as neural signature, performance on cognitive tasks, and response to specific interventions; 3, usefulness to the person with the hallucination as a meaningful way of making sense of his or her experience; and 4, consideration of the etiological influences of the hallucination (e.g. intrusive traumatic memories vs. neurological dysfunction). Thus, classification systems with the greatest validity and relevance would be responsive to research findings at a variety of levels of explanation: phenomenological, cognitive, neurological, etiological, diagnostic, intervention-based, and autobiographical. They suggest a preliminary subtype system specifically for AVHs (subject to empirical testing and further refinement), which includes the following types: hypervigilance, autobiographical memory, inner speech, epileptic, and deafferentation (due to loss of sensorial input). Furthermore, they note that AVHs might be understood on a continuum from externally located hallucinations, to internally located AVHs, to idea-like AVHs, to even delusions of reference (see also Humpston & Broome, submitted).

Importantly, this subtyping does not make distinctions between AVHs that occur within psychotic episodes and those that occur outside psychosis, with the exception of the epileptic and deafferentation subtypes. This is not to say that those distinctions are not important, but rather that the importance or relevance of such a distinction, or any of the distinctions classically used to define or classify AVHs, should not be assumed or taken for granted. However, while contemporary research efforts are looking to begin to answer some of these questions, there is currently little consensus on how to conceptualize the diverse phenomena called hallucinations, leaving clinicians and persons suffering from AVHs unclear about how best to proceed.

## RELEVANCE OF PHENOMENOLOGY

One potential way forward is by employing a phenomenological method of investigation, which can be termed “philosophical phenomenology” (McCarthy-Jones, Trauer, et al., 2014). This method is distinct from the form of phenomenology typically used in clinical practice, which emphasizes the observation of reliable and operationalizable signs and symptoms of mental disorder (e.g. low mood or hopelessness) without attempting to understand the underlying experiences that organize or give rise to these complaints (c.f. Parnas, Sass, & Zahavi, 2013). By contrast, philosophical phenomenology is interested in developing a rich understanding of “the essential structures of human experience and existence, both normal and abnormal” (Sass & Parnas, 2003, p. 429). It asks that researchers bracket any *a priori* assumptions, judgments, or theories about a phenomenon to try to understand the essential forms and features of experience, finally assembling these forms or features in a meaningful way to arrive at an overall structure or *Gestalt* of experience. Phenomenology is particularly interested in consciousness as a medium or background for experience, and emphasizes the ways that embedded structures or *forms* of experience (such as temporality, spatiality, intentionality, and embodiment) give rise to particular *contents* (e.g., seeing a chair or remembering an encounter with a friend), which may be experienced in different ways or modalities. It also considers the intertwined relationship between self and world. As Sass and Parnas note, “we are self-aware *through* our practical absorption in the world of objects” (p. 430); but also, all objects in the world appear to us through the lens of selfhood or consciousness.

There are several benefits to using this approach to investigate AVHs. As McCarthy-Jones, Trauer, et al. (2014) note, philosophical phenomenology “may result in the deprioritization of aspects of their phenomenology which, for good or bad reasons, have previously been deemed salient,” instead “re-focus[ing] on the character and meaning of the patient’s experience from their perspective” (p. 2). Distinctions that previously have been assumed to be important, such as whether AVHs are experienced internally or outside oneself, or whether they are experienced as part of a psychotic or nonpsychotic disorder, would lose their *a priori* status and would only be included in an analysis if they were truly relevant to the person who experiences them and if they were found to constitute an essential feature of the phenomenon. A phenomenological approach may also help to better understand the diversity of AVHs by highlighting their essential features and determining which features represent important differences and whether those differences are qualitatively distinct or lie somewhere along a continuum (McCarthy-Jones, Trauer, et al., 2014).

A final benefit of this approach is that it can contribute to an understanding of the overall picture of a person’s experience, helping to clarify the underlying pathology: highlighting the core features of specific symptoms can reveal “a phenomenological depth or structure of the disorder” (Parnas, 2011, p. 1122). As Parnas (2011) notes, “what the patient manifests is not isolated symptoms/signs with referring functions but rather certain wholes of mutually implicative, interpenetrating experiences, feelings, beliefs, expressions, and actions, all permeated by biographical detail” (p. 1126). It is the work of phenomenology to elucidate the full picture or *Gestalt* of a psychiatric illness and to establish its relationship with the patient’s symptoms as meaningful expressions of the illness.

