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Opinion Paper

# Auditory verbal hallucinations and the differential diagnosis of schizophrenia and dissociative disorders: Historical, empirical and clinical perspectives

Andrew Moskowitz [a,*], Dolores Mosquera [b], Eleanor Longden [c]

[a] Touro College Berlin, Am Rupenhorn 5, 14055 Berlin, Germany
[b] Institute for the Research and Treatment of Trauma and Personality Disorders, Avenida de Oza 5, 15006 La Coruña, Spain
[c] Psychosis Research Unit, Greater Manchester West Mental Health NHS Foundation Trust, Harrop House, Bury New Road, Prestwich, M25 3BL Manchester, United Kingdom

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ABSTRACT

*Introduction.* – Despite the long association between auditory verbal hallucinations (AVH) or voice hearing and schizophrenia, recent research has demonstrated AVH's presence in other disorders and in persons without a diagnosis, particularly amongst those with a history of traumatization. But are there differences in the *type* of voices between these populations?
*Objective.* – To consider the status of the relationship between AVH and schizophrenia, in comparison to certain posttraumatic disorders, and the implications of this relationship both conceptually and clinically.
*Method.* – The relationship between AVH and schizophrenia was reviewed from an historical and empirical perspective, in comparison to the posttraumatic or dissociative disorders, borderline personality disorder (BPD), posttraumatic stress disorder (PTSD) and dissociative identity disorder (DID). The relationship between AVH in general and dissociation was also considered. A psychotherapeutic approach to working with voices from a dissociation perspective was presented, along with a clinical case.
*Results.* – AVH in schizophrenia appear to be very similar to AVH in other disorders, with some apparent differences disappearing when the person's attitude toward their voices changes. However, compared to BPD, PTSD, or DID, AVH in schizophrenia tend to be first experienced much later in life (adulthood as opposed to adolescence or even childhood), rarely include 'child' voices, and exert significantly less control over the person's behavior.
*Conclusion.* – AVH are common in schizophrenia and posttraumatic disorders, and are not significantly differently manifested in these disorders. We contend that all voices are dissociative in nature, and can be most successfully treated through respectful engagement, which seeks to recognize the underlying purpose/concern of the voices, and transform the person's relationship with their voices. The dissociative etiology of AVH in schizophrenia, however, may be somewhat different from that in other disorders – a 'bursting through' of dissociative parts associated with severe depersonalization, as opposed to a more gradual development through absorption and intense focus on internal states. In concert with Bleuler's original proposal of schizophrenia as 'split mind', it is proposed that schizophrenia might represent a 'low level' dissociative disorder. Research to further explore this proposal is suggested.


## 1. Introduction

Auditory verbal hallucinations (AVH), or voice hearing, is often viewed as a dramatic and seemingly bizarre experience, particularly for those who have never personally encountered it. For many of those who hear voices, however, they are simply a part of their daily lives. Indeed, despite its strong association with schizophrenia in the public and in many professional minds, it is becoming increasingly clear that the experience of voice hearing is common in many clinical conditions, as well as in persons with no history of psychiatric service use.

* Corresponding author.
*E-mail address:* a.moskowitz@outlook.com (A. Moskowitz).

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While it has long been recognized that many persons who hear voices who do not meet criteria for a diagnosis of schizophrenia, there is a long-standing belief that certain types or forms of voices are typical of schizophrenia; this is the question of *pseudo-hallucinations* – voices considered less typically psychotic than the *true* hallucinations found in schizophrenia. But the search to find characteristics of genuine or psychotic hallucinations has turned into a sort of psychiatric Holy Grail, wherein each supposed characteristic of 'psychotic' hallucinations (such as perceived 'location' in the external world) turns out to be illusory. Does this mean that there are no differences at all between the types of hallucinations found in persons diagnosed with schizophrenia and other disorders (such as mood disorders, posttraumatic stress disorder [PTSD], and borderline personality disorder [BPD])? We will attempt to address part of this question in this paper – namely, what are the similarities and differences in the experience of AVH between persons diagnosed with schizophrenia and those diagnosed with disorders we will broadly call 'dissociative' (following the arguments arising from the Structural Dissociation of the Personality model [SDP]; Van der Hart, Nijenhuis, & Steele, 2006): PTSD, BPD and the DSM-IV or DSM-5 dissociative disorders (APA, 1994, 2000, 2013), particularly dissociative identity disorder (DID). We will not consider the experience of AVH in other psychiatric diagnoses, organic conditions, or in 'healthy persons' (including hallucinations associated with grief).

The paper will be structured in the following way. First, we will discuss the rationale for comparing schizophrenia to dissociative disorders, along with the basis for considering PTSD and BPD to be dissociative disorders; given that they are not classified as such in the ICD-10 (WHO, 1992), DSM-IV or DSM-5.[1] Then we will briefly review the history of AVH and diagnosis, including the 'pseudo-hallucinations' debate, Bleuler's creation of the concept of schizophrenia, and Kurt Schneider's first-rank symptoms of schizophrenia. We will then consider the literature comparing AVH in the diagnoses we are considering, the relationship between dissociation and AVH in general, and clinical experiences bearing on similarities and possible differences in voice phenomenology between these groups. Finally, we will end with a section considering clinical implications of these findings, along with recommendations for future research to help illuminate the many questions still remaining.

