Friday, 24 August 2018

SUMMARY

There are to me, three glaring facts questioning the rigour and quality of contemporary science, or expert by knowledge accounts, of the veracity and pertinence of the origin and relevance of symptoms in schizophrenia. Scrutiny of the freely provided narrative testimonials on mental health forums for schizophrenia and AVH, indicate extensive conformity between authors regarding the validity and plausibility of phenomenological accounts of symptoms experienced.

I believe that it is important not to disregard the fact that there is a dichotomy that exists between the patients and the clinicians. This polarisation is not the result of age difference, socialisation, inferred aetiology, accumulated life experience, or any other psychometric strata. He polarity exists between “experts by knowledge”, and “experts by experience”. The testimonials and descriptions are immiscible when formulating an opinion for hypothesising explanations for the symptoms. I propose that it is directly a result of i) having first-hand access to the data ii) having (first-hand) access to sufficient amounts of the data. Having said this, I am not oblivious to the untenable nature of the testimonial accounts written on the forums. But the agreement in the accounts of experience experts, is noteworthy, and there is no overlap in the hypotheses of clinicians and researchers.

This article intends merely to express a wish that clinicians should explicitly acknowledge the salience and soundness of explanations about symptoms their patients/consumers express, and incorporate rather than dismiss, and not argue into falsehood, the sometimes paranormal beliefs that patients (uniformly) hold. If the schizophrenia forums are read quantitatively, it becomes clear and certain that it is inappropriate to repudiate paranormal or ethereal accounts, and to discount or falsify the beliefs held by patients.

CONVENTIONAL SCIENCE BEHIND AUDITORY VERBAL HALLUCINATIONS

This is also written to save lives. I assert the known fact that Auditory Verbal Hallucinations (AVH’s) take the form of personal and interpersonal ‘dialogue’ exchanges, that are unavoidably and unarguably experienced in a social context. They are not strictly or necessarily, merely, a disorder of consciousness. As an expert by experience, I know first-hand that lives are lost because the subject’s AVH’s express hatred and bring relentless animosity, and they bully patients into suicide. This situation is compounded by isolation and perfunctory clinical scientific explanations. Psychiatry is dedicated to amelioration or attempted extinction of AHVs through (psycho) pharmacology. But success is moderate, and the side-effects of psychopharmacology and the comorbid impacts are very real and quite high.

There is a perversity for patients being medically treated for diseases featuring Auditory Verbal Hallucinations (AVH’s). The pharmacology is renowned for introducing very uncomfortable feelings, ghastly and lethal side effects. There is an abundance of testimonial evidence on the forums and in research, such as “Individuals with severe mental illness die approximately 25 years earlier than the general population” (Hartz, Pato, Medeiros *et al* (2014)).

There is also a paradox and “catch 22” with psychopharmacology. That is, if the consumer continues to report non-diminished symptoms to the treating clinician, the most likely result is an increase in the dosage and/or variety of medication prescribed. However, the patients ***know*** and hate the impact and side effects that the pharmacology brings. Increasing the dosage or variety of anti-psychotic medication is horrendous and terrible to the patient’s sense of wellbeing. Therefore, patients have substantial and real motives to under report or falsely report the amplitude and frequency of AVH symptoms, and to exaggerate largely the efficacy of their medication(s)..

This document hopes to argue persuasively about the science of psychotic disorders and those that feature AVH’s. The hope is to convince clinicians that they should briefly, on the face of it, ‘buy into’ and not falsify the paranormal or ethereal explanations that patients hold and express. Rather, they should ask for, investigate, perhaps ‘humour’, and play ‘devil’s advocate’, with regards to the ‘spiritual’ beliefs that patients hold about their voices. At the very least, they should ask for, and investigate,

these non-scientific explanations, in order to provide the patient with URL's to the mental health forums, where they 9the consumer) can find solace, and help.

FLAWS ARGUABLE IN CONVENTIONAL SCIENTIFIC MODEL

This brief essay isolates some incongruence in the robustness and rigour of contemporary science regarding the erudition of discernible positive symptoms of psychotic malaise. It hopes to persuade clinicians of the validity of their patients non-scientific beliefs accounting for their AVHs, based on a strict and philosophical re-application of the scientific method. This essay does not wish to displace or invalidate current scientific explanations and beliefs about AVHs, but hopes to show how the scientific method can be correctly and alternatively applied.

The secondary purpose of this essay is to provide support and background to the following additional; papers: "Is It Dangerous - Delusional Acceptance" and "1st Person Transcripts - Novel Coping Strategy as part of Hallucination-focused Integrative Therapy". These additional two articles hope to deliver life-saving results for individuals who live with the experience of hearing voices.

