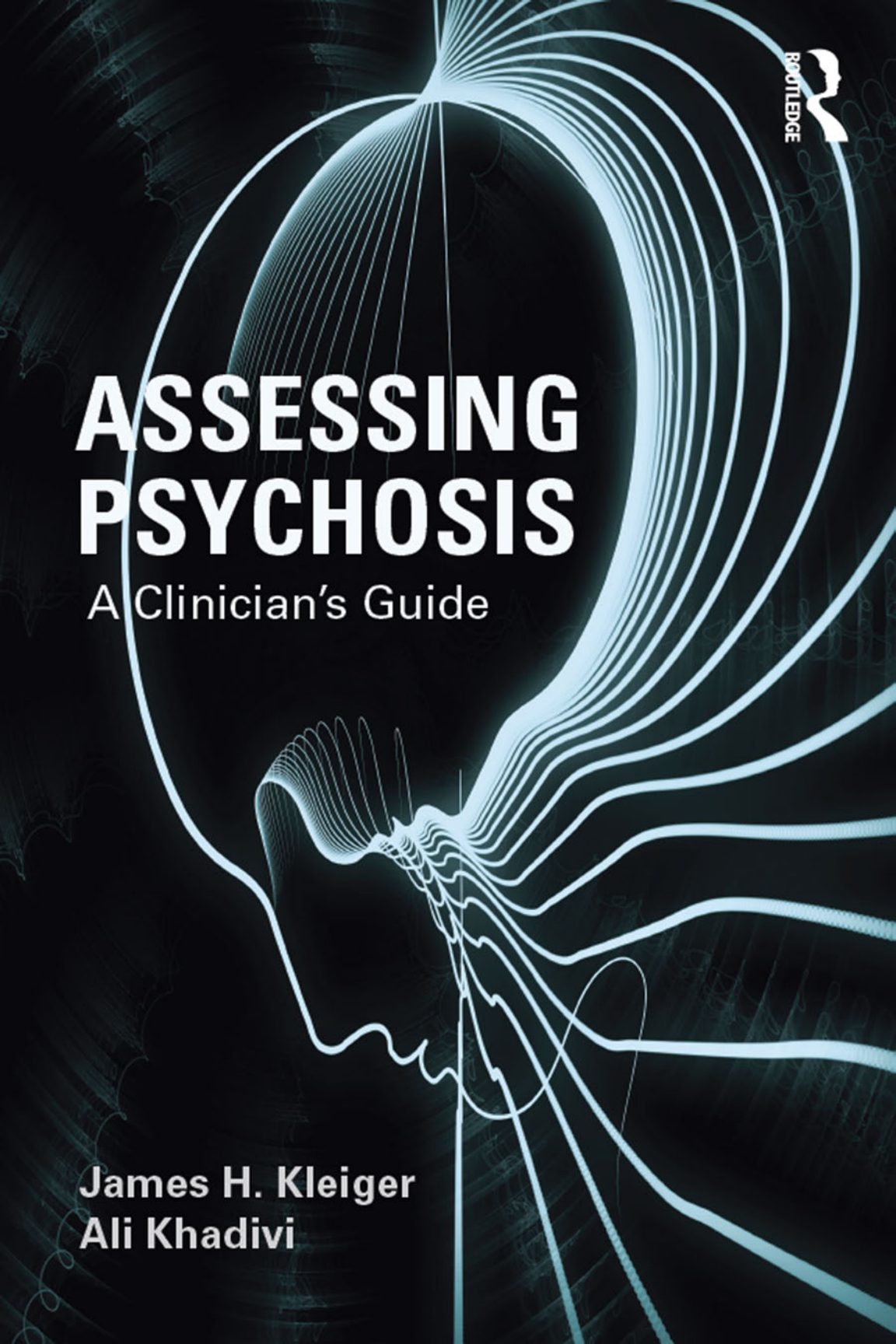
ROUTLEDGE
ASSESSING PSYCHOSIS
A Clinician's Guide
James H. Kleiger
Ali Khadivi

ASSESSING PSYCHOSIS

Assessing Psychosis: A Clinician's Guide offers both a practical guide and rich clinical resource for a broad audience of mental-health practitioners seeking to sharpen their understanding of diagnostic issues, clinical concepts, and assessment methods that aid in detecting the presence of psychotic phenomena. Practicing psychiatrists, psychologists, social workers, and psychiatric nurses will find this a valuable resource for clinical practice, training, and teaching purposes.

