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Review

Pseudohallucination: Divergent Conceptual Foundations and Their Consequences for Psychopathology

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SUMMARY

The concept of pseudohallucination remains a deeply problematic construct in Psychopathology, with persistent controversy undermining both clinical utility and research validity. This review identifies, through analysis of historical and contemporary literature, three primary definitions that underlie this conceptual fragmentation. These are categorized as the Insight-Based (prioritizing insight), Descriptive-Structural (emphasizing precise phenomenological description), and Pathognomonic-Psychotic (linking the phenomenon to chronic psychosis) definitions. The adequacy of these categorical frameworks is then evaluated through synthesis of modern research, which reveals insight as multidimensional and evolutive rather than binary, and hallucinatory experiences as existing on a phenomenological continuum that challenges a classification based on rigid divisions. Our analysis demonstrates that the incompatibility of these definitions, as well as the failure of reconciliation attempts, stems not from mere semantic differences but from a fundamental epistemological divide concerning the very method and aims of Psychopathology. Confronting this impasse, we propose a paradigm shift toward a dimensional and descriptive framework that moves beyond the hallucination/pseudohallucination dichotomy. This approach maps subjective experiences across multiple characteristics including perceptual qualities, insight, behavioral impact, sense of ownership and their evolution over time. Grounded in pragmatic synthesis, this reframing prioritizes precise description of lived experience over contested categorization, offering a coherent path to enhance clinical communication, diagnostic precision, and the scientific rigor of Psychopathology.

Key words: hallucination, psychopathology, phenomenology, insight, epistemology

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Introduction

The precise characterization of abnormal perceptual experiences represents a core challenge in Psychopathology, with implications for differential diagnosis, research validity, and therapeutic communication. The concept of pseudohallucination is central to this endeavor, yet it remains a construct marked by a persistent lack of consensus [1] since the beginning of its discussion in 19th century France and introduction of the precise term by Hagen in 1868 [2]. This is particularly relevant since the classification of a patient's experience as a hallucination or a pseudohallucination can influence clinical prognosis and treatment decisions, underscoring the need for conceptual clarity.

A historical and conceptual analysis indicates that pseudohallucination has its roots organized around three primary definitions. These are categorized as: Insight-Based Definition, which applies the term to hallucinatory experiences into which the subject has insight [3,4]; Descriptive-Structural Definition, which classifies it as a vivid, involuntary imagery with a

character of subjectivity and occurring in inner subjective space [5,6]; and Pathognomonic-Psychotic Definition, which links it to pure representations associated with secondary delusions in chronic psychosis [5]. The fundamental incompatibility of these definitions might be related with the natural instability and heterogeneity of mental symptoms [7,8] and points to an epistemological divergence concerning the methodology of Psychopathology – specifically, a tension between a pragmatic orientation toward clinical utility and a phenomenological tradition focused on the descriptive analysis of subjective experiences.

This longstanding conceptual situation is contextualized by developments in contemporary phenomenological and clinical research. Recent studies describe insight as a multidimensional, dynamic, and evolutive construct [9, 10], with correlates that vary across diagnostic groups and phases of illness [11]. Concurrently, the phenomenology of voice-hearing is increasingly framed as a broad continuum [12, 13], where dimensions such as the perceived locus of control are subjects of clinical interest [14, 15]. These empirical developments challenge the capacity of the historical, categorical frameworks that have structured the field to adequately capture the complexity of the hallucinatory experience.

The present paper aims to achieve three core objectives. First, through an analysis of the historical and contemporary literature, identifying and delineating the three primary definitions of pseudohallucination that structure the conceptual debate. Second, appraising these definitions in relation to modern empirical findings and examining the methodological foundations of their incompatibility. Finally, propose a shift in perspective towards a dimensional and descriptive framework. This approach attempts to move beyond the longstanding hallucination/pseudohallucination dichotomy by focusing on the systematic description of experiences across key parameters – such as perceptual qualities, insight, behavioral impact, sense of ownership and their evolution in time [16]. The aim of this perspective is to support diagnostic precision, cross-disciplinary communication, and the empirical investigation of psychopathological phenomena.

The main definitions

The discussion surrounding the concept dates back to the nineteenth century, beginning in French Psychiatry and subsequently influencing German, Russian, Latin, and Anglo-Saxon psychiatric traditions and has always been, both historically and semantically, dependent on the concept of hallucination – a caput mortuum [2]. In contemporary Psychopathology, we can now recognize, in terms of historical influence, clinical relevance and prevalence in literature, three primary, functional definitions of pseudohallucination – though these definitions are largely incompatible – and upon which other definitions are built.

1. Insight-Based Definition

One of the definitions, hereby called Insight-Based Definition for the sake of simplicity, is articulated by Bleuler, Goldstein, Sedman, and Hare, with its conceptual roots traceable to Falret's notion that if a hallucination occurs but "if images are experienced without belief in their reality, then we must accept that there is no insanity" [2]. Similarly, Bleuler conceptualises it as "Hallucinations, the morbidness of which is recognised despite the vividness of the deceptive perception" [17]. In this framework, the critical determinant is insight – perceptual qualities may be fully present, but if the individual recognises the perception as unreal, it is considered a pseudohallucination.

Hare's definition is practically identical, distinguishing subjective sensory experiences into four groups based on their origin, interpretation, and whether they are normal or morbid. The concept of pseudohallucination is thus reserved for those sensory experiences of morbid origin with a non-morbid interpretation by the patient, i.e. there is insight [3].