## PHENOMENOLOGY OF HALLUCINATIONS

Various models have been proposed regarding the phenomenology of hallucinations. Each emphasizes the basic structures of experience and the intertwined relationship between self and world, to consider the way hallucinations can appear against a particular background of consciousness. One such model, which is particularly concerned with schizophrenic AVHs, hallucinations may occur when mental processes and internal dialogue feel distant and strange, such that they are no longer situated naturally and meaningfully within the experience of the self (Sass & Parnas, 2003; G Stanghellini & Cutting, 2003). While this hypothesis primarily considers the experience of *internal* states of consciousness, another view emphasizes distortions in the way the *world* is apprehended. From this perspective, hallucinations arise as the result of a disruption of the goal-oriented encounter with the world, such that objects lose their relevance or valence as meaningful tools with which to interact (Merleau-Ponty, 1945/1962). Stanghellini (2009) describes this as “a loss of *ready-to-hand meanings* to be attached to things in the world...they appear as *devoid of their ordinary meaning*, i.e. the way one usually puts them to use” (p. 58). As a result, “the initiative [of being drawn to use or interact with an object] comes from [the subject] and has no external counterpart” (p. 395). Thus, real objects lose their practical meaning, and instead, meaning or practical value comes to be attributed to inappropriate or unreal stimuli.

These explanations suggest that for certain populations, hallucinations may arise as part of an overall, fundamental shift in one’s relationship to self and the world, when internal states of consciousness lose their transparency and taken-for-granted tags of mineness, and objects in the world lose their immediacy and functionality. Such theories may indeed apply to AVHs among certain individuals or populations, particularly those who experience such major transformations of the structures of self and world, but do they accurately address all AVH phenomena? In particular, does either theory provide a meaningful framework for understanding the experiences described by Kate, or other individuals with AVH? These questions spur further consideration of the ways in which a phenomenological framework may be used in a clinical context to help better understand the unique experiences of individual patients.

### THE CASE OF KATE: A PRELIMINARY PHENOMENOLOGICAL ANALYSIS

Although philosophical phenomenology may tend to privilege live interviews, it may also be applied to written narratives or case descriptions depending on the richness of the material presented (as an example of this approach, see Sass, Pienkos, Nelson, & Medford, 2013). In the case of Kate, Shapiro et al. provide detailed information and numerous quotations that can be used to develop at least a partial understanding of the ways her experience is structured. In the following preliminary phenomenological analysis, only descriptions of Kate’s immediate experience will be considered; this may also include descriptions of her behavior, such as facial expressions, vocal tone, and more complex behavioral reactions. However, all interpretations will be omitted or bracketed from this analysis, to avoid the influence of external presuppositions and judgments.

An especially rich source of information in this case study is Kate's hallucinations themselves. Several of their features stand out. One is that the hallucinations could take the form of ordering or commanding Kate to do or not do something, which Kate then had to choose to obey or disobey. If she disobeyed these commands, then she and her family were at risk of being killed. Another is that her hallucinations placed significant responsibility on her to protect others, both her family and the entire world: "Kate believed that if she 'didn't stop [the voices], it will be the end of the world" (Shapiro et al., 2014, p. 233). A third is that both the voices and Kate's beliefs about the voices suggested a sense of intrusion: giant eels or men with guns were felt to be invading the private space of her bedroom or home, while the voices invaded the private space of her mind.

Other information is available in the reactions Kate had to her hallucinations. Shapiro et al. note that Kate was reluctant to acknowledge her hallucinations as "not real," and that she experienced frustration with her parents when they tried to calm her down by demonstrating the falseness of her hallucinations or delusional beliefs. There appears to be a sense of needing or wanting acknowledgement or verification of her experience from others, especially authority figures. Furthermore, in response to her hallucinations Kate typically became afraid and looked to authority figures to take charge and protect her. It is notable that the hallucinations tended to place undue responsibility on Kate, while she responded by abdicating her responsibility to others.

These details suggest the presence of several core features that structure or shape Kate's experience of herself and the world. One aspect of this structure is related to Kate's fear of hostility and aggression, and her need to keep out and control these experiences. This may be related to a second feature, Kate's feeling of responsibility for the safety and protection of loved ones. A final element seems to involve feelings of helplessness and inability to handle the responsibility she feels, with a resultant need for others to protect or care for her. In summary, Kate experiences herself as threatened and invaded by hostility, and responsible for protecting others from this hostility, but unable or unwilling to manage it on her own; while experiencing others as endangered by her hostility but also the only means of protecting or saving her from it.

