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## Schizophrenia auditory hallucinations pdf

Skp Nav Destination PDF Separately, view article figures & audio video tables supplementing information, while most of the cognitive studies on auditory hallucinations (AHs) have been carried out in schizophrenia (SZ), a growing number of researchers are turning their attention to different clinical and nonclinical populations, often using SZ discovery as a model for research. The purpose of this article is to (1) present the latest findings on the cognitive mechanisms of AHs in SZ, (2) a review of findings from cognitive research conducted in other clinical and nonclinical groups, and (3) combines these latest findings as a collaborative framework. Firstly, the SZ study shows that the intellectual foundation of AHs includes deficits, self-source monitoring and disorders of executive control and inhibition, as well as distortions in mechanisms from on to cognitive and linguistic processes and emotional factors. Secondly, in line with the SZ study, the findings in other demographic groups Point to the role of processing from top down to disorders to inhibit management and negative emotions. Finally, we adopt an integrated form of AHs that combines the above findings. We recommend that AHs arise from interactions between abnormal neural activation patterns, which generate dominant hearing signals and upper-down mechanisms with errors in detecting executive deficit signals, and inhibition of inhibition, carpeting, expectations and memories, and the characteristics of the state that influence how these experiences are interpreted. Emotional factors play a particularly prominent role at all levels of this hierarchy. Our models are strikingly effective in describing the phenol characteristics of AH in the spectrum of disorders, auditory hallucinations (AHs), as well as hearing experiences that occur in the absence of corresponding external stimulation and are similar to empirical perceptions. Highly identified with psychotic disorders such as schizophrenia (SZ), AHs have traditionally been examined in the SZ population, the recent changes in AH research, however, have led to a strategic focus on other clinical groups and nonclinical based on observations that hallucinations and hallucinations are common in many psychiatric and also non-psychiatric populations (such as them are transdiagnostic). This lends itself to detecting symptoms such as AH, which consists of several physiological properties, while acknowledging that somewhat different phenomenological properties between transdiagnostic study groups may shed some light on specific mechanisms. The power of cognitive methods lies in its ability to provide possible and intuitive explanations for subjective symptoms (such as inability to provide them) and to create predictions about related neural mechanisms that can be tested using neurological methods such as magnetic resonance imaging and electroencephalographs. The first aim of this article is to present the latest theoretical developments in cognitive research related to AH while many of the high-quality reviews of the cognitive mechanisms of AH have been published in the past, this is the first time that different phenomenon properties of AH have been linked to their theoretical patterns in a single article. The second aim of this article is to provide an overview of the findings from the cognitive examination of AH in the non-SZ population and compare the findings with the SZ literature. The cognitive explanation for the gynecological properties of AH in SZ, approximately 70% of those diagnosed, the SZ AH report is widely accepted that AH in SZ is multidimensional and heterogenous.2 In the treatment of dimensional view of AH, this separate description is used to account for the different philosophical properties of AH, each of which may represent a specific cycle of brain structure and function. The failure of self-awareness by experience is seen as alien and separate from the mental process itself. (2) Reduces the sense of control over the onset of, content, and frequency of ah; One of the main features of AH in SZ is that they experience quite a separate experience of their own mental processes: the main experience is hallucinations, lack of self-attribute. In addition, and possibly secondary, the origin of these events tends to be improperly attributed to external agents. Several explanations have been proposed for the failure of self-awareness. One zero description of the fault in the process. This plays a role in predicting the sensory effects of their own actions through forward modeling/copying mechanisms. (especially internal speech) that becomes isolated from the predictive mechanism and misinterprets as originating from external sources. Analog processes are thought to exist for languages (including internal speaking). Actions and ideas to make failures in this system will lead to broader difficulties in self-awareness. Another version proposes an anomaly in the source review, which refers to the judging process used in internal/external discrimination. In general, these are associated with memory and other decision-making processes that retrieve and evaluate memory records to create a cohesive experience. It has been proposed that interfering with such source investigations result in the representation of incomplete mental events, and therefore the failure to identify their origins. Typically, these participants require participants to voluntarily monitor their movements online or to