Sedman is notable for having conducted a comparative study between pseudohallucinations, genuine hallucinations, and imagery. This study of 72 patients provided early support for the Insight-Based Definition by demonstrating distinct clinical correlates for different types of perceptual experiences. He defined pseudohallucinations as "hallucinations which are perceived through the senses, but recognised by the patient as not being a veridical perception" [4], confirming insight as the crucial factor. His findings revealed a significant association: genuine hallucinations were strongly linked to schizophrenia and schizoaffective disorder, whereas pseudohallucinations were more prevalent in individuals with specific premorbid personality traits, including self-insecurity, anankastic and sensitive features, and attention-seeking behaviors [4].

2. Descriptive-Structural Definition

Another definition, hereby called the Descriptive-Structural Definition, is primarily associated with the work of Kandinsky and Jaspers. Kandinsky, drawing from his observations of patients and from detailed description of his own hallucinatory experiences [5], differentiates hallucinations from "hallucination-like" phenomena, the latter being "subjective perceptions which in vividness and character resemble real hallucinations except that they do not possess objective reality" [5], in the sense that they do not possess the reality and concreteness of a perception but are figurative – they are seen by an "inner eye" [6]. Curiously, even though Kandinsky adopts

the term pseudohallucination as a subtitle for the longest section of his book, he considered the term pseudohallucination as confusing, preferring others such as "hallucination-like", "hallucinoid", "presentation", "illustration", and "illumination" [5].

Jaspers extends this idea by establishing six criteria that distinguish normal perception from normal imagery: 1) perceptions are of concrete reality, they have a character of objectivity while imagery is figurative and has a character of subjectivity; 2) perceptions appear in external objective space while images appear in inner subjective space; 3) perceptions are clearly delineated and detailed while images are incomplete; 4) in perception, "sensory elements are full and fresh" while in imagery are only occasionally so, most being "relatively insufficient"; 5) perceptions are constant while images dissipate; 6. images depend on will while perceptions do not [6].

Using these criteria, Jaspers classifies pseudohallucinations as a particular type of representation or imagery. While it retains the four last characteristics of sense-perception – clear delineation, full sensory elements, constancy, and independence of will – it lacks the first two traits – they are figurative, having a character of subjectivity, and appear in inner subjective space. Jaspers posits that these traits "divide perception sharply from imagery, as by a gulf, and there are no transitions" [6]. However, he later concedes that transitions might exist, stating that "pseudo-hallucination can change over into hallucination" or "all the phenomena combine" [6], but that sharp distinctions are necessary to create some kind of standard[6]. Insight and pathological significance play no part in this definition, unlike the previous one where they become the critical determinant. Likewise, the precise appraisal of these six traits that distinguish perception and representation, according to Jaspers, play no role in the previous definition.

3. Pathognomonic-Psychotic Definition

The last main definition, hereby called Pathognomonic-Psychotic Definition, starkly contrasts with the notion of pseudohallucination as devoid of pathological significance, as is argued in some sources [18], since it is associated by its very criteria with chronic psychotic states. This conceptualisation appears to have been marginalised in Anglo-Saxon Psychiatry, as most recent articles on pseudohallucinations either overlook it or mention it only superficially.

Its origins trace back to Lugaro, who defined pseudohallucinations by five key characteristics: they are pure representations, ego-dystonic, give rise to secondary delusions, result from cerebral irritation in the associative centres (not sensory centres like hallucinations, following Tamburini in this regard [19]) and are observed in long-term psychotic states such as chronic schizophrenia [2]. One might assume that this conceptualisation has little contemporary influence, but this would be incorrect. This definition persists, particularly in Latin countries, and variations of it are regularly found in current Psychopathology or Psychiatry textbooks. For instance, Vallejo Ruiloba defines pseudohallucination or psychic hallucination as a phenomenon that occurs within the mind and does not correlate with any sensory modality, making it hard to separate from other cognitive processes. Yet, the patient believes it to be real – i.e. there is no insight. Vallejo adds that, when they are present, these pseudohallucinations guide us to the diagnosis of Schizophrenia [20]. Similarly, Ricardo Capponi refers to both Jaspers' definition and the presence of insight but, when discussing verbal pseudohallucinations, describes them as the hearing of thoughts or inner voices, an internal dialogue that feels imposed upon the patient, indicating severe disturbances in identity and boundaries of the self, potentially leading to delusions of control and influence. Admitting that these are frequently described as thought passivity phenomena, Capponi argues that they are phenomenologically pseudohallucinations or psychic hallucinations as they are mental representations projected in internal subjective space [21].

Main Differences

In summary, Pathognomonic-Psychotic Definition and Insight-Based Definition stand apart from the Descriptive-Structural Definition because they directly or indirectly consider insight. On the other hand, Pathognomonic-Psychotic Definition differs from the Insight-Based Definition because each considers an exact opposite valence of insight, the former its absence and the latter its presence. Consequently, the pathological significance attributed to each of these two definitions is drastically different. The former is taken as indicative of psychosis and Schizophrenia and the latter is commonly regarded as related to certain personality traits. The Descriptive-Structural Definition makes no claim regarding pathological significance.

Other Definitions

Lastly, it is opportune to refer that in addition to these definitions, there are also more lax definitions, commonly found in clinical practice, where the only criterion seems to be that the phenomenon is "anything that isn't an actual genuine hallucination", even if it is an illusion or another type of phenomenon. Examples of this can be found in various articles, where pseudohallucinations are described as "the feeling of perceiving sounds and colours more intensely" or as having "seen movements in pictures hanging on the walls" [22]. Another example is the use of a modified Descriptive-Structural Definition

which doesn't account for its criteria of sense-perception – clear delineation, sensory freshness, persistence, and independence of will – potentially labelling completely normal representations as pseudohallucinations.