Another motivation for publishing this paradigm is to augment the veracity of hypothesised etiological explanations for AVH afflictions, including "misattribution" and "sub-vocalisation". The latter two hypotheses are insulting to me as a person who lives with AVH's. I wish to argue against the invalidation, falsification, and expulsion of the beliefs patients hold about their voices, and I believe that extremely intelligent clinicians can easily find pathways that integrate and accommodate the unusual beliefs patients have explaining their AVHs, because ultimately, the patients do not abandon their beliefs after consultation and medication, and despite their psychiatrists proposal to do so, it is these embedded beliefs that may ultimately lead to suicide

AN ALTERNATIVE APPLICATION OF THE SCIENTIFIC METHOD

The following diagram shows the scientific method. It demonstrates the proven approach to conducting quality scientific thought, utilising experimentation and evidence based thinking.

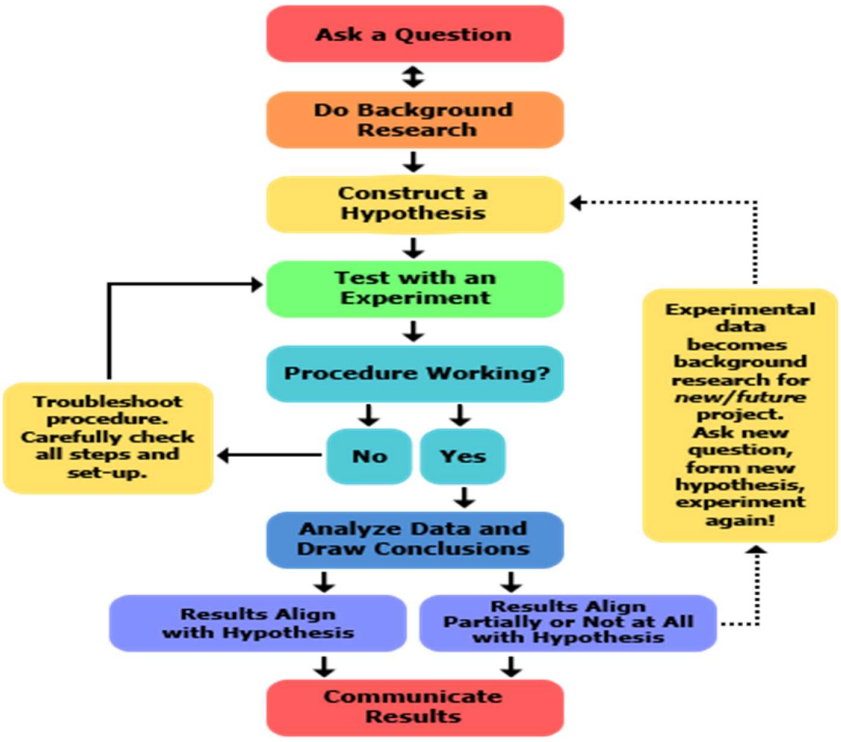


Image courtesy of : https://www.sciencebuddies.org/blog/digital-classroom-scientific-method-quiz and https://theethicalskeptic.com/2018/03/31/the-scientific-method-contrasted-with-the-experimental-method/

The various hypotheses of aetiology of AVHs that have gained support provide reliable and data valid explanations of causality of afflictions featuring AVH's as a key symptom(s). But now, we also have valid new first-hand insights into schizophrenic experiences across modalities, thanks to the testimonials in mental health forums.

The application of the scientific model thus far has produced hypotheses including neuroscientific explanations of abnormalities in brain morphology, over-activation and dysregulation of neurotransmitter and other neurobiological processes, appraisal errors, cognitive biases inter-relating with faulty bottom-up and top-down processes, neurophysiological intrusive cognitions, dopamine imbalances, and generally brain damage.

There is common agreement in research papers that an area that offers opportunities for further research and investigation is phenomenology. I would like to provide an alternative interpretation of the standard model that accommodates the real life beliefs that schizophrenics invariably hold

CONTEMPORARY SCIENTIFIC MODEL FOR POSITIVE SYMTPOMS FEATURING AVHS

FLAW # 1 – DICHTOMY BETYWEEN DIRECT ACCESS AND SECOND HAND DATA

Inherent in comprehension of schizophrenia and other psychoses, a disparity can exist between the clinical explanations (understanding) of the symptoms, and the reports of people presenting. This divergence is often biased and dismissed by the clinician on the grounds that the patient is delusional. However, only the patient has first-hand access to the data (the symptoms). Theoretically, the strength of this divergence can be empirically measured, by 1) the descriptive measures of first-hand reports to the psychiatrist, and 2) the statistical analysis of testimonials on WWW schizophrenia forums.