identify whether the items in memory come from a manual or other task (agency). However, errors can be the result of cognitive processes, in addition to self-monitoring or sources, such as bias responses or difficulties in assessing vague stimuli that can obscure a patient's ability to recognize their own actions or mental events. These criticisms of the evidence supporting the link between AH and deficit self-monitoring, and a few sources have failed to replicate these. Recent meta-analysis shows that impairment in self-monitoring and source has been reported continuously during paradigm, interstimulus and modal periods in patients with SZ, and especially those with AH.8 such disorders are thought to occur earlier than later stages of data processing, although such early deficits will undoubtedly affect the higher order process. One problem with this literature is that deficit detection also occurs with other symptoms (such as Frith et al4), while there is a possibility that underpinning ah cognition may be shared in some symptoms, but it also shows that such impairment is not enough for ah to occur. The method involved in problem awareness is derived from the signal detection theory model. This method is used to test the source detection hypothesis. And the theory suggests that haunting individuals may be less sensitive to adoption, but show lax decision-making criteria about accepting signs as real and prejudiced in response to inappropriate events. Source 9 The strength of this model is the difference between signal detection and response bias, consistent with the idea that attribution must be different from the previous processing process. It is also compatible with the above models, since self-monitoring issues may lead to incorrect decisions about the source of the data, especially for the forecast mechanisms associated with the self-generated actions. The latest version of this SDT 10 posit perceived hypervigilance (may be linked to anxiety). It improves bias in response and makes it highly likely that errors in cognitive processing and signal acceptance are real. The desire to reduce uncertainty under threat also leads to increased detection of vague signals, reduction of hearing thresholds and hallucinations. While the above format provides an explanation for the verbal and non-verbal types of AH, the internal speech theory has focused on giving ah's account verbal, they suggest that information about misunderstandings of internal speech may be obtained by comparing the phenomenon of internal speech in a person haunted with internal speech. Speaking internally and proposing that AH occur during the transition from a short-term to an extended internal dialog box, especially during periods of high cognitive load or stress.12 Although the information contained in the phenomenon of internal speech in the haunting person also cannot fully address this model (see Langdon et al13), a pattern that uses such phenomena is useful in pointing to the evolution and dynamics of neural information as more distinct signals that may be altered by factors such as mood. In summary, despite the different explanations for self-awareness deficits in AH, studies generally converge on finding that AH is linked to deficit detection and faults. One major difficulty with this literature is that cognitive deficits in self-monitoring/sources and SDT have been linked to other symptoms of SZ so, while these deficits may still play an important role in the formation of AH and maintenance, it appears that such cognitive mechanisms may bolster a range of other mental symptoms. My own verbal thoughts, 16 Although extreme variability exists at the level, AH (and indeed verbal thought) is seen as controlling.17 The cognitive explanation thus included the idea that AH was involved in the failure to control the content of consciousness.18 which is generally assumed to reflect the breakdown in one or more of the executive functions that control and control thoughts and actions. The difference of executive function is an isolated component (although correlated) has provided a useful framework for considering reducing the sense of control in AH inhibition. Early studies of AH tended to use the term fairly inhibition and reported negative findings on measures of negative priming and interventions (such as Peters et al19) since then, with cumulative evidence demonstrating a link between AH and a particular type of suppression called deliberate cognitive inhibition (such as Waters et al5). For example, different aspects of inhibitory processing can vary, especially between cognitive inhibition and deliberate behavior, versus automatic inhibition and inhibition of interference control. The study used this model in conjunction with work that demanded volitional suppression of memory events and unrelated memory tests, predicting that AH in SZ was associated with deficits in intentional cognitive inhibition. Identifying differently, specific forms of prefrontal inhibition control may allow hearing signals to be relatively independent and difficult to control effectively. Improving interest and working memory There has long been a growing interest in the involvement of attention and working memory processes to AH.14, although early studies concluded that shop evaluation work and physiological loops were not associated with positive symptoms (such as David and Lucas20). However, recent functional imaging data shows that patients with AH exhibit reduced activity in the memory cycle to work verbally, although there is no deficit in