Received: 4 June 2025 | Accepted: 2 September 2025

DOI: 10.1111/papt.70014

the british psychological society
promoting excellence in psychology

INVITED ARTICLE

From psychotic perceptual aberration to dissociative part of the self: An historical and personal overview of changing perspectives on voice hearing

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Abstract

Relational approaches to voice hearing (VH), which emphasize changing a person's attitude towards and relationship with their voices, challenge the medical view of VH as a psychotic symptom that can only be managed, typically through medication. In this paper, we review historical perspectives on VH, exploring factors that led VH to be classified as a core symptom of schizophrenia in the late 20th century. Around the same time, an alternative paradigm emerged through the Hearing Voices Movement, which argued that VH was a variation of normal human consciousness that should be accepted and explored without stigma. Dirk Corstens, a psychiatrist working within that perspective, joined forces with Andrew Moskowitz, a clinical psychologist with experience with dissociative disorders, to publish a paper entitled 'Auditory Hallucinations: Psychotic Symptom or Dissociative Experience'? In that seminal paper, Moskowitz and Corstens (2007) argued—after reviewing research on VH in the general population, similarities in VH between clinical and non-clinical populations, and the relationship between dissociation and voice hearing—that VH was better understood as essentially normal and dissociative in nature, rather than pathological and psychotic. They further argued that voice hearers would benefit from dialogical approaches seeking to understand the purpose of their voices and change the voice hearer's relationship to them. Since then, research and clinical trials have strongly supported all the tenets of the 2007 paper, to the point that relational or dialogical approaches to VH are now rapidly becoming an acceptable complement or even alternative to medical treatment for hearing voices.

KEYWORDS

dissociation, pseudo-hallucinations, psychosis, schizophrenia, voice hearing

Almost twenty years ago, we published an article in the *Journal of Psychological Trauma* entitled 'Auditory hallucinations: Psychotic symptom or dissociative experience?' In that article (Moskowitz & Corstens, 2007; published simultaneously as a chapter in the book *Trauma and Serious Mental Illness*, Haworth Press), we made the—at that time—radical hypothesis that auditory verbal hallucinations (AVH), or voice hearing, were more accurately conceptualized as *dissociative* than as *psychotic* in nature, and as essentially normal rather than pathological. This hypothesis was daring for several reasons: (1) There was only limited evidence in 2007 to support our position, (2) the dominant paradigm argued for *two types* of voices—true, or psychotic AVHs, and *pseudo*-hallucinations (non-psychotic or non-pathological)—and (3) certain voice-hearing experiences—namely, hearing voices commenting on one's behaviour or two or more voices conversing with each other—were considered *pathognomic* for schizophrenia. That is to say, from 1980 to 2013, the period covered by the American Psychiatric Association's DSM-III (APA, 1980), III-R (APA, 1987) and IV (APA, 1994), having those particular, common voice-hearing experiences fully met the symptom criteria for a diagnosis of schizophrenia (other criteria—such as impaired functioning—also had to be met for a schizophrenia diagnosis). How this came to be the case in 1980, with the publication of the DSM-III, is where our story begins.

VOICE HEARING AS A CARDINAL SYMPTOM OF SCHIZOPHRENIA

In the early 1970s, researchers were concerned that psychiatric diagnoses were too vague and unreliable, unable to be consistently applied. It was felt that accurate research on psychopathology, crucial for advancing understanding and treatment, could not be conducted utilizing the existing diagnostic systems. There was particular concern over the diagnosis of schizophrenia, as several studies (e.g. Kendell et al., 1971) had demonstrated that the diagnosis was used in a much broader fashion in the United States than in Great Britain. Because of this, psychiatrist Robert Spitzer (who became the lead editor of the DSM-III) and two of his colleagues, in developing a set of diagnostic criteria specifically for psychiatric research (the *Research Diagnostic Criteria* or RDC; Spitzer et al., 1975, 1978), turned to a British instrument called the *Present State Examination* (PSE, Wing et al., 1967). The PSE's diagnosis of schizophrenia relied heavily on Kurt Schneider's *first-rank symptoms*.