## 2. Dissociation, structural dissociation of the personality, and dissociative disorders

The term dissociation is used in many ways, which has led to considerable confusion. Furthermore, the best use of the term has been often contested – for example, a spirited debate between supporters and detractors of the concept of *structural dissociation of the personality* (SDP) can be found in a 2011 edition of the *Journal of Trauma and Dissociation* (Cardeña & Bowman, 2011). The theory of SDP harks back to the original ideas of Pierre Janet, and considers dissociation to be a *division of the personality* as a result of *traumatizing* experiences. This is sometimes referred to as a *narrow* conception of dissociation, in contrast to a *broad* conception, which includes *alterations of consciousness* such as absorption (an intense focus on one part of one's current experience, either in the environment or in one's head) or depersonalization (feeling disconnected from one's self or numbed; Van der Hart & Dorahy, 2009). Such alterations in consciousness do not necessarily require or lead to a division of the personality. But there are disagreements about this, as some argue that absorption, particularly involving intense inner experiences, may contribute to the development of dissociative disorders (Bigelsen, Lehrfeld, Jopp, & Somer, 2016; Dalenberg & Paulson, 2009). And while chronic depersonalization, as in depersonalization disorder, does not seem to involve a division of the personality (and AVH is not common; Simeon & Abugel, 2006), some forms of depersonalization (such as not recognizing oneself or experiencing seeing one's body from a distance) do seem to be a part of SDP.

While we agree with the SDP position that dissociation is best considered as a division of the personality following traumatization, it may be possible that some forms of absorption or depersonalization can predispose for, or lead to, dissociative disorders. We will return to this possibility at the end of the paper. The theory of SDP argues that some mental disorders not currently considered as dissociative disorders should probably be classified as such. A brief summary of the theory will illuminate the basis for considering PTSD and at least some forms of BPD to be dissociative disorders.

The theory of SDP states that traumatizing incidents divide the personality into at least two parts (each with its own first person perspective). One part believes that the trauma is reoccurring in the present, and responds on the basis of specific defensive patterns (fight, flight and various freeze or immobility responses, or their psychological equivalents). The second part is trying to function in daily life, and as such avoids reminders of the trauma. In the theory of SDP (Van der Hart et al., 2006), the former is referred to as the *Emotional* part of the personality (or EP), and the latter as the *Apparently Normal* part of the personality (or ANP; the specific reasons for these names will not be discussed here). These parts are *dissociated* from each other, and often fear each other – issues that must be addressed in treatment.

In simple PTSD, Van der Hart et al. (2006) argue that there is one EP and one ANP – corresponding to the well-recognized PTSD symptom clusters of *re-experiencing* and *avoidance* symptoms. However, they insist that these are not only symptom clusters, but also dissociative parts of the personality. This is referred to as *Primary* structural dissociation.

While BPD is not widely considered to be a dissociative disorder, it is well recognized that extensive childhood trauma is very common in this disorder (Karamanolaki et al., 2016). Van der Hart et al. (2006) argue that most cases of BPD represent a more complex form of SDP, in which one ANP but several EPs develop – associated with different fear responses or different danger situations. This is considered to be *Secondary* structural dissociation. Finally DID, in which childhood trauma is ubiquitous and very severe, includes several ANPs and several EPs; it is considered to be an example of *Tertiary* structural dissociation.

In contrast, *schizophrenia* is almost universally considered *not* to be a dissociative disorder (but see Scharfetter, 2008), despite the recognition that childhood trauma is common (Longden & Read, 2016; Read, van Os, Morrison, & Ross, 2005; Varese et al., 2012). However, AVH are common in schizophrenia, and appear to be dissociative in nature (evidence reviewed below). Because of this apparent paradox, it is useful to compare voice hearing in schizophrenia to disorders which are considered to reflect the full range of structural dissociation, from primary to tertiary – PTSD, BPD and DID.

## 3. AVH and pseudo-hallucinations

It has long been recognized that experiencing hallucinations – and, in particular, hearing voices – need not be considered a sign of

[1] The theory of SDP considers most, but not all, cases of BPD to be dissociative disorders. But all BPD cases are characterized by structural dissociation of the personality. For the sake of simplicity, we will consider BPD and PTSD to be dissociative disorders because they are characterized by structural dissociation of the personality (as described below). What is clear is that the level of dissociation increases from PTSD through BPD to DID, and that schizophrenia manifests lower levels of dissociation than these disorders. It is less important, for the sake of our argument, whether BPD and PTSD are called 'dissociative', 'posttraumatic', or 'trauma-related' disorders.