memory function, performance 21 that the verbal memory cycle is associated with AH, but behavioral inefficiency may reflect a broader pattern of language processing deficits in AH.22, while cognitive evidence for attention and memory in work may not reflect a wider pattern of language processing deficits in AH.22. The role of attention is clearly involved in early sensory sensing mechanisms. Although not directly linked to the sense of process control, empathy may work in AH through determining the resources allocated to processing and correcting errors in between. The processing of 10 sets-shifting of Hugdahl23 has argued that a proper understanding of the basic neurocognitive of AH requires inclusion. Ability to shift attention away from sound He proposed that AH involves enabling the inner bottom-up of speech recognition areas in the left hemisphere and executive control from top to bottom that is unusual. In the dichotic listening paradigm, which further increases the stimulating input, patients with SZ and AH frequently fail to demonstrate the advantages of the expected right ear, which indicates a functional deficit in the perisylvian region on the left. Reducing the response to right ear stimulation is thought to occur because the left hemisphere is already involved in processing; In addition, patients with AH show difficulty in shifting attention focus to the opposite ear. The implication is that AH involves difficulty in adjusting attention, and in achieving executive control from the upper onto of the sound, and the inability to change, may be the result of a focus of increased attention on haunting voices. Deficits in interest and defining changes may play a totally different role by determining the expectations and resources that are allocated to these unintended hearing signals and by Limited Ability to ration and transfer attention to other adaptive data The quality that is acceptable to the important physiological properties of hallucinations is the acceptable quality. The person who haunts the sound and the voice, the voice can be described in terms of the parameters of volume and clarity. These distinctive characteristics of AH have been explained in terms of processing, looking down, down. Factors from on down reflect the influence of internal factors and representations stored in perception, which include knowledge and memories, earlier expectations, perceptions and mental images. Specifies that all actions of awareness consist of interaction between the lower input and the joint. Limiting from top to bottom, the imbalance between these factors in perception has been recommended to enable awareness in the absence of external stimulation. Many of the theories posit that the combination of distorted input from the sensory information below up and aberrant top-down factors causes the latest version of AH.24.25. This model is also based on the fact that sensory data processing processing from the environment is not passive due to rapid By showing stored memory, other sensory experiences and expectations from top down on the down. What is experienced is therefore a process that contributes to subjective perceptions of reality. Over time, this incorrect processing leads to a hard wiring of the network, which creates a subjective experience that distorts sensory input and misrepresentation. Empirical evidence for processing from on-down on the rise in SZ patients with AH verbal, mainly from SDT studies, with the task using verbal stimulation detection in noisy situations 14,26 recommended and expectations 27,28 and expectations meaning26 These results support the conclusion that the upper-down processing is down. Especially in the form of strong meaningful expectations may lead to ah experience, at least of verbal nature. In addition, the idea of introducing an interesting explanation for reporting the experience of the phenomenon in the absence of clear external signals.26 This is so, the person with THE AH will be more conducive to conditioning and the impact of the implicit or clear feedback.29 However, it did not explain all their results because of the reported differences in bias decisions rather than sensitivity to detecting bias 9Consistent with sensory-ear conditioning patterns, one recent study indicated that hallucinations patients get sensory and ah these are more resistant to extinction.30 This effect may determine whether subjective experience is reported as hallucinations or real percepts. Evidence from multiple sources of effects affecting AH in psychiatric patients tends to be negative (although not always) and general feelings reported by patients with AH, including anxiety and depression, 16.32. While the belief that a benevolent voice tends to be associated with positive emotions (such as enthusiasm and respect), increased distress in listeners is also associated with a lack of ability to control AH, perhaps through the influence of the process of breaking the frequency of the experience.34 Ultimately, a host of evidence indicates the important role of emotions as a stimulant of AH, as a therapeutic factor, 32 and in determining the need for care.35The Support for the role of emotions derived from the link between dissociation and hearing.36 The relationship between hallucinations and childhood trauma, prompted recently However, the presence of AH in nonhelp seeking community samples suggests that their own experiences are not always problematic, there is evidence for greater positive emotional prowess of THE AH experience in those who do not seek psychiatric