Kurt Schneider was a German psychiatrist who conducted a series of research studies in the 1930s in Munich, Germany, in which he sought to refine psychiatric diagnoses. Schneider (1937) argued, on the basis of examining roughly 5000 psychiatric inpatients, that certain symptoms were highly predictive of schizophrenia (in the absence of obvious organic pathology; Moskowitz & Heim, 2019). The symptoms (initially 9 and then 10) came to be called the 'first-rank' (and later, simply 'Schneiderian') symptoms of schizophrenia. Many of these were passive influence symptoms (feeling that one's thoughts, actions, emotions, etc. were 'caused' by an outside agent), but two were auditory verbal hallucinations: *Stimmen in Form von Rede und Gegenrede* (voices conversing or arguing) and *Begleitung des Tuns mit halluzinierten Bemerkungen* (a voice or voices commenting on one's behaviour).[1]

Spitzer was convinced that the PSE's use of relatively specific Schneiderian symptoms like 'voices commenting on one's behaviour,' as opposed to 'delusions' or 'hallucinations', could increase the reliability of the diagnosis of schizophrenia and therefore increase its scientific validity. He utilized the first-rank symptoms for the RDC schizophrenia diagnostic criteria and then for the DSM-III. Importantly, for Schneider, and for Spitzer and the DSM-III, the *content* of the voices was unimportant; it was only the *form* of the voices (e.g. conversing with each other or commenting on the person's behaviour) that mattered.

[1]The reasons why Schneider thought these symptoms to be predictive of schizophrenia, instead of a posttraumatic or dissociative disorder, have been explored elsewhere (Moskowitz & Heim, 2019). Contemporary research suggests that the majority of Schneider's first rank symptoms (including voices commenting and conversing) are actually *more* common in dissociative than in psychotic disorders (Moskowitz, Mosquera & Longden, 2017).

MAASTRICHT AND THE BIRTH OF THE HEARING VOICES MOVEMENT

The DSM-III, published in 1980, firmly and authoritatively (published by the American Psychiatric Association) established voice hearing as not only a symptom of schizophrenia, but a key signifier of madness—associated with the most severe psychotic 'disease', schizophrenia, more than any other disorder. However, only a few years later, a very different paradigm within which to understand voice hearing—the *Hearing Voices Movement*—was born.

The Hearing Voices Movement emerged from an encounter in the mid-1980s between Patsy Hage, a voice hearer who sought help for dealing with her voices, and Marius Romme, professor of social psychiatry at the University of Maastricht. Patsy heard several voices, including those she identified as gods. When she asked Prof. Romme if he believed that her voices were real, he replied, 'I believe that you *think* they are real'. According to the story, Patsy angrily left the room and returned two weeks later with Julian Jaynes's book *The Origin of Consciousness in the Breakdown of the Bicameral Mind* (1976), which claimed, on the basis of a detailed analysis of Homer's and other ancient texts, that everyone heard voices (including those attributed to gods) which helped to guide their decisions until around 3000 BC, and that hearing voices was a relic of past millennia. She challenged Prof. Romme's pathological conception of voice hearing, which she felt could not help her, and pressed him to address the *meaning* of voice hearing. As a consequence of this, Prof. Romme realized that the medical model was inadequate in helping voice hearers come to terms and cope with their voice hearing. Adopting a social psychiatric approach, he teamed up with Sandra Escher, a journalist who would later become his life partner, to find people who heard voices and were able to cope with them. Following a television show in 1987 highlighting their new perspective, they were contacted by several hundred voice hearers and began to organize conferences in the Netherlands, where participants shared strategies for coping with and understanding their voices. They reported on these conferences in their first article in *Schizophrenia Bulletin* (Romme & Escher, 1989). As the movement grew, *voice hearer* became an identity (Woods, 2013), detached from the pathological context to which it had belonged for centuries. This new perspective constituted a real paradigm shift. The emancipation of voice hearers became the central principle of the voice-hearing movement. Meanwhile, Romme, Escher and others developed the Maastricht Hearing Voices Interview (MHVI; Romme & Escher, 2000), and the *construct*, a concept which gave voice hearing a new meaning within the context of the voice hearer's personal life (Romme et al., 2025). The MHVI took a natural developmental perspective on voice hearing, informed by Sandra Escher's research on voice hearing in children and on the frequently significant impact of early trauma. It explored a wide range of aspects of voice hearing in a very 'matter of fact' manner, including when each voice began, what triggered it, what it said, how the person understood each voice, etc. The 'construct' was the proposed meaning of the voice, based on an exploration of what and/or who the voice represented in the context of the person's life experiences. A report was generated based on the MHVI, and the voice hearer was asked to review and comment on it or correct it. This alone was often therapeutic and led the voice hearer to feel fully engaged in the process.