A Critical Appraisal of the Main Definitions

1. Insight-Based Definition

In a critical perspective, this definition's foundational criterion is inherently problematic. It relies on a binary construct (presence/absence of insight), whereas contemporary research firmly establishes insight as a multidimensional and dynamic phenomenon that waxes and wanes over time, existing in a dialectical relationship with other clinical variables [9]. This definition's celebrated clinical utility is thus achieved by reductively collapsing a complex experience into a single, unstable metric. The empirical evidence underscores this complexity. Insight has correlates which are not universal but vary significantly by diagnosis and illness phase. In Schizophrenia-Spectrum Disorders (SSD), it is linked with higher IQ, better executive function, premorbid adjustment and frontal and parietal gray volumes, whereas in non-SSD psychosis insight was correlated with general functioning and female gender. Insight was poorer in SSD patients and worsened over time [10]. Crucially, the very predictors of insight – such as neurocognition, social cognition and symptom dimensions – might only become relevant in more advanced phases of illness, appearing to have little effect on insight at the onset of psychosis when comparing patients with chronic or multiple-episode psychosis and patients with recent-onset psychosis [11]. This demonstrates that insight is evolutive, not static. Furthermore, the clinical picture can be complicated by other symptoms such as intellectual ambivalence in Schizophrenia where a patient may affirm that his experience is both his neighbours really commenting on his actions and, simultaneously, a fabrication of his "psychosis". The patient lives in a double ontological orientation, both our shared social reality and the private immanent sphere where the psychotic phenomena are articulated.

This dimensional nature of insight is reflected in various scales that measure distinct domains – from insight into presence of symptoms, attribution of symptoms, social consequences, need for treatment and into mental disorder. Importantly, these domains can be mapped onto three core strata of insight: (1) meta-representational awareness – recognizing an experience as a symptom; (2) situational attribution – accurately ascribing its origin to one's own mind or a disorder; and (3) action-guiding uptake – translating this awareness into seeking or adhering to treatment. All of these are influenced by a web of social and cultural factors, personal experiences, beliefs, expectations, memory and executive functions [23] and in themselves influence divergent clinical outcomes. Furthermore, the clinical assumption that pseudohallucinations are more prevalent in Personality Disorders is challenged by phenomenological research on the phenomenology of hallucinatory experiences in Borderline Personality Disorder (BPD). Multiple studies [24,25,26,27,28] concluded that the hallucinatory experiences in BPD do not show significant phenomenological differences from the voices found in SSD. This includes beliefs regarding the origin of their voices [26,28]. The finding that SSD patients may more frequently identify dialogues between voices as "unreal", although not being a phenomenological distinction, appears to be a reflection of the insight criterion, thereby circularly weakening the very definition this evidence calls into question [27].

Anchoring the definition of pseudohallucination to the presence of insight thus becomes a fundamentally unsound endeavour. It creates an arbitrary distinction where two perceptually identical experiences are classified differently based solely on a patient's fluctuating awareness at a given moment in their illness trajectory. We question the validity of the pseudohallucination construct itself when defined by insight, as it appears to name not a distinct phenomenological entity, but a person's relationship with their symptoms which might represent a transient phase.

2. Descriptive-Structural Definition

While valued for its phenomenological rigor, the Descriptive-Structural Definition imposes an artificial division that fails to capture the fluid and heterogeneous nature of hallucinatory experience. Its rigid criteria assume static, pure perceptual qualities, which are far rarer in clinical practice than the definition suggests.

This is evidenced by the growing consensus around a symptom continuum, where experiences range from imagery with perceptual qualities to full-blown hallucinations. Within this continuum, dimensions like localization, vividness, reality testing, temporal continuity, functional impact, degree of control over the experiences, presence of secondary delusions and whether they are triggered by external cues have been proposed as not being binary but graded, making sharp distinctions between hallucinations and pseudohallucinations clinically challenging [12,13]. Empirical surveys (phenomenological survey, 199 participants with experience of auditory hallucinations) [29], (hierarchical cluster and multidimensional scaling analyses, 100 patients with history of auditory verbal hallucinations) [30] support this model suggesting that it could inform therapeutic decisions and reveal distinct phenomenological clusters–one characterized by self-attribution, repetitive content, low linguistic complexity, and external spatial location and another by systematised content, high linguistic complexity,

internal spatial location, multiple voices and attribution of the voices to external sources [29] –with potential neurobiological correlates [30]. The overlap between thought and perception is further blurred by the existence of "thought-like voices" which tend to be more complex and distressing than typical "auditory voices" [14], and which are associated with a higher severity of suicidal ideation than so-called genuine hallucinations [15].

The definition's core distinctions appear to collapse under longitudinal and qualitative evolution. In schizophrenia, hallucinations often evolve from a loss of cognitive control with thought interferences and thought blocking and a progressive gain of auditory quality followed by a blur of the phenomenological space compromising the discrimination between thoughts and auditory images in the inner space which later seem to be projected externally as the "as if" quality is lost and "mineness" dissipates [31]. This progression is accompanied by qualitative changes in content and complexity [32,33]. Crucially, spatial location – a cornerstone of the Descriptive-Structural Definition – proves to be an ambiguous and fragile dimension for patients. Many cannot clearly localize their experiences, reporting voices as diffusely "everywhere and nowhere," or shifting between internal and external space [32]. One study (80 individual with a lifetime diagnosis of a SSD disorder) [14] found that only a small minority of patients with SSD (17.5%) had experiences conforming to conventional definitions of auditory hallucinations, while the vast majority reported quasi-auditory, thought-like, or mixed patterns.