## **DIAGNOSTIC IMPLICATIONS**

These features suggest conflicts around ownership, responsibility, and agency, as Kate seems to be grappling with concerns about whom the aggression belongs to, whose responsibility it is, and who is capable of handling it. Such conflicts can be found to some degree in both psychotic and nonpsychotic disorders (see, for example, Shapiro, 2000). They are also reminiscent of some experiences that have been found to be characteristic of schizophrenia-spectrum disorders. For example, Kate's struggles with accepting ownership and responsibility for aggressive impulses bear resemblance to loss of thought ipseity, the sense that thoughts and feelings no longer feel like they belong to oneself (Parnas et al., 2005). She also struggles with establishing firm boundaries around her experiences, fearing that these experiences will have a catastrophic effect on others and feeling burdened by responsibility to save or protect them from these effects. This aspect shares features with the sense, among some persons with schizophrenia, that one's internal experiences may magically influence external events in the

world, or that one has an extraordinary, messiah-like duty or help or protect others in the world (Parnas et al., 2005; Sass, Pienkos, Skodlar, & Jones, in preparation; G. Stanghellini & Ballerini, 2007).

However, as noted above, a philosophical phenomenological approach to psychopathology does not rely on the presence of one or more characteristic symptoms to determine the existence of schizophrenia (or any disorder), but emphasizes instead the relationship of these symptoms to the underlying structure of experience. Thus, while the hallucinations and other psychotic experiences in schizophrenia point to a global organizing structure of alienation from and disorganization of the basic components of self and world (e.g., Sass & Parnas, 2003), this does not seem to be the case with Kate. Instead, her hallucinations might be seen as representing an attempt to reconcile or compromise conflicts around anger and hostility, but which do not suggest a more fundamental disturbance of selfhood or subjectivity. That is, Kate does not appear to manifest global difficulties around feeling herself to be the stable, originating center of her experience or feel alienated from other thoughts, perceptions, emotions, sensations, memories, etc., disturbances of basic selfhood that have been found to reliably distinguish schizophrenia-spectrum disorders from other disorders (Nelson, Thompson, Chanen, Amminger, & Yung, 2013; Nelson, Thompson, & Yung, 2013; Parnas, Handest, Saebye, & Jansson, 2003).

In this way, she might be viewed as having more of a characterological disturbance, one that could certainly result in symptoms of anxiety, depression, or even, in times of severe stress, psychosis (Barnow et al., 2010; Kernberg, 1967; van der Zwaard & Polak, 2001). This is consistent with findings by Sass, Pienkos, Nelson, and Medford (2013) on similarities between depersonalization disorder (a form of dissociative disorder) and schizophrenia: while depersonalization symptoms were related to more defensive or compensatory processes, the experiences in schizophrenia seemed to arise in response to a more profound disturbance of “the very sense of existing as a distinct origin of awareness or perspective on the world” (p. 438), although it should also be noted that certain features of schizophrenia may also have defensive or compensatory functions. (Note that this discussion is not to suggest that Kate has depersonalization disorder, merely that certain psychiatric phenomena may share similar superficial features while the underlying disturbances remain distinct.)

## **IMPLICATIONS FOR TREATMENT**

Interestingly, the tentative conclusions of this analysis are quite similar to the formulation developed by Shapiro et al. The major difference is the way in which these conclusions were reached. While Shapiro et al. tend to rely on theoretical models taken from both behavioral and psychodynamic theory, the phenomenological approach starts without any theory, instead letting Kate’s experience speak for itself, drawing out the basic features from her experience, and assembling them into a meaningful picture.

The decision to take a phenomenological approach could be important for someone with Kate’s particular concerns. If she is indeed struggling with conflicts around control, passivity, and helplessness, any intervention that reinforces a power or control dynamic could have a negative impact on treatment outcome. Kate’s psychiatrist takes care to address this issue in

treatment, both by assigning a diagnostic status that reduces reliance on a “patient” identity, while encouraging Kate to assume more responsibility for her actions and her emotions.