James H. Kleiger, PsyD, ABPP, ABAP, is a diplomate in clinical and assessment psychology and Fellow in the Society for Personality Assessment. Dr. Kleiger is a practicing psychologist and psychoanalyst in Bethesda, MD. He is past President of the Baltimore Washington Society for Psychoanalysis and previously the Director of the Postdoctoral Psychology Training Program at the Menninger Clinic in Topeka, KS. He is the author of *Disordered Thinking and the Rorschach* (The Analytic Press, 1999), along with numerous papers, book chapters, and presentations on assessing thought disorder and psychosis, psychotherapy, and psychoanalytic perspectives of psychological assessment.

Ali Khadivi, PhD, is Associate Chairman for Clinical Care, Evaluation and Research, Department of Psychiatry, Bronx-Lebanon Hospital Center, and an associate professor of clinical psychiatry and behavioral sciences at the Albert Einstein College of Medicine. A Fellow in the Society for Personality Assessment, Dr. Khadivi is an assessment psychologist, teacher, consultant, supervisor, and lecturer who has written and presented extensively on the topic of assessment of psychosis and severe mental illness. He maintains a clinical and forensic psychology practice in New York City.

This page intentionally left blank

ASSESSING PSYCHOSIS

A Clinician's Guide

James H. Kleiger and Ali Khadivi

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First published 2015
by Routledge
711 Third Avenue, New York, NY 10017

and by Routledge
27 Church Road, Hove, East Sussex BN3 2FA

Routledge is an imprint of the Taylor & Francis Group,
an informa business

Library of Congress Cataloging-in-Publication Data
Kleiger, James H., 1952–, author.
Assessing psychosis : a clinician's guide / James Kleiger, Ali Khadivi.
p.; cm.
I. Khadivi, Ali, author. II. Title.
[DNLM: 1. Psychotic Disorders—diagnosis. WM 200]
RC469
616.89075—dc23
2014034610

ISBN: 978-0-415-71510-2 (hbk)
ISBN: 978-0-415-71511-9 (pbk)
ISBN: 978-1-315-88208-6 (ebk)

Typeset in Sabon
by Apex CoVantage, LLC

FOR MY PARENTS, NANNETTE, NIKE,
KATIE, AND MARGY (JHK)

FOR MY DAUGHTERS, ANA AND LEILA (AK)

This page intentionally left blank

CONTENTS

TABLES

ACKNOWLEDGMENTS

Like any successful relationship, co-authorship requires openness, honesty, and trust. What began as a shared passion fortuitously evolved into a lasting friendship. First, each of us is grateful to the other for sharing a difficult but gratifying journey.

Nothing is possible without those who parent and teach. We have been fortunate in having the best of both. We thank our parents and a legion of teachers, supervisors, and mentors.

Dr. Kleiger expresses his gratitude to Nelson Jones, Irwin Rosen, and Marty and Lui Leichtman. Each has served as a special guide, friend, and role model. Heartfelt appreciation also to the many colleagues and supervisors at the Menninger Clinic in Topeka, Kansas during the 1980s and 1990s, all of whom provided incredible intellectual nourishment, support, and friendship. Of course, thanks would be incomplete without mentioning the brotherhood of the Topekamen, most notably Steve Lerner, Frank Barthell, and Mahasen Disilva. Many Maryland colleagues like Joseph Silvio, Paula Oser, Sara Hedlund, Jennifer Babcock, Siobhan Hannes, Linda McGhee, Ruth Berkowitz, David Wyner, Janet Dante, Michael Stutz, Gregory Bowman, Rachel Ritvo, and Lisa McCurry also deserve thanks for the friendship and support they have provided.

Dr. Khadivi wishes to acknowledge and express his gratitude to his mentor, Dr. David Shapiro, whose perspective on psychopathology and whose understanding of the "dynamic of the working of the mind" was influential in his development as an assessment psychologist. In addition, special thanks to Dr. Jeffrey Levine, the Chair of Department of Psychiatry, at Bronx-Lebanon Hospital Center, whose critical clinical thinking has been inspiring, and for his continued support over the years.

Finally, Dr. Khadivi particularly would like to express "deep appreciation and gratitude to my wife, Dr. Yasmine Saad, whose encouragement, and support was instrumental in finishing this book."