Specifically, schizophrenia practitioners rely on the summary verbal testimonial reports of individuals, who, ironically, by virtue of their illness, are regarded as unreliable sources of information. Currently, a schizophrenia diagnosis is based on achieving criteria of irregularities of perception and expression. In contrast, most other medical diagnoses (eg: oncology) do in fact pay strict attention to the symptoms related by the subject, and include analytical insights from biopsies, blood pathology etc, in addition to imaging and scanning etc. They have and rely on first-hand access to the symptomd.

However, in psychotic disorders, there is little availability of empirical data, mainly patient testimony. There is zero empirical data about the symptoms. This results in two problems. Firstly, the information from the patient regarding the characteristics and intensity of the symptoms, strictly limits the clinician to 100% here-say symptom data. Here-say is notorious for inaccuracies and is unreliable, so much so that it is inadmissible in the law courts, for example.

Secondly, the positive symptoms have complex and bizarre qualities that are very difficult to describe. This often motivates the doctor into prompting the patient about their the character of the symptoms, which is "putting words in people's mouths". The result can result in recycled pro-forma insight into the patient's symptoms. It is also noteworthy that the negative valence of AVH's symptoms, and the inevitable disparaging nature other positive symptoms is humiliating to the patient, impeding their ability and enthusiasm to describe symptoms in detail and at length; they can be embarrassing and difficult for the patient to relate.

The net effect this above limitations are that clinicians may not discover the details of this patient's personal subjective experience, instead attending to the prevalence, amplitude, frequency of the briefest descriptions of symptoms. As such, the character and nature of the patient's symptoms is generally assumed. I regard this as "the application of the symptoms of other individuals".

ACCESS TO 'FIRST HAND' DATA

There is an additional inconsistency in the assessment and diagnoses of psychotic illnesses that further weakens the scientific model. In other diseases, it is fundamental for the treating physician to closely attend to the patient's reported and measurable front line (first rank) symptoms. But for conditions involving AVH's, it is common that after an initial period, the subject meets with their psychiatrist once per month or less. If the subject hallucinates (audibly) for at least 8 hours per day, then after 30 days, they will have experienced 240 hours of hallucinations they are requested to describe, if the doctor proposes offering

pragmatic advice, in addition to prescribing medication. The result is that the psychiatrist can only suggest routine coping strategies, relying mostly on the belief that the medication is efficacious. But, efficacy is limited, and the patients often hate it.

The need for additional advice from the treating psychiatrist is expressed. “Medium- to long-term cohort studies of this kind suggest that around 20% of people diagnosed with schizophrenia show complete recovery and, overall, 40% regain good social functioning, with 16% of early unremitting achieving late phase recovery” (Barnes 2011). Testimonials appearing in online WWW mental health forums indicate lower efficacy levels of prescribed medications when assessed in first person by the subject, who is never free of the paradox described *supra*.

Imagine attempting to summarise 240 hours of television viewing, or 240 hours of university lectures, into a one or two minute summary; it would be impossible to properly convey sufficient information to facilitate psycho-emotional or psychosocial coping strategies. Reason urges that an attempt to condense this much information into a two-minute summary (or less), will inevitably result in the omission of salient features and themes in the symptoms, namely the AVH dialogue data. There is no science behind the treatment of phenomenological data. This is a serious omission, because it is the social and interpersonal hatred and bullying in the AVH’s that lead to suicide, and the efficacy of the medication is variably fixed.

Inspection of the WWW mental health forums quickly imparts the primary burdens for patients. Firstly, the insufficient relief provided by the prescribed pharmacology. Secondly, the hardship of coping with the symptoms at face value, and their real-life consequences. Thirdly, the impact and harm stemming from the failure to manage and cope with *prima facie* features of the first and second rank symptoms. Fourthly, the horrendous side effects of the psychopharmacology, that makes patients non-compliant and dismayed.

Regarding *prima facie* symptoms. If one collates a longitudinal set of phenomenological transcripts, or proxies of them as per YouTube (“Schizophrenia Voices Simulation”), there is evidence of the idiosyncrasies that lead the person experiencing the phenomena to conclude paranormal origins. Elements such as each voice having a particular individual and unique personality, and a unique attitude. The fact that these personalities / attitudes (individuals) come and go, often in “shifts”. The voices use of terms such as “we” or “him” or “her”, that are plural nouns and pronouns, used by voices when referring to other (individual) voices, that the hearer cannot know or verify. These knowable features of the voices cannot be explained by misattribution or subvocalization. Another factor that is unknown regarding the ‘agency’ that seems apparent in the AVH’s is the timing of statements made by the voices, in particular, the relationship between an AVH statement, and other (modality) hallucinations (such as somatosensory, tactile, gustatory or olfactory hallucinations). The patient clearly and certainly needs the clinician to arm them with effective coping strategies, and references to the mental health forums, where understanding and solace can be found.