This heterogeneity extends beyond psychotic disorders. In Autism Spectrum Disorders (ASD), for example, individuals may report sensory anomalies, vivid inner speech, or source-monitoring difficulties that produce experiences challenging the clear percept-representation binary, further undermining rigid phenomenological criteria based on spatiality or sensory vividness alone.

In reality, patients frequently learn the terminology of "hearing voices" from clinicians; their primary experience is often not one of mistaking hallucinations for normal perception, as even when experienced in external objective space it is of a nature very dissimilar from our shared social space, but of encountering something phenomenologically alien, acontextual, and impoverished [34,35]. Also, the most common characteristic allowing patients to distinguish hallucinations from their own thoughts might not be loudness, clarity of verbal imagery or spatial location, but verbal content distinct from the patients' ordinary verbal thought, lack of control and a characteristic non-self 'sound' [36].

Further, the very concept of perceptual "objectivity" (Leibhaftigkeit) is critiqued by Mayer-Gross [37], who argues that it fails to convey the disruption of the embodied self in its relationship to the hallucinatory object, that the very distance between foreground and background becomes disturbed. In fact, the hallucinatory experience can occur in a very different phenomenological space, a fragmentary space where it becomes highly salient compared to other perceptions and thus being detached from both foreground and background. Hallucinations are not mere perceptions without object but they involve themselves an alienation from the perceptual world and an inability to detach from the hallucination. Ultimately, hallucinations may be better understood not as false perceptions, but as disorders of self-consciousness – the becoming conscious of an inner dialogue [38].

This evidence portrays a reality that is incompatible with this definition's sharp divide revealing it as relatively arbitrary and artificial which, because of the stagnant quality of such sharp distinctions, doesn't fully represent the complexity of patients' lived experiences. The assertion that "images depend on will while perceptions do not" is further challenged by involuntary imagery in both Psychopathology and creative professionals. This view fundamentally undermines not only Jaspers' dichotomy but also the DSM's definition of a hallucination as a "perception-like experience" [39]. The hallucinatory experience does not mimic perception; it emerges from a pathological modification of the patient's immanent sphere [34], representing a qualitative break from the perceptual world that the rigidity of the Descriptive-Structural Definition doesn't appear able to contain.

3. Pathognomonic-Psychotic Definition

This definition faces significant theoretical and practical challenges. A primary issue lies in its claim that "pure representations" give rise to secondary delusions. This appears to identify a key cognitive alteration in psychosis, where patients act as "bad statisticians" assigning meaning to evidence that is weakly supported and therefore accepting hypotheses that a nonpsychotic individual would reject or attempt to validate with additional evidence [40]. As detailed above, aberrant sensory or sensual input in psychosis might not be a driving factor for hallucinations or the elaboration of delusions. The main factor might lie in an aberrant interpretation of intrusions. However, this very model highlights a contradiction: if the core pathology is an aberrant interpretation, then the main driver of delusions is not the sensory quality of the experience but the lowered threshold for accepting unfounded explanations. Indeed, fully-fledged hallucinatory phenomena can emerge in non-psychotic individuals (*e.g.*, in OCD) where their self-generated nature is acknowledged. The critical difference in psychosis is not the presence of a "pure representation," but the externalization and delusional elaboration of that representation due to this cognitive bias [40].

This process of externalization might find its mechanism

in the anomalies of imagination characteristic of schizophrenia. As noted earlier, hallucinatory experiences often evolve from internal thought-like phenomena into externally projected perceptions [31, 32]. This continuum might be underpinned by a tendency for the spatialization of imagination, which exhibits increased vividness in the schizophrenia spectrum [41, 42]. When this is coupled with a dissolution of ego boundaries and altered source monitoring, these vivid, spatialized representations can lose their sense of ownership, progressively transforming into "visions" or "alien messages" [43,44]. Therefore, what Pathognomonic-Psychotic Definition categorizes as a distinct "pseudohallucination" may also simply be one phase in a dynamic process where an internal representation is influenced by anomalies in imagination and self-experience.

Additionally, the definition's handling of insight is problematic. While it indirectly incorporates insight with the opposite valence of the Insight-Based Definition (i.e., absence of insight), it remains vulnerable to the same criticism regarding the dimensional and fluctuating nature of insight, which cannot reliably support a categorical distinction.

A most critical flaw, however, might lie in this definition's circularity. Pseudohallucinations are defined by their association with chronic psychotic states, which in turn becomes a diagnostic indicator of those same states. This circular reasoning reifies diagnostic categories rather than clarifying phenomenological experiences. Finally, this definition risks blurring the crucial distinction between pseudohallucinations and first-rank symptoms, as it encompasses phenomena where defining perceptual properties are entirely absent [16], thereby being vulnerable to creating more diagnostic confusion than it resolves.

Conciliation attempts

Along such wildly different definitions came attempts at conciliating them to clarify the concept and reach a unified approach. One of the most influential attempts was Kraupl Taylor's [45], which identified both Hare's and Jasper's definitions, connecting them with the English and German traditions respectively, and arguing that both had value in Psychiatry. However, the clear incompatibility of these definitions suggested that the first should be labeled as "perceived" pseudohallucination and the former as "imaged" pseudohallucination. It is important to nevertheless note that Taylor's definition of "perceived" pseudohallucination does not entirely overlap with Hare's definition since Taylor accepts that it could happen in healthy people or, in other terms, it could have a non-morbid origin, unlike Hare's definition.