Together we are grateful to the army of like-minded friends and colleagues in the Society of Personality Assessment, whom we have known, laughed with, and learned from over the years. Special acknowledgment to

Jed Yalof, Don Viglione, Tony Bram, Irv Weiner, Phil Erdberg, Bruce Smith, Odile Hussein, Barry Ritzler, Leslie Morey, Barton Evans, Steve Finn, Greg Meyer, Joni Mihura, Virginia Brabender, Marvin Acklin, Charles Peterson, and Marshall Silverstein.

We wholeheartedly express our gratitude to Joanne Freeman and Alissa von Malachowski for their painstaking efforts, their incredible attention to detail, and, most of all, their patience, in helping shape this manuscript into readable form. For their keen eye for detail and skillful editing, we are humbly thankful. We also thank Nancy Heneson and John Kerr for their enthusiastic support of our project. To George Zimmar, a special thank you for giving us the green light to undertake this book a year ago. George, we appreciate your steadfast support and encouragement.

None of this is ever possible without the loving presence, quiet support, patience, and encouragement of our families. For the long nights and lost weekends spent writing, we thank our families and apologize for the distractions and absences. Without the blessing of our spouses, we would not have undertaken the project. To our children, the very best of us, we give thanks for their courage, intelligence, wonderment, and faithfulness. We are truly lucky men!

Finally, it is customary that authors give thanks to their patients. We would not only be remiss in not doing so, but none of this would have ever been possible without our patients, who trusted us and tolerated our sometimes clumsy efforts to listen and understand. For what we have learned, we are grateful; and for lessons yet to learn, we eagerly await the opportunities that lie ahead.

ABBREVIATIONS

AHRS	Auditory Hallucination Rating Scale
APSS	Attenuated Positive Symptom State
ASRM	Altman Self-Rating Mania
BABS	Brown Assessment of Beliefs Scale
BAVQ	Belief About Voices Questionnaire-Revised
BCIS	Beck Cognitive Insight Scale
BIPS	Brief Intermittent Psychotic State
BNSS	Brief Negative Symptom Scale
BPRS	Brief Psychiatric Rating Scale
BSABS	Bonn Scale for the Assessment of Basic Symptoms
CAARMS	Comprehensive Assessment of At-Risk Mental States
CAHQ	Characteristics of Auditory Hallucinations Questionnaire
CAINS	Clinical Assessment Interview for Negative Symptoms
CASH	Comprehensive Assessment of Symptoms and History
CAT	Children's Apperception Test
CDRS	Characteristics of Delusions Rating Scale
CDSS	Calgary Depression Scale for Schizophrenia
CFI	Cultural Formulation Interview
DDE	Dimensions of Delusional Experience
DICA	Diagnostic Interview Schedule for Children and Adolescents
DSSI	Delusions Symptoms State Inventory
EPOS	European Prediction of Psychosis Study
FTD	Formal thought disorder
ICD	International Classification of Diseases
MDS	Major Depression Rating Scale
MMSE	Mini-Mental Status Exam
MOCA	Montreal Cognitive Assessment
PANSS	Positive and Negative Syndrome Scale
PDI	Peters Delusional Inventory
PQ	Prodromal Questionnaire
PSE	Present State Examination

PTSD	Post-traumatic stress disorder
RDC	Research Diagnostic Criteria
SANS	Scale for the Assessment of Negative Symptoms
SAPS	Scale for the Assessment of Positive Symptoms
SCID	Structured Clinical Interview for DSM-IV
SCoRS	Schizophrenia Cognition Rating Scale
SDSS	Simple Delusional Syndrome Scale
SG	Story Game
SIPS	Structured Interview of Prodromal Symptoms
SIS	Structured Interview for Schizotypy
SMVQ	Southampton Mindfulness of Voices Questionnaire
SOPS	Scale of Prodromal Symptoms
SPQ	Schizotypal Personality Questionnaire
SSPI	Signs and Symptoms of Psychotic Illness
SSRS	Schizophrenia Suicide Risk Scale
SUMD	Scale to Assess Unawareness of Mental Disorder
TCO	Threat/control override
TDI	Thought Disorder Index
TDQ	Thought Disorder Questionnaire
TLC	Thought, Language Communication
TLI	Thought and Language Index
ToM	Theory of Mind
TP	Thought Problem
VAAS	Voices Acceptance and Action Scale
VAY	Voice and You
VPD	Voice Power Differential
WMAPLE	Wisconsin Manual for Assessing Psychotic-Like Experiences
YMRS	Young Mania Rating Scale

This page intentionally left blank

INTRODUCTION

> And suddenly you know: It's time to start something new and trust the magic of beginnings.
>
> (Eckhart, 1981)