PARADOX OF PROOF OF LACK OF STIMULI

The final problem with the contemporary scientific model is the dichotomy that commonly exists between “experts by knowledge” and “experts by experience”, and their explanations of causality. The explanations of psychiatrists amount to supposition, since there is a little if any (and there will always be – see *sup*) experimental data describing hallucinations, and a multitude of unverified hypotheses. Regarding experimentation, which is necessary to promote a hypothesis into being a theory, one cannot isolate perception of a non-existent phenomenon (an hallucination) from ambient environmental stimuli. Though it is possible but not yet undertaken, that one can test for a reaction to a phenomenon that does not exist.

There are a number of popular hypotheses that the psychiatrist will refer to, but none of them are fully proven. All the advice is aimed at explaining that the symptoms are hallucinations, for obvious reasons. However, there is overwhelming evidence in online mental health forums, where the majority of contributors express attempts to deal with what seem to be supernatural and alternative spiritual explanations. In theory, it is possible to statistically measure the strength and proportion of patients testifying alternatives to the ‘mere’ ‘hallucinations’ explanations. The dichotomy clearly exists between clinician and subject, but I think it is wrong to assert that the patient is incorrect in their opinion.

Whenever there is first-hand exposure to the front-line symptoms of schizophrenia, namely, AVH’s, there is measurable probability of a parapsychological explanation (not yet measured in research). But when there is zero first-hand access to sufficient amounts of these symptoms, there is only ‘an hallucination’ explanation. Of course, the medical ezxpert always wins, and invariably diagnoses as delusion. But the fact remains, that the delusion diagnosis is supposition, because it results from zero first-hand evidence of the symptoms. But, strictly speaking, there is also zero evidence to prove that the explanations

provided indicate delusions, since no-one can prove that the paranormal entity does not exist. In other words, the evidence for hallucinations is lack of evidence of anything else, hence, as a syllogism, there cannot be evidence of hallucinations

However, translating the phenomenology into empirical values can be done using transcripts, (without which there is no actual material evidence of the symptoms), the content ie, dialogue, of the AVH's must necessarily either be lies, or truthes. It must necessarily be so. If the patient were misattributing or subvocalizing, there would be a correlation in proportion, between the AVH that were proven to be 'saying' (stating) truth that is known and proven, the truth that is not yet known or proven, and that which can never be known, and hence proven to be lies.

Finally, a note about 'common' AVH content. I contend that no individual hates themselves as much as AVH's express hatred their victims. Simply because any/all person(s), understand and appreciates the reasons behind their decisions and behaviour. Each person, no matter their age, knows that they are acting according to the best possible decisions they make for themselves, given their knowledge and understanding of the world. This fact about everyone results in a normal amounts, styles and degrees of self-criticism, as any healthy person would have. No healthy person hates themselves to the extent that the AVH's hate and criticise.

There is an abundance of evidence to support the extraordinary spiritual type claims from subjects, evidenced in their testimonies on the WWW forums. Examples include voices working in shifts, having names, planning and plotting against the victim, awareness of social conventions and how to destroy them, evident individual personalities and attitudes, bullying (therefore relying on outnumbering the victim), and other interpersonal and personal idiosyncrasies, especially apparent when voices refer to other voices. Most phenomenological studies thus far have managed to quantitively identify the prevalence pf features such as "voices inside or outside the head", and "voices changing gender", and "being alone does not increase the frequency of the voices", and many more strata.

The common conclusions of the subjects involve the terms such as telepathy, demons, ghosts, beings, hate crimes, devils, and so on. These explanations can be distinguished from testable human origins, such as government mind control, conspiracies, past neighbours, because such explanations can be falsified and tested relatively easily. Reality testing requires some reflexiveness on order to eliminate confirmation biases and cognitive distortions, but it can be taught to victims. However, I have developed a coping strategy that is unique. The process of reality testing is best conducted using 1st person transcripts (as outlined in the essay that accompanies this – "1st Person Transcripts - Novel Coping Strategy as part of Hallucination-focused Integrative Therapy 080719.pdf".

Despite the controversial, implausible, and for a scientist, affronting tenure of these non-scientific explanations, if strict rigour of the scientific method is applied, there is no more evidence to refute these explanations, than there is to support them. The strong dichotomy between clinicians and subjects can be explained by first-hand data access, versus or no access to exact data at all. It can be further explained by access and availability to sufficient (very large) amounts of data, as denoted *supra.* Furthermore, the strength of this dichotomy is measurable and quantifiable. So too are the statistics and taxonomy/variety of exotic, spiritual, paranormal and non-scientific explanations, beliefs and conclusions.