DIRK CORSTENS, VOICE DIALOGUE AND TALKING WITH VOICES

In 1992, the second author, Dirk Corstens (DC) joined the Maastricht research team investigating voice hearing as a psychiatrist. He became involved in research and conferences for voice hearers and those who supported them. Encounters with voice hearers, inside and outside the consulting room, and the opportunity to follow-up with them over the years, was crucial. In the first year of the conferences, some of the participants slept at the back of the room because they were too sedated by medications. The following year, they took part in the discussions; the year after that, they climbed onto the podium!

More personal encounters with voice-hearing friends led to important lessons for understanding voice hearing in general. These included Ron Coleman, a charismatic speaker and creative thinker, with whom DC gave workshops (Coleman, 2018), Louise Pembroke, an activist voice hearer who radically advocated for the right for self-harm under extreme circumstances as a life-saving intervention (Pembroke, 2003)—also one of the participants of the voice dialogue experiment (discussed below), and Jacqui Dillon, an advocate activist for self-help and thinking differently about psychiatry (Read & Dillon, 2013). These individuals, among others, were invaluable in developing a professional approach based on user experiences.

Around 1993, Marius Romme invited psychologist Robert Stamboliev, who had introduced Voice Dialogue to the Netherlands, to spend five days teaching Voice Dialogue to professionals, including DC. He worked with a number of patients, including voice hearers, who were being treated in the social psychiatric service. Voice Dialogue (Stone & Stone, 1989) is a therapeutic approach developed by two California psychologists—Hal and Sidra Stone—who argue that everyone has different 'parts' of their personalities, or subpersonalities (which they called 'selves'), which could be engaged with in conversation by the person and/or the therapist. It was designed for use with non-clinical populations, but Romme and DC thought that voice hearers might benefit from this approach. By viewing 'symptoms' as expressions of subpersonalities and engaging in dialogue with these parts, meaning was discovered. For example, an intelligent young woman who was considered psychotic was suddenly understood differently when it was discovered that her 'psychotic world' derived from stories from the 'Star Wars' movies—her protection for dealing with unpleasant experiences in early childhood that could now be discussed and processed. Thanks to this session, she was, in time, able to break free from these experiences and work towards a university degree. The first two voice hearers DC treated with Voice Dialogue demonstrably improved (Moskowitz & Corstens, 2007). A woman who had been forcibly admitted to hospital for four years because of severe self-harm caused by her voices heard her voices telling DC that they wanted to help her but were frustrated because she would not accept their help. Her subsequent conversations with her voices enabled her to start collaboratively working with them as supporters. Five years later, DC heard from her; she told him that she now heard only one voice, which was positive, and that her life had completely changed and that instead of massive doses of medication, she was now only taking just one mg of the anti-psychotic medication haloperidol. The second patient heard a tormenting voice telling him to throw himself in front of a train. In conversation with this voice, DC was able to understand the anxiety behind the voice's apparently destructive commands and guide it to a 'teacher' position who adapted a protective attitude; this led to the voice no longer evoking fear but rather support in the patient. These therapeutic experiences, and those that developed from them, gained during various other activities in social psychiatry, became the source for further refinement of the method, which was expressed by DC through publications and presentations. One of those presentations occurred at a snowy conference in Hamburg in March 2006, where DC met Andrew Moskowitz (AM).

ANDREW MOSKOWITZ, VOICE HEARING AND DISSOCIATIVE IDENTITY DISORDER

Having worked with Bessel van der Kolk at his trauma clinic in Boston in the 1990s, the first author, Andrew Moskowitz (AM), moved in 1999 to New Zealand to teach at the University of Auckland. It was there that he first learned about dissociative disorders, including dissociative identity disorder (DID), in the community and prison system—through associating with two of the most experienced New Zealand clinicians working in this field—Ondra Williams and Margaret Needham. In this process, he discovered that many persons with DID not only switched from one dissociative part of their personality to another (when triggered) but experienced dissociative parts *intruding* into consciousness in the form of voices. That is to say, for persons with DID, voices represented dissociative parts of the personality which

would communicate with other voices or with the person[2] in addition to, or instead of, directly taking over executive functioning (i.e. control of the body). These voices often commented on the person's behaviour or spoke with each other, thus meeting the (first rank) symptom criteria for a DSM-IV diagnosis of schizophrenia.