Similarly, there have been attempts to develop additional categories to address the complexities associated with pseudohallucinations. One such effort is the subdivision of pseudohallucinations into three distinct subtypes: nonpsychotic hallucinations, which would include isolated instances where reality testing remains intact, such as in grief reactions or vivid internal imagery often associated with dissociative pathology; partial hallucinations, which are described as "fading hallucinations with increasing insight," where the individual gradually recognises the unreality of the experience; and, lastly, transient hallucinations, that would be characterised by a temporary lapse in reality testing, commonly observed in individuals with borderline personality disorder [12].

Some other conciliation attempts lie in different interpretations of the previous definitions. For example, it is argued that Jaspers' second criterion for sense-perception – that it happens in external objective space instead of internal subjective space, distinguishing it from representation – has a metaphorical meaning, and that external objective space would mean that it is apparently real, while internal subjective space "actually means that it is phenomenologically apparent to individuals that the voices aren't real" [13]. This interpretation of Jaspers' phenomenological space ends up blurring the distinction between the Insight-Based Definition and the Descriptive-Structural Definition previously expounded. Some arguments are presented against this interpretation. For example, Rasmussen argues that Jaspers' conception of inner subjective space or inner life is indeed a metaphor, but that the reference would be to "consciousness that defies a spatial description" [43]. But the main argument comes from Jaspers himself, as he criticised Goldstein for "the confusion between the character of objectivity and reality judgment" [46].

Although not in themselves attempts at conciliating the different main definitions explored above, through the aggregation of different elements from them come into life two more influential conceptualisations.

Fish's definition appears to be a synthesis of two perspectives. He describes pseudohallucinations as phenomena that "occur in full consciousness, are clear and vivid, though lacking the substantiality of a perception, and are not located in outer space" [47], closely aligning with the Descriptive-Structural Definition. To this he adds the fundamental characteristic of the Insight-Based Definition – "The patient knows that they are not real perceptions, i.e., has insight," – and interestingly notes that this concept is of "pure academic interest with no prognostic or diagnostic value in schizophrenia" [47], curiously distancing it from the Pathognomonic-Psychotic Definition. Fish's synthesis thus represents a pragmatic turn, Prioritazing clinical communication and conceptual utility over ontological purity – a purity that, while conceptually useful, risks artificially dissecting the phenomenon from its lived context. This compromise

prefigures an argument for a descriptive framework that aims to preserve the integrity of subjective experience while enhancing clinical utility.

Another interesting suggestion is that of Pio de Abreu [48], in which a bridge seems to be created between the Descriptive-Structural and Pathognomonic-Psychotic definitions. He defines pseudohallucination exactly by Jaspers' criteria but adds that many of the supposed genuine hallucinations have pseudohallucinatory characteristics, including that patients with schizophrenia are the ones who experience it the most. According to Pio, there is extreme conviction in exterior reality even though the phenomenon is experienced "with the inner eyes," "the spirit," or "inside the head" [48], thereby connecting them with a deficit in judgment and an incapacity for transposition, i.e., changing the point of reference. A similar conception is shared by Elie Cheniaux [49].

An Epistemological Divide: The Methodological Roots of Conceptual Confusion

The profound disagreement over the pseudohallucination concept is not merely a dispute about definitions but signals a deeper, epistemological crisis: What constitutes valid knowledge in Psychopathology?

Mental symptoms are inherently unstable objects. As constructs they are derived from individual interpretations of experiences, themselves frequently not clear, thus becoming personal and unique to the individual [7]. Its particularity to the individual and inaccessibility to anyone else create a tremendous challenge to the grouping of specific mental symptoms in accordance with their commonality and the establishment of their conceptual boundaries which might be further aggravated by the natural fluctuation of the symptom. The shortcoming of definitions to truly represent the essence of mental symptoms is further convoluted by the interpretation of the clinician where clinical implications and contextual criteria add to an already low resolution image.

This stands in stark contrast to general medicine. Edema is always edema, irrespective of the patient's insight or whether its cause lies in a cardiac, lymphatic, or even atmospheric origin. In Psychopathology, however, the same subjective experience may be labelled differently, or different experiences labelled the same, being its expression greatly modified both by the patient's capacity to express the underlying subjective experience as well as by the clinician's own constructions and pragmatics of the interview. Insight and agency themselves can change the way a symptom is expressed and probably even the very experience of the phenomenon. Fully perceptual and exterior experiences might be labelled as interior when insight and agency are preserved while a subjective interior "voice" may be projected externally when insight is absent and there is an exterior attribution of agency. Mental symptoms exist in a web of multidirectional influences and perhaps this influence is as fundamental as the precise description of the phenomena in question not only in the understanding of the patient's experience but also in its diagnostic and prognostic implications even though we currently lack the tools to reduce the noise induced into these constructs by the very processes involved in their elaboration [8].

The intersubjective nature of the clinical interview itself constitutes a crucial source of conceptual instability. The elicited phenomenon is not a pure, pre-existing entity but is co-constructed through a dialogic exchange shaped by historically evolving diagnostic regimes and the clinician's implicit attitude. The shift from classical descriptive traditions to modern operational criteria, such as those in the DSM-5, has recursively shaped the very appearances of experience brought to light in clinical practice. Diagnostic manuals that list "hallucinations" as a key criterion for disorders like schizophrenia naturally steer the clinician's inquiry toward sensory-perceptual language (*e.g.*, "Do you hear voices?"). This framing can prompt a patient to articulate an internal, thought-like intrusion in auditory terms, potentially inflating reports of "voices" while marginalizing descriptions of alien thoughts or passivity phenomena. Conversely, a prompt like "Do you have thoughts that feel alien or as if they are not your own?" may lead to a description emphasizing cognitive intrusion and loss of agency.