help.38 Psychiatric problems in the study of AH cognition in SZ A number of lessons, how can be obtained from the long history of AH research in SZ. In being able to fully engage, interesting theoretical structures emphasize the importance of striving for accuracy in high creation when choosing a task. Cross-branch discipline work may help to identify knowledge gaps and bridge those gaps through combining different methods. Increased cooperation between cognitive science (and linguistics), physiological and neuroimaging methods will benefit the development of the theory. For example, different tools and methods may be used to test assumptions derived from one field. This is based on a concerted effort and may be a data collection between the centers. Secondly, selecting and grouping participants is important. Adequate design may compare patients with the same different diagnosis in the presence/absence of AH associated with the state, although a group of patients who have never experienced AH will have to tease the state/characteristic factors with a few longitudinal studies of AH, although these are useful for observing characteristics, fluctuations of symptoms and underlying mechanisms in the same participants. The issue of symptom assessment is also important. The presence and severity of different AH properties must be evaluated using a well-vetted scale2. For example, many AH studies show that cognitive deficits are shared in other symptoms, often delusional or passive symptoms. The role of insights receives little attention, although poor insights may play an important role in some aspects of the AH phenomenon (see the AH cognition model section), so studies must be reported in a transparent manner about the type and range of clinical experiences seen in their samples, so that the prescribed memory of THE AH findings may be examined. Finally, the number of other confounds can be limited. Interpretation of cognitive discovery. These include the effects of variability in intelligence, attention and working memory, the effects of medication, psychiatric comorbidities, and possible social and psychological effects of shame and negative experiences. While these variables are not always controlled, researchers should record. In detail and consider that there are several factors that may affect performance. However, the study of AH in the non-SZ population is a particularly useful algorithm due to the potential to independently understand the MECHANISM of AH from other symptoms associated with SZ studies with non-SZ populations, so it can explain and test assumptions about the causes of AH without intervention from other symptom profiles. In this section, we examine the existing cognitive findings obtained from studies in different groups. The most intensively studied populations, including healthy individuals who sometimes experience AH, the estimated prevalence of AH in this group is approximately 15%. Cognitive studies often focus on individuals who score high on levels such as the improved Lanay-Slade hallucinations scale (LSHS-R). Cognitive examinations show that their performance patterns tend to be similar to the SZ group, although they are lowered, consistent with observations that complex self-awareness problems and cognitive quality are phenomenological properties contained in clinical and non-clinical samples. Studies in healthy people show spontaneous bias and misattribution39 as well as processing from top down onto too many 40 by contrast, findings about self-examination work have been somewhat mixed, with some studies showing difficulty in self-awareness, 41 and others did not find a correlation between hallucinations- tendencies (including all forms) and self-awareness for actions42. While this sense of reduced control is a less benign feature in non-linear individuals compared to the SZ group, the study continues to show broad anomalies about the task of deliberate inhibition. Although these are thought to be largely mediated by the effects of comorbid.45 symptoms, ah physiological studies in the nonclinical group show that the emotional quality of AH is less negative and intrusive than in SZ, but the findings show more negative emotions and abnormal mood control strategies compared to healthy individuals without these symptoms. Another method is to define the AH analog group in terms of sensitivity to hallucinations, hypnosis and hypnosis. Studies have shown that these may be linked to executive disorders and inhibitors of 47Despite data characteristics of transdiagnostic studies, with paucity of cognitive monitoring conducted in other clinical populations. Studies have shown that AHs in this group are linked to difficulty in self-examination tasks, as demonstrated in the 48Studies distortion paradigm. Of frontier personality disorders, it shows that AHs has a prevalence of approximately 20%-50% with philosophical properties similar to those in SZ. Cognitive studies in this group showed a link between AH and deficits in executive function (especially inhibition). Negative emotions may be important as ecological factors of AH in borderline personality disorders, with studies reporting increased incidences of childhood trauma and emotional abuse (free from the presence of delusional paranoia) and loss of emotional control, for example, Kingdon et al.49. It's interesting to note that hallucinations in Parkinson's disease The deficit in executive control has also been reported in individuals with epilepsy presented with a history of frequent AH and (pictured) hallucinations in eye