Over the next few years, AM discovered the limited literature which examined the prevalence and significance of the Schneiderian/first-rank symptoms in persons diagnosed with DID. This research consistently found most of these symptoms (including the two voice-hearing symptoms) to be *more* common in DID than in schizophrenia, which frequently led to a misdiagnosis of DID patients as schizophrenic.[3]

Around the same time, AM discovered, through Margaret Needham, that there were a series of psychological approaches that posited that normal personality was not unitary but multiple, consisting of autonomous or semi-autonomous parts each with its own sense of agency. This idea could be traced back to Carl Jung's notion of *complexes* (Moskowitz & Heim, 2019) and was developed in perhaps its most elaborated form in the therapeutic approach called *Voice Dialogue*. This approach, in which AM received training in New Zealand (and, as discussed above, DC was trained in the Netherlands), provided the foundation for considering voice hearing to be on a continuum with the dissociative parts of DID on one end, and 'normal' personality on the other.

In 2005, AM moved to Scotland to take a clinical senior lecturer position in trauma psychology at the University of Aberdeen. The 'clinical' part of the position was a 40% commitment to work in the Scottish National Health Service (NHS). Soon, much of the clinical work he was doing consisted of individual therapy with voice hearers, where he applied the techniques he had learned from working with persons with DID.

In March 2006, AM heard DC speak at a conference in Hamburg, talking about working with voice hearers by building dialogue between the voices based on the *Voice Dialogue* model. They articulated an attempt to collaborate at that point. Later that year, AM presented a paper on voice hearing at the International Society for the Study of Dissociation conference in Los Angeles and was approached by Steven Gold, who was preparing a book on trauma and severe mental illness. Dr. Gold asked AM to submit a chapter on the topic for the book, and AM agreed, later asking DC to join. In 2007, the book was published—also as a special edition of the *Journal of Psychological Trauma*.

THE 2007 PAPER: *AUDITORY HALLUCINATIONS: PSYCHOTIC SYMPTOM OR DISSOCIATIVE EXPERIENCE?*

As far as we know, the first presentation that voice hearing per se was dissociative in nature, and certainly, the first argument that voices *not* be considered a psychotic symptom was put forward in this 2007 paper/chapter.

In this manuscript, AM & DC reviewed a number of domains relevant to voice hearing: (1) *historical perspectives* on the *interpretation* of voice hearing and the concept of *pseudo*-hallucinations; (2) *research perspectives* on the differences between so-called *pseudo*- and *true* hallucinations, on the frequency of voice hearing in both non-clinical and clinical populations, on the differences between diagnostic and non-clinical groups on characteristics of voice hearing and on the relationship between dissociation and voice hearing; and (3) *clinical perspectives* on dialogical approaches to working with voices. The historical, research and clinical domains addressed in this seminal article are summarized below.

[2]Technically speaking, this would be another dissociative part of the personality rather than a 'person'. The part of the person with DID interacting with the external world at work or in school is typically still highly constricted in its functioning—demonstrating only a limited repertoire of behaviours and excluding a wide range of emotions and memories of disturbing experiences held by other parts of the personality.
[3]Richard Kluft was at the forefront of arguing for the prevalence of 1st rank symptoms in DID and helped to explain the reasons for this. Indeed, in direct opposition to the DSM-IV, he suggested that such symptoms (including the two voice hearing symptoms) should be seen as an indication of the presence of DID, entitling his 1987 article 'First-rank symptoms as a diagnostic clue to multiple personality disorder' (as DID was then called).

All of the arguments presented here have been further supported by research published over the past 20 years.