This tension reflects a deeper divide identified as the personalistic and naturalistic attitudes. The clinician must constantly navigate between understanding the autonomous "center of spontaneous action and affection" [37] which is the person (the personalistic attitude) and technically examining the patient in a scientific way as a carrier of pathology (the naturalistic attitude, seeking causal explanation). Operational diagnostics often entrenches the naturalistic attitude prematurely, framing questions through a disease lens. A phenomenological approach, in contrast, attempts a form of pretheoretical attitude, an Epoché – bracketing presuppositions, including diagnostic ones, to attend to and understand the patient's experience as closely as it presents itself. An interview informed by this bracketing might first probe the quality of presence, spatial ambiguity, or sense of ownership ("Does it feel like your own thinking?"), rather than leading with perceptual assumptions. Consequently, the same experiential core – a disturbing, alien verbal intrusion – could be reported as either a "voice" (aligning with a DSM-oriented hallucination) or a "thought" (resonating with a more descriptive pseudohallucination or passivity phenomenon), depending on the implicit framework guiding the interview. This il-

lustrates how the very tools meant to clarify symptomatology can blur the categorical boundaries they seek to establish. It underscores the necessity of a descriptive approach that not only maps experiences across multiple dimensions but also cultivates methodological awareness in the interviewer, encouraging a disciplined suspension of diagnostic preconceptions to better capture the structure of lived experience.

This inherent ambiguity of the subject matter of Psychopathology poses a foundational challenge - the problem of validating knowledge derived from unstable phenomena. It is precisely this epistemological dilemma that precipitates a fundamental division in the field, giving rise to the irreconcilable methodological approaches embodied by the conflicting definitions of pseudohallucination.

Taylor touches on this issue when he points out that the "ultimate suggestions by Hare were guided too much by considerations of clinical usefulness" [45]. However, without clearly differentiating how Jaspers' approach might differ in this regard, Taylor concludes that both definitions "have their value in psychiatry" [45] which somewhat obscures the deeper distinctions between the two.

Indeed, Hare's argument for his conceptualisation of pseudohallucination is strongly influenced by its utility in clinical practice, as he states, "From the psychiatric view, the experience of a sensation is less important than the way in which the subject interprets it" [3]. He further argues that the term pseudohallucination should be restricted to morbid experiences interpreted in a non-morbid way by the patient[3]. This stance, traceable to Falret, prioritizes clinical utility and diagnostic implication, effectively making Psychopathology an extension and tool of Psychiatric practice. Here, phenomena are not defined in isolation and critical factors like insight become imbued in the very definition.

In contrast, Karl Jaspers' method diverges significantly from this approach. He emphasises that diagnosis is the least relevant factor and that if it becomes the main objective it will influence what should emerge from the investigation itself, restricting it, and warning that "The chaos of phenomena should not be blotted out with some diagnostic label but bring illumination through the way it is systematically ordered and related. Psychiatric diagnosis is too often a sterile running round in circles so that only a few phenomena are brought into the orbit of conscious knowledge" [6].

The debate here is not merely about the definition of pseudohallucination in isolation but concerns the very method of Psychopathology, which is what leads to the birth of different definitions of the same concept in the first place. For Hare and others who support the Insight-Based Definition, the psychopathological method is guided primarily by its clinical usefulness, rendering Psychopathology an extension of Psychiatry, with definitions of psychopathological phenomena being influenced by diagnostic considerations.

Jaspers, however, opposes this. He argues that phenomena must be isolated, even if that makes them clearer and sharper than they really are. By scrutinising and clearly defining the patient's immediate experiences, Jaspers aims to create a collection of individual phenomena that can be grouped into basic types. With this intent, he employs the method of Phenomenology "the study which describes patients' subjective experiences and everything else that exists or comes to be within the field of their awareness" [6]. This approach "gives a concrete description of the psychic states which patients actually experience and presents them for observation. It reviews the inter-relations of these, delineates them as sharply as possible, differentiates them and creates a suitable terminology"[6]. Thus a sharp distinction is created between pseudohallucination and hallucination proper, as well as normal representation. In this framework, insight isn't a part of the clearly defined and isolated subjective experience of pseudohallucination since it does not change in any way what is directly experienced in its most basic form. Moreover, Jaspers separates "psychiatry as clinical practice and Psychopathology as science" [6] emphasising that "the psychiatrist has to look to Psychopathology to provide him with a certain general concepts and laws" and "to whom science is only one resource among many" [6]; for psychopathologists, however, science itself is the sole aim of their work. This perspective suggests that Psychiatry should be dependent on Psychopathology rather than the other way around. He further asserts about the psychopathologist that "Their major concern is not the usefulness of science (this comes automatically as progress is made) but what the real, distinguishable phenomena are, what truths can be discovered about them and how they can be tested and demonstrated" [6].

Thus, an insurmountable epistemological chasm takes form. On one side, Psychopathology is guided by its practical application in Psychiatry, while on the other, it exists as an independent science that Psychiatry uses as a fundamental building block. These approaches thus become fundamentally irreconcilable. Consequently, different concepts emerge, with even the fundamental block of the subject matter itself differing – one taking mental illnesses themselves as primary and how they express themselves through signs and symptoms, while the other is based firstly on the actual conscious psychic events, mainly concerned with pathological phenomena but taking in the full range of psychic reality.