disease 51 so there may be common mechanisms such as cross-modal mechanisms that are subject to common diagnostic categories, evidence pointing to joint impairment in inhibitory functioning, emotional problems, and mechanisms from down on into different demographic groups. While non-self-awareness is an important clinical feature of AH in all groups, evidence about the role of self-examination/source is inconsistent, although this may be a reflection of the lack of investigation in this area. These findings reflect the patterns of cognitive performance shown in SZ. The conclusions from these observations are limited. However, due to the publication bias, to be sure, only positive findings are reported in the literature. While the similarities in Being stressed, very little is known about how cognitive profiles differ between groups. The cognitive model of AH, here we combine the evidence from above is a sticky pattern. We created a model first proposed by Frith and Dolan52 and later described by Aleman et al24 and Hugdahl.23. The discovery of cognitive, imaging, physiology and ah-related phenomena can complement and support this explanation. Open in a new tabDownload Temporal unfolding slide of auditory hallucinations (AHs) In the clinical and non-literary population(AH) Arising from the interaction between (a) signals caused by excessive use of brain-auditory neural activity and (b) a range of mechanisms from top down onto that create highly complex and multi-versatile experiences. Mechanisms from the upper onto then these include: (1) The deficit to detect signals leads to processing errors. (2) intentionally inhibiting the deficit that leads to a reduced sense of control of this perceived experience; This model can be used to describe changes in the phenomenon properties (bottom row dash) so that the severity or position of the cognitive deficit determines the individual differences in the extent to which the AH feature exists. Aberrant, may be caused by triggering a deviation of activation in areas associated with the language responsible AH.22.53 activation may be determined by environmental and/or internal factors (such as mood) conditions. One of the consequences of such abnormal neural activation, including over-acceptable hearing signals, causes

unexpected hypersalient sensory information. This may explain the problem of detecting the source, because it would prejudice such internal material against being seen as alien and separate from internal mental processes and caused by external influences. Only Of hearing signals (such as patterns of speech within intrusive memories) may be more likely to be converted to AH and accounted for as certain verbal philosophical properties of AH, other processes involve mechanisms from on-down to influencing content patterns and definitions of AH, different modes of attention, the ability to control cognitive cognition/previous experiences, and emotional processes influencing patterns and content. The sequence of processes can be as follows: First, the deficit in signal detection increases the detection of vague or pronounced signals and increases the likelihood of accepting signals as real and meaningful. Secondly, such information cannot be suppressed by a deliberate deterrent mechanism that goes wrong and becomes free to work. This will lead to the failure to effectively contain and control the onset of these hearing signals. Over time, expectations and hypervigilance increase the likelihood of recurrence of such experiences (creating cognitive cues), which leads to increased bias and lowering the threshold for accepting signs that are real. The content of AH may be determined by factors such as expectations, visual perception, mental and previous experiences/knowledge (such as memories) that shape the perception of idiosyncratic and highly personal reality. Therefore, the voice of a family member and radio personality, the voice of God and the sound of a barking dog can be realized. Finally, the meaning of AH is determined by the characteristics of the state and the characteristics that influence how these experiences are interpreted. In the case of SZ, the presence of decreased insights, delusional beliefs, negative stereotypes/beliefs about yourself (such as low self-esteem). Beliefs about the world and all the negative effects combined to create a complex and complex system of beliefs. For example, the perception may be seen as a plot from the Central Intelligence Agency (CIA) or as a message about the need to save the world. Emotions play a particularly prominent role at all levels of this generation (source, form, content and meaning), perhaps by giving the first traumatic insult (hit). In this emotional event, linked to trauma, rupture and other severe negative emotions may influence the source of AH by increasing the shot rate of neurological activation and hearing signals. They also tend to determine the format and content of the signal due to the priority. This ensures that emotional and personal content is processed through neutral information. This creates a bias against negative data, hypervigilance and negative schemas that will help increase the processing and memory recall of affected materials. Painful life events also create intrusive memories that can affect the frequency of experience and perceptions about uncontrollableness. Finally, more. This will influence the broader aspects, such as beliefs and meanings that come from AH (omnipotence, etc.). The area side prevents us from examining other philosophical properties involved, such