It is unarguable and unambiguous is that the patient is probably unable to dispel their explanations, in preference for the scientific (hallucination) explanations provided by a psychiatrist. Especially when the hallucination explanation provided by the clinician, is defeated due to the social and interpersonal nature of the AVH symptoms. This leads to increased isolation of the patient, because the doctor now expresses lack of agreement, lack of sympathy and so lack of support. And even if the clinicians explanation, namely, "they are only hallucinations", is taken on board by the consumer, they (the consumer), still has to deal with the confronting interpersonal nature of *prima facie* personal attacks on the subject by their symptoms.

First hand exposure to the phenomena and subjective explanations are stratified by salient psychosocial factors such as age, scientific knowledge and understanding, worldly experience, wisdom, and secondary research psychoeducation. However, no empirical study provides evidence of the salience or confoundedness of these modulators. There is however evidence that they are not very strong, and even individuals with good scientific understanding prefer extraordinary explanations.

A further weakness in the conventional science demonstrates the dangerous failure of scientific. It is perverse. When a subject hears their AVH's 'say something', science suggests that the patient responds with something like "…you are just an hallucination". But the reality is that the AVH immediately responds with "No I'm not". As such, the patient has just been defeated argumentatively, like Monty Python, leaving them defenceless to inevitable and certain further expressions of hatred, malevolence, and bullying, resulting in the well-measured likelihood of suicide.

INABILITY FOR CONFIRMATION BY EXPERIMENTATION

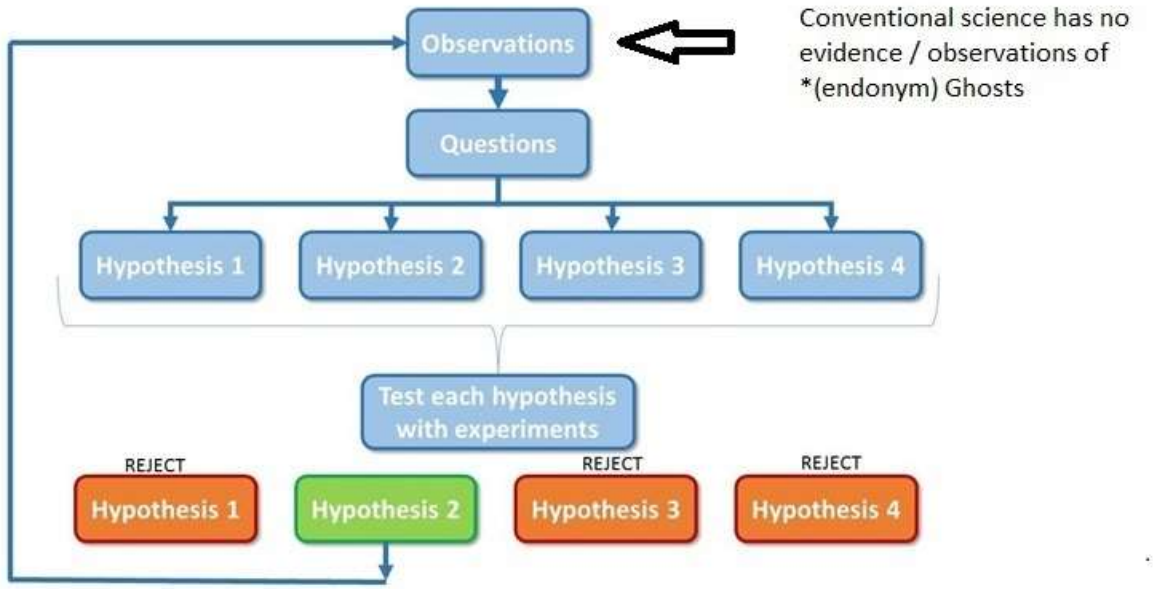
Though it is impossible to quantitatively measure a non-existent stimuli (an hallucination), the strength of a perceptual response to one is measurable. In studies, this feature can lead to an inability to refute a null hypothesis, and the impossibility of a hypothesis to meet a predicted outcome, necessary to validate a hypothesis into a theory. It is also relatively unachievable to isolate a perception from the continuous cognitive construction of the immediate world, necessary to quantify a particular response to an experimental introduction of a non-existent stimuli (an hallucination).

The expertise and authority of psychiatrists and psychologists stems neuroscientific investigation, and relies upon deductive and inductive reasoning, consolidated by quantitative analytical scientific research. It is not derived from first hand access to the data. Utilising a modus ponens argument: if there is no measureable stimuli, then it is an hallucination. However this is not encapsulated, thorough or immutable. It is more correct to assert: if there is no measureable stimuli, then there can be no perception of one. More importantly: if there is a perception, there must necessarily be a measureable stimuli, even if it is ambient sensitivity to the lab environment.