Regarding the Pathognomonic-Psychotic Definition, diagnosis becomes part of the definition of the phenomenon itself, particularly when one of the principal criteria

is its occurrence in chronic psychotic states. This approach aligns more closely with the Insight-Based Definition in its methodological aspect, although it differs in its diagnostic implications.

The core issue, therefore, is that the three definitions of pseudohallucination are not competing answers to the same question but the products of different, fundamentally irreconcilable epistemological foundations of Psychopathology. Insight-Based Definition's pragmatic stance treats conceptual validity as derivative of clinical utility; Descriptive-Structural Definition pursues objectivity through descriptive precision even if through an excessive isolation of the particular experience; Pathognomonic-Psychotic Definition's nosological essentialism defines validity through a circular movement based on nosological categorisation. These tensions echo broader debates in philosophy of Psychiatry. Understanding these divides reframes pseudohallucination not merely as a conceptual issue but as a boundary object between Psychiatry's clinical and diagnostic domains and how Psychopathology should stand in relation to them. Unfortunately, Psychopathology has recently tended to become more historicised, focusing on the accumulation of discoveries over time rather than developing a coherent structure and logical method to organise them. As a result, these definitions are presented alongside one another, as if sprouted by mere coincidence, without acknowledging the fundamentally different approaches from which they originate.

This epistemological inconsistency extends beyond the concept of pseudohallucination. It recurs throughout Psychopathology as seen in debates over the nature of delusional perception, with some arguing it is a morbid alteration of thought while perception remains intact[35], while others suggest that perception itself is radically altered [50,51], where the first conception originates from a Psychopathology based in precise divisions of mental structure – thought and perception, for example, similar to the Descriptive-Structural Definition – while the second originates from a Gestaltian analysis where this sharp divisions do not occur and are actually criticized as being born from an outdated Psychopathology [50]. Similarly, some textbooks on Psychopathology present Conrad's stages of schizophrenia development as if they were stages of delusion development[18], when at each stage the limits between disorder of thought, perception, Self, mood, and others are recurrently broken as they are seen as completely artificial by a Gestaltian analysis. This misinterpretation often leads to the erroneous conflation of Conrad's Trema with delusional atmosphere, despite Conrad's establishing that delusional atmosphere is only one of many possible manifestations of Trema, which can also include behavioural or mood changes [50].

Towards a Dimensional and Descriptive Framework

Given the entrenched epistemological divides, a productive path forward may lie not in enforcing a single, rigid definition, but in accepting conceptual heterogeneity while adopting a more precise, descriptive framework. This approach would replace categorical binaries with a dimensional understanding of symptoms.

A promising direction involves expanding the concept of hallucination itself to incorporate a wider phenomenological spectrum. This model would move beyond the hallucination/pseudohallucination dichotomy by conducting a dimensional evaluation of key characteristics, including perceptual qualities (objectivity, phenomenological location, vividness, sensory fullness, constancy and dependence on will), degree of insight, sense of ownership, level of behavioral influence and also their evolution in time.

Under this framework, a phenomenon could be identified as a hallucination based on the specific configuration of these dimensions. For instance, an experience with only faint sensory qualities might still be considered pathological (i.e., hallucinatory) if it is coupled with low insight and a high influence on behavior, thereby distinguishing it from non-pathological sensory irritations common in healthy individuals or disorders like OCD. Conversely, a fully perceptual experience in a neurological condition, regardless of insight, would still be categorized as a hallucination. This results in a more nuanced taxonomy that acknowledges two broad types: "veridical hallucinations" (imagery indistinguishable from perception, as in the DSM-5) and "sensory-irritation hallucinations" (experiences with eventually limited perceptual properties that the individual might hold as being real, where low insight, high preoccupation and rejection of ownership become key pathological markers) as proposed elsewhere [16].

To translate this conceptual proposal into practice, consider a hypothetical profile for a patient, "M." At an initial assessment, M reports a vivid, repetitive verbal commentary experienced "inside the head", mostly in the evening, over which she has no control and that she attributes to her own self because she has been living a highly stressful situation at home (high vividness, internal location, preserved ownership, low conviction, absence of willful control, limited duration). This profile might correspond to historical categories of imagery or pseudohallucination. Over six months, the experience evolves: the commentary becomes more critical and persecutory. M. becomes convinced it is a real communication from a neighbour, even though she still describes it as happening "in my head" reporting "I don't know yet how he does it, but he doesn't stop commenting, saying mean things about me all day and all night",

denying any other possible explanation for her experience. Despite its unchanged internal spatial quality, the experience has undergone a profound transformation (stable location and vividness, but loss of ownership, development of full conviction and constancy). While the core perceptual vividness and spatial location may not have changed dramatically, the dimensional shift in sense of ownership, conviction, and behavioral impact (M now isolates herself and avoids the neighbour) delineates a distinct phenomenon with quite different implications for risk, prognosis and treatment, even though it might still, under a Descriptive-Structural Definition, be labeled a pseudohallucination. Under an Insight-Based Definition, it would now constitute a hallucination. We argue that mapping this evolution on a dimensional grid – thus tracking concreteness, phenomenological location, vividness, sensory fullness, constancy, dependence on will, degree of insight, sense of ownership, level of behavioral influence and temporal pattern – offers more actionable information for risk assessment, treatment planning and understanding the lived experience than a simple re-categorization from "pseudohallucination" to "hallucination." It demonstrates how validity resides in the explanatory power of the evolving profile.