as variability in verbal content with nonverbal and differences of outer space, while little evidence exists about the cognitive foundation of these AH properties, neuroimaging evidence points to different pathways that can provide explanations for changes in such properties. On the other hand, the localization of the outer space can be caused by differences in activation in the neural pathway. In the dormitory, which projects according to the front platinum temporal and parietal pulp areas, overall, the difference in neurological activity is the basic function for AH verbally and non-verbal, and for the outer inner nuances, which may provide the basic ear material (source) for the AH process from top down on as described above to the shape. This signals to perceived reality, which is personally relevant. For example, neural activity in the temporale panel, with an prediction of an inferior parietal cortex, may lead to external audio translation, while increased activation in the premotor area may contribute more noise than non-verbal sounds. People who show hypervigilance for stimuli that are emotional and self-related are more likely to recognize this signal as important words, such as located outside the head. In summary, we propose that AH occurs through interactions between hypersalient hearing signals (sources) and mechanisms from top down, consisting of various modes of error processing, cognitive control/previous experiences that control the patterns and content of AH, along with the influence of state characteristics (insights, systems, beliefs, etc.), which define meaning. Finally, phenothological changes can be explained by individual differences in the severity of the deficit and the localization of neurological activity. Obviously, there are several subtypes of AH2 that require a combination of 54 different cognitive variations of AH in the non-SZ population, the above proposed model can be used to describe changes in AH properties and the discovery of cognition in the population, in addition to SZ (Figure 1), essentially, hearing signals are a mandatory element for hallucinations to occur. Although this has not been tracked in non-SZ populations, it should be possible to detect increased spontaneous auditory signals and reduce neural suppression during concealed speech in these groups. Here we propose that To process sz-related and consistent with evidence to date, the mechanism from top to down consists of a combination of deficits in error processing and deliberate mismanagement mechanisms, leading to increased attention of these perceptual aberrant signals and the failure to suppress such signals. However, the process from top down on the other can be an important factor that differs clinically from non-clinical hallucinations. Emotional factors can be one of those different factors. The time or severity of the injury and previous negative experiences may occur outside the critical window, which leads to different AH experiences with greater positive emotional courage and reduced hydration and behavior, seeking help in non-psychotic individuals. Personal characteristics (such as the presence of insights) in healthy populations influence these perceptions of experiences, so that these experiences are interpreted in the context of benign reasons without searching. Enthusiasm for meaning, as is the case in psychopathic individuals. Obviously, many issues need to be clarified. Further differences are also needed in the AH bolstering process that discriminates against psychopaths, nonpsychotic clinics, and non-qualde individuals. Unfortunately, there is currently insufficient evidence of phenomanosic characteristics and the intellectual and biological foundations of AH in different conditions. Emerging evidence will lead to greater understanding and clear predictions about the AH basic processes in different groups. In conclusion, all our comments about AH are slowly accumulating, and now we are in a position to provide a more comprehensive form of AH that can include broad phenomanological changes, above, as part of the research foundation building process that may in the short-term inform new guidelines and theories towards the investigation of AH, hopefully this review on the current state of knowledge will allow researchers to select and combine the most appropriate research focus for their transdiagnostic research in AH. In the meantime, the investigation, using novel design, careful phenomanological assessment, and cross-branch research protocols, urgently needs to improve the power of cognitive methods to evaluate the underlying mechanisms AH, it is clear that the important road for research is to cross the border between cognition, imaging phenomena and neurological instruments. Such a framework that directly interfaces with different scientific fields will facilitate progress in Basic causes and maintenance of AH and in the development of new therapeutic interventions. The FW funding is funded by the National Health and Medical Research Council, and we would like to thank Richard Bentall and Daniel Freeman for their input in the previous version. We would also like to sincerely apologise to the author, who cannot include important work due to the journal cap on the number of references. Conflict of Interest: The author stipulated that there is no conflict of interest related to the subject of this study. reference 7., . . . , external speech blame in patients with hallucinations and illusions, vol. (pg-)8.), . . . 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