For most of human history, voice hearing has been considered supernatural in nature—communication from divine or demonic sources or, in some cultures, messages from ancestors or recently departed loved ones. The first known physical or medical interpretation was by Teresa of Avila in the 16th century who, concerned that some of her nuns who heard voices would be persecuted by the Inquisition (as hearing the voices of Satan or demons), argued that *some* voices arose simply for physical reasons, such as suffering from melancholia or having a 'weak' imagination (Sarbin & Juhasz, 1967). She argued that such individuals should be treated 'as if' they were sick; her position proved influential and voice hearing began to be seen as a symptom of an illness.

Then, in the 19th century, systematic attempts were made to distinguish between different *forms* of voice hearing, with some classified as pathological and others more 'normal', creative or spiritual. According to Berrios and Dening (1996), there was a series of debates at the *Société Médico-Psychologique* in Paris, which sought to determine 'whether all hallucinations were abnormal; and whether location (internal vs. external) and insight (present vs. absent) were relevant factors to the definition of pathological hallucinations' (p. 756). Karl Jaspers (1963) added an additional factor—the level of reality accorded the experience. According to Jaspers, *pseudo*-hallucinations were experienced in 'inner subjective space' (i.e. located as coming from inside the head) and did not appear as real as genuine perceptions. This conception of pseudo-hallucinations—with the added component of intact insight—held sway through most of the 20th century. By contrast, *true* hallucinations—which were considered pathological—were believed to be experienced as originating from an *external* source and as concretely real (i.e. like genuine perceptions); insight was generally absent.

However, insight is not a *characteristic* of voices, but an *interpretation* of them (part of me/my illness/external agents such as demons)—essentially, whether or not voices are interpreted in a way that could be seen as delusional. As such, it cannot be considered a variable that distinguishes between different *types* of voices. That leaves the degree of perceived reality and, particularly, the perceived location of the voices as key distinguishing features between so-called *true* and *pseudo*-hallucinations.

It was evident even back in 2007 that voice hearing was a common experience in the general population (particularly in young adults; around 10% in Barrett & Etheridge, 1992; Posey & Losch, 1983; Tien, 1991), with only a minority of voice hearers coming to the attention of mental health professionals. Three large-scale population studies (7000–15,000 participants; Johns et al., 2002; Tien, 1991; Van Os et al., 2000) had found only 22–33% of voice hearers to be clinically distressed or involved with psychiatric professionals. Most were functioning well while hearing voices.

In addition, both externally *and* internally localized voices were common in all clinical and non-clinical populations; indeed, one study (Honig et al., 1998) found that 40% of their non-clinical voice hearers (i.e. no history of clinical mental health system contact) heard exclusively *external* voices. Many persons, in all groups, heard both internal and external voices, and there was no evidence that perceived location could aid in differential diagnosis. Further, most voices—both internal and external—were perceived as real as genuine perceptions; perceived location was not related to judgments of the voices' perceptual clarity (Oulis et al., 1995). The lack of validity of any formal distinction between psychotic and non-psychotic voices is perhaps best summed up by the title of one study from that time—*On the Non-significance of Internal* versus *External Auditory Hallucinations* (Copolov et al., 2004).

Having established that voice hearing was broadly similar in all groups, we next sought to examine dissociation as a possibly explanatory mechanism for voice hearing. As noted in a previous section, a few authors (e.g. Kluft, 1987; Ross et al., 1990) had examined the prevalence of the first-rank or Schneiderian symptoms of schizophrenia, which included two voice-hearing symptoms, in Dissociative Identity Disorder. Though limited in number, these studies consistently found those symptoms—voices commenting on one's behaviour and voices conversing with each other—to be common in DID, in some studies more common than in schizophrenia. In addition, a few studies had begun to examine the relationship between dissociation *scores* on the Dissociative Experiences Scale (Carlson & Putnam, 1993)

and hearing voices. All studies (there were only four) discovered a robust relationship between the variables, with one (Glicksohn & Barrett, 2003) finding 25% shared variance between measures of dissociation and voice hearing. All authors concluded, in one form or another, that dissociation conveyed a 'predisposition' to hearing voices.