Volumes about psychosis are not new. In fact, psychosis is one of the most studied areas in psychopathology. Countless volumes, scientific investigations, and professional journals are devoted to the diagnosis and treatment of psychotic conditions. So the discerning reader may wonder why we decided to write another book about psychosis. The answer lies in our avid interest in psychosis, assessment, and diagnosis. Our decision to keep the focus on assessment issues defines the unique scope of the book. By assessment, we mean methods of seeking to identify and understand the nuances of psychosis to arrive at a sound diagnosis. Our stress is on a multi-method approach, as opposed to relying on a single form of information gathering. We are keenly interested in clinical interviewing, which some may feel is a lost art. At the same time, we value the role that psychological assessment and, where appropriate, empirically validated structured interviews and rating scales can play in the diagnostic and treatment planning process.

Although our professional backgrounds are diverse, both of us share a particular interest in the diagnosis of psychotic phenomena. Through our training at Cornell and the Menninger Clinic, we learned about psychodynamic psychological testing, clinical interviewing, and the art of listening to patients whose painful experiences with mental illness inspired us to learn more about their struggles. Dr. Kleiger approaches the subject from an outpatient setting, evaluating qualities of thought organization in a broad range of individuals with psychotic-like symptoms. Dr. Khadivi has a forensic practice and works in the trenches of an urban psychiatric hospital, where he evaluates patients in the emergency room and acute inpatient wards and teaches and supervises interns and residents. A series of workshops merging the ideas of two like-minded colleagues with a common interest in assessing psychosis sowed the seeds for this book.

Although our initial work focused more narrowly on psychological testing and interviewing, we wanted to broaden our scope and prepare a practical guide to help clarify confusing concepts, sharpen diagnostic distinctions, and provide ample clinical examples of the psychotic phenomena that we describe.

First, we wish to state what this book is *not* about. Although we take a broad look at the phenomenology and symptomatology of psychosis, we have generally excluded a neurobiological perspective from our multi-method approach to assessing psychosis. The decision to exclude this weighty body of literature was made consciously. For one thing, we are not neuroscientists or medical researchers. We are clinicians who are interested in developing a more practical understanding of psychosis and detailing assessment methods available to the clinical practitioner in a routine office or hospital setting. This underscores an essential focus of this book—namely, our wish to communicate directly and in a straightforward manner with practicing mental-health professionals from a variety of disciplines to clarify areas of diagnostic murkiness and provide a current review of the more salient issues involved in understanding and assessing psychosis.

Nor is this a book about psychological testing. While we come from the proud tradition of psychological assessment, we wanted to write an inclusive text that would be helpful to a broad range of mental-health professionals at different levels of training and experience. Psychological assessment and traditional use of psychological tests are important, and we have devoted a chapter to this subject; however, our goal was to approach testing in a way that also would make it more accessible for the nonpsychologist, who has less experience with traditional assessment instruments.

Moreover, we have not written a book for an audience of psychosis researchers. Although we cite hundreds of references drawn from current and past scientific investigations, this book is intended as a clinical guide, not as a research treatise. We reference countless studies but provide no original research of our own.

In describing what our book is not about, we have gradually revealed our mission and intended audience: to clarify diagnostic issues and focus on effective methods of assessing psychosis that will be useful to the clinical practitioner. To accomplish this, we have organized our handbook into four sections.

Part I includes three orienting chapters on understanding psychotic symptoms and experiences from both personal and traditional conceptual perspectives. Chapter 1 introduces major features of psychosis and incorporates a close-up, personal-narrative perspective of individuals who comment on their psychotic experiences. In Chapter 2, we take a wide-angle view of the symptoms of psychosis and provide more detail

and texture regarding the common features that make up the psychotic experience. We extend our introduction to concepts and features of psychosis in Chapter 3, in which we discuss the phases of psychosis.

In Part II, we turn to the subject of diagnosis, with two chapters focusing on past and current diagnostic practices and another chapter addressing conceptual issues relating to whether diagnosis conforms more to a traditional categorical model or a contemporary dimensional model. Chapter 4 provides an overview of the evolution of diagnostic classification. Chapter 5 introduces the dialectic between categorical and dimensional approaches to diagnosis. In Chapter 6, we focus on developments in the DSM-5 and discuss differential diagnosis of psychotic symptoms and disorders.

We devote Part III to assessment methods and include three chapters to survey different traditions for assessing psychosis. We spotlight clinical interview techniques in Chapter 7 and psychological testing in Chapter 8. Because of the proliferation of research instruments developed to assess every conceivable aspect of psychosis, Chapter 9 provides an overview of some well-known structured interviews and rating scales developed in research settings.