This pragmatic, dimensional perspective also invites a critical reflection on what is gained and lost by current diagnostic terminology's deliberate de-emphasis of older constructs. Modern classifications, notably the ICD-11 and DSM-5-TR, have moved away from the contested term "pseudohallucination." The ICD-11 defines a hallucination as a "sensory perception of any modality occurring in the absence of the appropriate (external) stimulus" [52], explicitly noting that insight may or may not be present. The DSM-5-TR describes hallucinations as "perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control" [39]. This shift gains operational reliability and diagnostic simplicity – it reduces the ambiguity of adjudicating between hallucination and pseudohallucination and avoids the problematic linkage of insight to diagnostic significance. However, it loses phenomenological precision. Both definitions retain a perceptual model that frames the experience primarily in terms of sensory fidelity, stimulus correspondence, vividness, and involuntariness. This implicit sensory-perceptual framework may not adequately capture experiences characterized by internal location, ambiguous sensory quality, or fluctuating "as-if" phenomenology. By adopting this broad, perception-anchored category, crucial qualitative distinctions are flattened, and a ready vocabulary for the middle of the experiential continuum is discarded, potentially obscuring links between specific symptom structures and underlying pathology.

The dimensional approach proposed here seeks to recover this lost descriptive granularity without resurrecting the old categorical dichotomies. It offers a path toward a more neutral, descriptive language for future classifications – one that can accommodate a broader spectrum of anomalous experiences by mapping them across multiple validated dimensions, rather than forcing them into categories based on contested perceptual metaphors or unstable insight criteria.

Epistemologically, this dimensional approach represents a pragmatic synthesis. It transcends both the reduction of phenomena to their diagnostic utility and the pursuit of pure, isolated essences. Instead, it posits that a psychopathological concept is valid not by its correspondence to a single idealized "reality" (be it perceptual or nosological), but by its functional capacity to map the complex, multi-dimensional landscape of lived experience in a way that is both descriptively precise and clinically informative. Validity is thus found in the explanatory power of the dimensional profile, not in a categorical verdict.

This shift towards a dimensional system aligns with broader efforts to classify the inherent heterogeneity of mental symptoms. For example, a proposed model based on five levels of clinical differentiation – conventional categorical form, diagnosis (which may alter the symptom's structure), sensory modality, abstract criteria (often of historical origin) and symptom content – could provide a clearer distinction of these constructs in order to better map this complex landscape[8]. This shift might also prove to be particularly useful for capturing the complex, overlapping symptom profiles found in conditions with high psychiatric comorbidity, such as ASD. In ASD, the phenotypic variability and frequent co-occurrence of anxiety, mood, and attentional disorders create a clinical reality that strains conventional, categorical diagnostic frameworks anchored in rigid percept-representation dichotomies [53]. The experiences reported – encompassing sensory anomalies, vivid inner dialogues, and source-monitoring difficulties – directly challenge the validity of such binaries and underscore the insufficiency of definitions based on isolated phenomenological criteria. This reality reinforces the argument for a flexible, dimensional approach that can map the unique configuration of experiences within each individual, moving beyond the contested categories that have historically oversimplified such complexity.

Ultimately, the goal is to prioritize the precise description of the lived experience over the application of a contested label. By systematically documenting the dimensions of each phenomenon, clinicians and researchers can communicate more effectively, acknowledging the diversity of experiences without being constrained by the irreconcilable definitions of the past.

Conclusion

The protracted debate surrounding pseudohallucination ultimately reveals less about the nature of a specific symptom and more about the fractured epistemological foundations of Psychopathology itself. Our analysis demonstrates that the three primary definitions are not competing answers to the same question but the products of incommensurable epistemological stances. The Insight-Based Definition bases itself on a metric of clinical utility; the Descriptive-Structural Definition seeks to identify pure forms through phenomenological isolation; and the Pathognomonic-Psychotic Definition circularly ties the concept to nosological categories. This tripartite division mirrors a broader disciplinary ailment where knowledge accumulates as a "corpse which has left the guiding tendency behind it" [54] –a heap of disconnected facts without a unifying methodological thread.

This impasse necessitates a paradigm shift. Review of past reconciliation attempts underscores that the solution lies not in choosing one historical definition over another or in superficially mixing them together, but in transcending the categorical framework they all share. The proposed dimensional and descriptive framework offers a possible path forward. By replacing the hallucination/pseudohallucination dichotomy with a nuanced mapping of experiences across multiple dimensions–perceptual quality, insight, behavioral impact, sense of ownership and their evolution–we adopt a pragmatic epistemology. In this model, validity is derived not from correspondence to an idealized essence or reductive clinical utility, but from the functional capacity of a detailed profile to accurately capture the complexity of a patient's lived reality and through it inform clinical understanding.

Embracing this approach might permit the transformation of the conceptual confusion surrounding pseudohallucination from a liability into a catalyst for progress. It encourages a Psychopathology that is scientifically rigorous in its commitment to precise description, clinically useful and able to communicate the true heterogeneity of human experience. This synthesis offers a way to structure the field's accumulated knowledge, providing a hypothesis for a "guiding tendency" that might enable an advance in both the science of Psychopathology and the quality of care provided to those whose experiences we seek to understand.

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Conflicts of interest

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Authors' contributions

João Afonso de Miranda identified the object and planned the study. João Afonso de Miranda wrote the first draft of the manuscript which was revised by Ângela Ferreira, Carolina Batista, Filipa Catarro, Joana Marta, and Nuno Ribeiro. João Afonso de Miranda and Filipa Catarro approved the final version.

Ethical consideration

This study is conceptual and did not involve research on human or animal subjects. Ethical approval was not required.

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