Finally, the 2007 paper addressed clinical models for working with voices, on the assumption that they were dissociative in nature and represented parts of the self which needed to be understood. Based on the work coming out of Maastricht and the Hearing Voices Movement, therapeutic approaches from the trauma and dissociative disorders field (Brewin, 2003; Ross, 2004), and the Voice Dialogue model of working with 'healthy' individuals, DC and AM directly engaged with the voices of dozens of voice hearers (with appropriate safeguards, including getting permission from the person). The goal of this approach was not to get rid of the voices (indeed, this often needed to be explicitly emphasized in order for the treatment to work); rather, it was to improve the relationship between the voices and the person, and between different voices. The results—as in the vignette presented at the end of the 2007 paper—were often dramatic. Typically, when the voice hearer expressed an interest in the voices—instead of shunning them—they were transformed from negative/destructive to positive/supportive. It was realized through this approach that most voices became problematic only when their 'messages' were being ignored or not understood.

Based on reviewing all of the above historical, research and clinical evidence, we stated our position—radical not only for that time but, in many quarters, still today:

> AH [auditory (verbal) hallucinations] should no longer be considered psychotic symptoms, but simply one of a number of experiences (including various traumas) that can, under certain circumstances, induce delusions and lead to entry into the mental health system. Further, we believe that the evidence is strong enough to argue that, not only are voices non-pathological phenomena, but that they are dissociative in nature. As such, our position goes further than that of authors who have argued that dissociative experiences provide a predisposition or diathesis for AH
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> (Moskowitz & Corstens, 2007, p. 55).

PROGRESS SINCE 2007: FURTHER COLLABORATIONS AND PUBLICATIONS

Considerable work over the past two decades has supported every facet of the position AM & DC took in their 2007 paper. Important publications, presentations and collaborations between AM & DC and their colleagues (particularly Eleanor Longden) are discussed below, as well as relevant independent work by other clinical research teams.

In 2007, DC met Rufus May and Eleanor Longden and began working with them; this led to the publication of a paper five years later about the practical use of Voice Dialogue with voice hearers (Corstens et al., 2012). Rufus May, a clinical psychologist with lived experience, made an award-winning film in 2008 about voice hearing and Voice Dialogue together with the actress Ruth Wilson ('The Doctor Who Hears Voices'). In 2013, Eleanor Longden, a psychologist and expert by experience, gave a groundbreaking TED talk about her voice-hearing experiences. A year before, she had published a comprehensive review of the relation between trauma, dissociation and voice hearing—essentially, an update and elaboration of our 2007 paper (Longden et al., 2012). Public media became an important vehicle for informing the world about the Hearing Voices Movement—namely, that voice hearing is a part of natural human diversity that can be a number of things: a burden, an important way out from difficult life circumstances, a gift, a sense of identity and a feeling of belonging to a group of peers.

Research conducted since 2007 confirmed that hearing voices is a common human experience, and that most persons who hear voices do not receive psychiatric care. In addition, the

concept of pseudo-hallucinations has now been firmly demonstrated to lack scientific validity. A careful systematic review of voice characteristics and phenomenology in a range of clinical and non-clinical groups found no significant differences between groups on 20 out of 21 variables (including perceived source location, perceptual vividness, personification, duration and negative content; Waters & Fernyhough, 2017); only age of onset distinguished between the groups—considerably *later* in schizophrenia compared with other clinical groups and non-clinical voice hearers. Thus, there is no empirical basis on which to suggest that different *forms* of voices—*true* and *pseudo-hallucinations*—exist.

The role of dissociation in voice hearing has also become firmly established. While research has consistently found high levels of childhood trauma in voice hearers, two studies demonstrated that dissociation powerfully mediated between childhood trauma and voice hearing, emphasizing its importance (Perona-Garcelán et al., 2012; Varese et al., 2012). Two recent meta-analytic reviews of the literature (Longden et al., 2020; Pilton et al., 2015) found robust correlations ($r \geq .50$) between measures of dissociation and voice hearing in both clinical and non-clinical populations. Such strong and consistent correlations indicate the centrality of dissociation to voice hearing.

Both clinicians working in the dissociative disorders field and therapists using the Voice Dialogue model have found dialogue between dissociative parts of the personality to be therapeutically effective. AM & DC, along with a number of other individuals, have adapted these models to work with voice hearers.