Obviously this reasoning is not extremely robust. Alternatively, using modus tollens reasoning: if there is no measureable stimuli, there can be no perception of it, only of other environmental elements. Without these predicate antecedents being true, it is not prudent to further conclude anything based on the relationship between an absence of measureable stimuli, and the constructs of perception. It is deemed to be an illusion when there is a false or faulty perception, and an hallucination when there is a perception in the absence of any measureable stimuli.

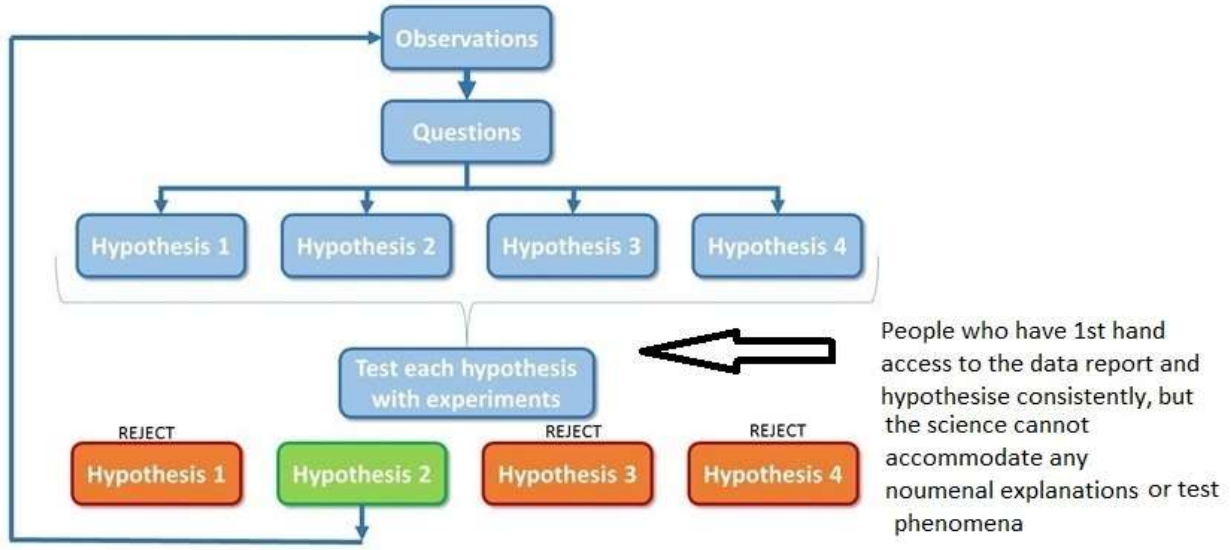
Blanke, Pozeg, Hara *et al* (2014) report that "Our findings …highlight the subtle balance of brain mechanisms that generate the experience of "self" and "other," and advance the understanding of the brain mechanisms responsible for hallucinations in schizophrenia." This is done without regard to measureable stimuli. The point I am asserting is that the science of hallucinations is not certain and strongly founded, and not rely on experimentation with hallucinations, since they rely on something that does not exist, and can therefore never be artificially introduced.

The diagram below conceptualises the current scientific model applied to schizophrenia and associated psychoses. The arrow has been included to identify a stage of process where there is remarkable and noteworthy incongruence between the data of schizophrenia etc (that has only recently become serendipitously sufficiently available and measureable), and the erudition and position held by specialist medical scientists and clinicians.



Original image courtesy of https://indiabioscience.org/columns/education/experiences-in-using-scientific-method-as-a-structure-to-teach-biology

The diagram below isolates a flaw or incongruence in the scientific model when applied to schizophrenia. The arrow indicates the region of incongruence between those who have direct access to the copiously large quantities data, and clinicians who rely on second hand descriptions of the data.



Original image courtesy of https://indiabioscience.org/columns/education/experiences-in-using-scientific-method-as-a-structure-to-teach-biology

I do not dispute the evidence acquired through MRI, fMRI, PET and potentially EEG apparatus, that indicates brain damage as a cause. However, it is possible to work with an ideological account that supports the supernatural explanations held by patients, whilst knowing and maintaining the epistemological fact that the ideology is 'wrong' (unsupportable scientifically), and that it is *per se* delusional.

THE CRITICAL IMPORTANCE OF SYMPTOMS

It is important to remember that once a subject has met the criteria for a diagnosis of schizophrenia, there is still on opportunity to closely examine their symptoms, having used the DSM V to meet the criteria of the presence of a category of symptoms. "Efforts to understand the psychological processes underlying experiences such as AVHs would be more successful if the phenomena themselves are studied directly than if diagnostic categories (e.g., schizophrenia) are studied' (Persons, 1986, in Oyebode 2012).