However, the interpretive stance itself could be viewed as reinforcing a power relationship between Kate and her psychiatrist. That is, by telling Kate what is real and what is not, and by interpreting to her why Kate’s experiences are occurring, her psychiatrist assumes the position of authority figure, again placing Kate in a more helpless position. Indeed, an alternative way of understanding Kate’s reluctance to label her hallucinations as false is that this would require accepting an authority figure’s version of reality over her own. This is not to say that simply agreeing with Kate or reinforcing her hallucinations is appropriate, of course. However, it does suggest that involving Kate in her treatment as an expert on her own experience could be particularly therapeutic in light of her unique conflicts. Such considerations would not be inconsistent with cognitive behavioral approaches like the one described by Shapiro et al., which generally attempt to help individuals develop an adaptive understanding of their symptoms and awareness about related beliefs, with the aim of “making sense of voices...and aiming for meaningful change within the context of valued goals” (Thomas et al., 2014, p. S203). The major difference would be an emphasis on working *with* Kate to understand the meaning and function of her AVHs, rather than formulating or interpreting them *for* her.

Although the phenomenological analysis completed here was of course done without Kate’s participation, and could easily be used as a way of taking an authoritative stance and imposing meaning on her, this need not be the case. Indeed, recent calls for survivor-led participatory research emphasize that the involvement of mental health service users at all levels of research design and implementation is crucial for developing a more accurate understanding of mental illness, for spurring innovative approaches to treatment, and for transforming the power imbalance between service users and psychiatric research and care (Jones, Harrison, Aguiar, & Munro, 2014; Schrader, 2013; Woods et al., 2014).

In the past several decades, an approach to working with AVHs has arisen that further encourages the empowerment and self-determination of voice hearers. The Hearing Voices Movement (HVM) is an international movement, led by service users/psychiatric survivors, that promotes the agency of persons who experience “voices” or AVHs, and that strives to depathologize the experience of voice-hearing. As Corstens et al. (2014) explain, the main values of the movement include the belief that voices are meaningful, that voices can be understood in the context of a person’s life events, and that diverse explanations for voices are encouraged, including (and especially) explanations contributed by voice-hearers themselves. (Note that not all persons who experience AVHs agree with this approach; see, for example, Woods, 2013, p. 268.)

Viewing voices as meaningful responses to life circumstances is a strong departure from the traditional psychiatric perspective that AVHs are more-or-less meaningless psychotic phenomena. In fact, there are obvious parallels between this approach and Shapiro et al.’s perspective that Kate’s hallucinations were important in developing a better understanding of her central conflicts. This choice of whether to view hallucinations as meaningful and relevant can obviously have significant implications for treatment and outcome. As the sociologist Tanya Luhrmann (2012) writes, it can mean the difference between a positive and a negative prognosis,

between psychotherapy-focused interventions and heavy reliance on medication, and between seeing a person's experience as meaningful and seeing it as "un-understandable" (as Jaspers (1946/1963), and most mainstream psychiatric traditions, have tended to view schizophrenic symptoms). Shapiro et al. were similarly aware that the way they viewed Kate's AVHs could impact both their interventions and the way Kate experienced herself and her own role in recovery, and their thoughtfulness in this regard appears to have had a positive impact on Kate's outcome. This commentary would only suggest that a further bracketing of theoretical interpretations, to let Kate's experience speak for itself, could offer a even clearer picture of the form of Kate's hallucinations and their role in her life, while simultaneously contributing to the development of her confidence and autonomy as a maturing adult.

## **CONCLUSIONS: THE VALUE OF PHENOMENOLOGY FOR CLINICAL WORK**

As described in this paper, the diversity of experiences subsumed under the category of hallucinations is substantial, and many of these phenomena may bear little resemblance to one another beyond superficial similarities. However, it has also been suggested that the way in which these symptoms are understood has serious implications for treatment. Thus, it seems to be of utmost importance that the doctors and clinicians who work with the individuals experiencing these symptoms develop a clear picture of the basic forms and meanings of these phenomena. Just as medications may be ineffective or even harmful in treating hallucinations borne out of traumatic life experiences, for example, so might a narrative, meaning-driven approach like the one endorsed by HVM be inappropriate for those whose hallucinations represent a disorganization or dissolution of the basic structures of subjectivity. Incorporating the basic elements of phenomenology into the assessment and formulation of symptoms such as hallucinations seems to be crucial for developing hypotheses that actually fit the patient's experience in order to choose treatments that are appropriately matched to a particular phenomenon. Perhaps even more importantly, this approach can create opportunities for agency and empowerment in the patient him- or herself, a practice that may have potentially profound therapeutic, and political, implications.

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