In 2010, DC drafted a research proposal to evaluate the effectiveness of the dialogical approach of working with voices, which he entitled Talking with Voices. However, he did not have the time or financial support to implement it. Craig Steel, from the University of Reading, did and conducted the first pilot study of the Talking with Voices approach with 15 voice hearers using a multiple case series design (Steel et al., 2019, 2020). The results were impressive. Eleanor Longden, who was now working at Manchester University with Tony Morrison, built on this and conducted a feasibility study ($n = 50$; Longden, Corstens, Morrison, et al., 2021; Longden, Corstens, Pyle, et al., 2021) and, when that proved successful, a multiple centre randomized control trial ($n = 300$; Longden et al., 2022), which is discussed further elsewhere in this special issue.

While the focus of this paper (and the special edition of this journal) is squarely on relational approaches to working with persons who hear voices, it must be noted that considerable work has been done for decades on *psychological*—as opposed to *medical*—approaches to understanding and treating voices, along with (other) psychotic symptoms. Cognitive-behavioural approaches, particularly out of the UK, have led to theories and models of voice hearing that posit psychological mechanisms linked to their development, and treatment approaches that address relevant psychological variables. Some of these approaches, such as Trauma-Focused CBT for Psychosis (Tf-CBTp; Paulik et al., 2019), even acknowledge a close link between trauma and voice hearing, and the psychological meaning of specific voices, but do not emphasize dissociation or use dialogical approaches for treatment.

However, it should be noted that dialogical approaches to working with voices have proliferated in recent years and include Relating therapy (Hayward et al., 2017) and Avatar therapy (Ward et al., 2020). These dialogical approaches (in Avatar therapy, it is the therapist who plays the role of the voice), while recognizing the importance of the voices' function in the person's life, are primarily based on decreasing the person's distress experienced while hearing voices and increasing their assertiveness and sense of control in relating to the voices. Helping to transform the voices' *role* in the person's life is either not emphasized at all or is a secondary consideration. Further, while the *traumatic* nature of voices is recognized by these approaches, they are typically not viewed as *dissociative* in the sense of being a core aspect of the voice hearer's personality. Thus, we feel that these approaches, unlike Talking with Voices, are important first steps for helping voice hearers but do not go far enough. They still view voices as symptoms or experiences to be managed or controlled, rather than essential parts of the person that need to be respected and understood in order for true healing to occur.

CONCLUSION

While considerable work conducted over the past two decades has revolutionized our view of voice hearing, mainstream psychiatry continues to pathologize voice hearing and view it primarily as a symptom of schizophrenia. Despite the groundbreaking work of the Hearing Voices Movement normalizing voice hearing, the rigorous research studies establishing the central role of trauma and dissociation in voice hearing and the carefully designed clinical trials demonstrating the efficacy of accepting and engaging with voices, considerable stigma remains. One cannot help but feel that the entrenched professional resistance to this new paradigm of voice hearing is—at least partly—based in the fear of seeing human personality as *non-unitary*—with multiple centres of consciousness. If voice hearing is seen as an essentially normal response to extreme life circumstances, it means that no firm line can be drawn between sickness and health, and that all of us have vulnerabilities and wounded parts which need to be recognized, heard and healed. Contemporary psychiatry would benefit from listening to what Eugen Bleuler had to say, more than a century ago, about trauma, dissociation, voice hearing and schizophrenia:

> Independently of the conscious personality, wishes and fears regulate ideas to their liking and combine them in a compact complex, whose expressions emerge as 'hallucinations'; these appear to be so consequential and deliberate that they simulate a third person… But it is merely a piece of the split-off personality
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> (Bleuler, 1905/1918, p. 279).

> And not infrequently, after a careful analysis, we had to pose the question whether we are not merely dealing with the effect of a particularly powerful psychological trauma on a very sensitive person rather than with a disease in the narrow sense of the word
>
> (Bleuler, 1911, p. 300; translated from the German by Suenje Matthiesen).

AUTHOR CONTRIBUTIONS

Andrew Moskowitz: Conceptualization; writing – original draft; writing – review and editing. **Dirk Corstens:** Writing – review and editing; writing – original draft.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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How to cite this article: Moskowitz, A., & Corstens, D. (2025). From psychotic perceptual aberration to dissociative part of the self: An historical and personal overview of changing perspectives on voice hearing. *Psychology and Psychotherapy: Theory, Research and Practice*, *00*, 1–11. https://doi.org/10.1111/papt.70014