A detailed evaluation of the research of phenomenological explanation reveals a lack of empirical robustness, and abstracts and summaries an acknowledgement of lack of insight. "Understanding of the variation in subjective experiences of hallucination is central to psychiatry, yet systematic empirical research on the phenomenology of auditory hallucinations remains scarce."

The result is that one cannot completely dismiss the fact of the dichotomy between individuals having first hand encounters with the phenomena, and those who despite the utmost honourable intentions, only have second hand knowledge of the phenomena, and tend to work from *pro-forma* insight of them..

CONCLUSION - PROOF THEORUM AVAILABILITY IN META-ANALYSIS

This essay is not protesting or disputing any of the current research or science, or suggesting it is incorrect, or anything less than outstanding, life-saving, and of the highest quality, including hypotheses of causality of AVH's. However, the facts and reasoning that deny the supernatural accounts by patients, is the absence of any evidence to support such explanations. But there is no evidence to show an absence of stimuli.

This essay intends to elucidate a couple of anomalies in the science of AVH's, that necessarily excludes unworldly explanations. It can claim to provide a 'sympathetic ear' to the reports and testimonials of the subjects who can only find understanding in esoteric forums, and online venues, that act like a 12 steps program, where only other initiates can appreciate and relate to the testimonials made by others having the same diagnoses.

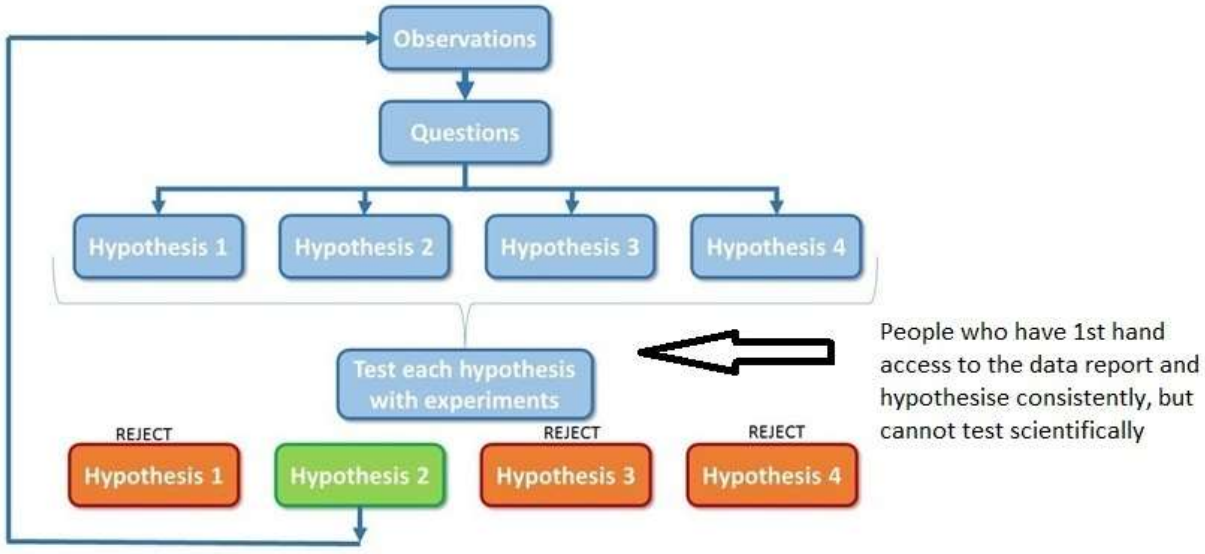
This paper has no intention of detracting from the work of clinicians and front line health care professionals. But these same professionals, without hesitation, agree that the only acclaimed experts of the unique symptoms and the subjective impact of medication, are the patients themselves. It is because of the difficulty, near impossibility, of expertise with the symptoms, that health care providers must maintain vigilance against malingering.

There is an obvious, unarguably correct foundation that underpinning the current paradigm of treating schizophrenia. There is proper obedience to the prohibition and exclusion of superstitious explanations to account for the bizarre but consistent phenomena experienced as symptoms, which comprise the defining criteria of a schizophrenia diagnosis. The negative valence of the aberrations and sensorial anomalies across various modalities are the delineating characteristic that distinguishes the 1% of subjects who present to clinicians for treatment, in contrast to the other 17% who do not.

There is properly no entertainment of any explanations of positive symptoms that involve form or agency, though these are commonly attested to by patients, in their attempt to account for the prominent features of the psychopathological subjective experiences that characterise the illness.

A PRIMA FACIE MODEL

If one reads at length the mental health forums that provide an opportunity for sharing, interaction and solace for those people who live with the experience of hearing voices, there is abundant evidence that they support paranormal assertions. Based on the reasoning above, I would like to suggest an opportunity for an alternative additional appraisal that empowers the subjects. It is reliant on their ability to simultaneously work with their symptoms at face value, yet know that despite the common sense understanding of what they hear, it is considered delusional.



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A P*rima Facie* framework could be simultaneously utilised, whilst maintaining cognizance that these face value beliefs are unsupportable (essentially delusions). This approach would utilise the phenomenology to improve treatment outcomes and minimise reliance on disabling pharmacology.

Not only does this disease feature social isolation as a second rank symptom, the isolation includes a disparity between clinician and patient, leaving the patient without any support, feeling that no-one at all understands their pain and circumstances, especially the personal style of hateful, critical and vindictive AVH's. It is the interpersonal characteristics of the phenomena, the hurtful and hateful 'bullying' of the symptoms, that results in such a high suicide rate.

In my own case, working with delusions at face value has proven to yield exceptionally efficacious coping and management strategies. A *Prima Facie* Framework has at its foundation a reverence and veneration of phenomenology. It provides esteem to the patient. Its effectiveness could be investigated and measured. It can be assessed for its ability to improve life quality factors and wellbeing for patients with schizophrenia.

> *Reality: https://www.behavioral.net/article/just-accept-it-voices-are-real?page=1*
>
> *Submitted by jessarenella on Mon, 08/20/2012*
>
> *To say that the voices are real is to grant legitimacy to the person's subjective experience. I hope this example clarifies what I mean:*
>
> *When a patient goes to a doctor for knee pain, the doctor acknowledges that experience as real and makes inquiries about the type of pain, when it started, what makes it feel worse/better, etc. The doctor doesn't say, "The pain doesn't exist" or "I've examined your knee and I don't see any evidence of pain." Even if the doctor takes an MRI of the knee and there is no structural damage, the doctor would work with the patient to find another explanation for the pain before saying "The pain isn't real and the sooner you accept this the quicker you will get better."*
>
> *Jessica Arenella*

If you browse the freely published testimonials of especially young individuals struggling with AVH, and listen to the schizophrenia voices simulations on YouTube, it becomes evident that the hostility and the negative emotional valence of the symptoms (phenomenology) is unambiguously contemptuous. The content of these hallucinations is sometimes claimed to be indicative of underlying mental anomalies, however I strongly protest that they must be assessed at face value, and as such are unambiguously hateful, and would obviously lead to suicide. The AVH symptomology is similar to internet trolling, or schoolyard bullying.

There is a paucity of research that utilises empirical analysis of qualitative data. This is paramount because direct transcriptions of AVHs are qualitative evidence Employing AI, NLP or machine learning, a set of designations of numerals could be systematically applied to any qualitative corpus (namely a record / transcription of AVH symptoms) to provide statistical measures. Data converted this way could provide new diagnostic opportunities and indicate AVH propensity for lethality.

The contention that leads to conflict is the significance and directness suitably applied to the data that is the symptoms. There is considerable weight apportioned to residuals of analysis (for confoundedness, co-efficiency or salience etc) that suggest that there is a propensity for hidden, obscure deeper meaning to the paucity of properly recorded data available.

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0) Audiotapes were transcribed and were processed using the grounded theory-based approach of “coding consensus, co-occurrence, and comparison” described by Dennis et al.26 Transcripts were independently coded by 2 coders (S.S. and C.D.) to this desacribes“ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3283145/

1a) too much of this phenom shit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4998935/

1) This article provides tables of what schizo’s suffer with, as per Reliability of the BSABS https://www.karger.com/Article/PDF/106311

2) Again, as above: https://www.researchgate.net/publication/7583892_EASE-scale_Examination_of_Anomalous_Self-Experience

3) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5764292/ beliefs about voices

4) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3984518/ claims schizo is a disorder of the self… (compare as a function of (1) above)

The following talks about primary / secondary symptoms, but as yet I have not located powerful research thatdemosytrates any recording or meausurement of any sympaoms at all

5) “Studies of first-episode patients hopefully get closer to primary symptoms, so the lack of diagnostic differences in symptomatology in the present study raises further questions about a fine categorical distinction between affective and nonaffective psychotic disorders.” https://www.google.com.au/search?num=20&rlz=1C1CHBF_en-GBAU808AU809&ei=54sJXOXaEoiz9QPprYSgDg&q=treatment+diagnosis+phenomenology+measurement+schizophrenia+psychosis+symptoms+mortality&oq=treatment+diagnosis+phenomenology+measurement+schizophrenia+psychosis+symptoms+mortality&gs_l=psy-ab.3...23320.31437..31807...1.0..1.1523.11986.5-6j5j2j1.....0....1..gws-wiz.....0i71j33i10.my_SUf1fJrE

“must not underestimate the many ways stress can affect one.No shame in that.Also,i do know RV and telepathy are fact,not fiction.I just wonder why “ http://www.abovetopsecret.com/forum/thread918770/pg1

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