Part IV focuses on special assessment issues and populations. Assessing psychosis without an appreciation for cultural influences on diagnosis leads to a culturocentric collection of false-positive diagnoses. Thus, in Chapter 10, we introduce cultural issues involved in the assessment of psychotic phenomena. Chapter 11 provides an overview of the issues in assessing high-risk patients or those considered to be at high risk for converting to psychosis. Although this cutting-edge body of work is largely dominated by the research literature, we include it because early detection is perhaps the most important area in psychosis assessment.

The next two chapters discuss assessment of suicide (Chapter 12) and violence risk (Chapter 13) in psychotic conditions. Although base rates for suicide and violence in individuals suffering from psychotic conditions are relatively low, the stakes for missing predictors of suicide and a propensity for violence in psychotic individuals are very high. Chapter 14 surveys assessment of psychosis in adolescents and children, for whom much of the adult assessment literature does not pertain. This chapter focuses on differential diagnosis, testing, and interview techniques. Our concluding chapter both takes a look back and offers a glimpse into the future with regard to understanding and assessing the diversity of the psychotic experience.

It is our hope that we have treated the serious subject of assessing psychosis with sufficient breadth and depth. Our aim has been to clarify, but not oversimplify, complex and confusing terms, concepts, and techniques that may have drifted over time and become murky. Our desire has been to remain faithful to the large body of science behind diagnosis

while never objectifying and losing sight of the critical importance of the individual by becoming overly fascinated by or overly focused on the symptoms.

The case examples we cite are based on our joint clinical experience. Most are actual patients while others are composite sketches used for teaching purposes. In all cases, the material has been carefully disguised.

A final note: We have elected to use gender pronouns in random fashion throughout this text in order to avoid the cumbersome "he/she, him/her" verbiage.

James H. Kleiger and Ali Khadivi

Part I

CLINICAL FEATURES OF PSYCHOSIS

This page intentionally left blank

1

OBSERVING AND LISTENING TO THE PSYCHOTIC EXPERIENCE

> Alone in my room, wrapped in a blanket, I whimpered and talked aloud to myself, recalling the lost glory of my youth when I considered myself, and was considered by others, a bright and capable person. It seemed that was all gone now. I wondered whether what I was experiencing was some sort of psychotic break, the sort that ambushes a person who until then has lived an ordinary life, auguring a new existence full of torment and struggle.
>
> (Krauss, 2010, p. 131)

Think about the following clinical encounters and answer the question, "Is this patient psychotic?"

Tricia, a 24-year-old grad student coherently describes hearing voices and seeing visions but states that she knows that these visions come from within and are not real. She does not tell others about these daily experiences for fear that they will think she is sick. She used to believe she had magical powers; her voices and visions made her feel special and provided constancy in her life. However, over time, they became a negative chorus, causing her distress. Eventually, she came to the realization, with both sadness and relief, that these were not real. Nonetheless, she continues to hear voices and see visions. She is actively hallucinating, so her therapist concludes that she must be psychotic. Do you agree?

Didia was born in a village in Africa and moved to a large American city to study. She recently told the resident she was seeing in therapy that she had been haunted by the spirit of a tribal elder from back home, after she had had sex with her boyfriend. She told her therapist that she was hearing a spirit voice at night, telling her that she was bad. The resident worried that she was becoming psychotic and phoned his supervisor to see if he should arrange hospitalization.

Brian, a 30-something single man, anxiously reports that an unnamed organization has hacked his computer and is sending him coded messages to get him to target government buildings, yet describes all of this without odd language or a disturbance in the focus, filtering, or pacing

of his speech. He denies that he is hearing voices or having other unsubstantiated perceptual experiences. On psychological testing, he shows no classic signs of a thought disorder. Is he delusional or psychotic? Does he have a thought disorder?

Parents brought their 18-year-old son, Martin, who was covered in green paint, to the emergency room. More alarming was the fact that a neighbor found him on his hands and knees examining insects in the middle of a busy street. When questioned about his odd behavior and appearance, Martin smiles but does not speak. He is psychotic, right?

Eleven-year-old Timmy speaks in a distracted and unfocused manner. We see similar looseness and fluidity in his Rorschach responses, which contain some odd, invented words. Timmy's mother reports that he has ADHD and was previously evaluated by a speech pathologist. Should we conclude that he has a thought disorder and might he be psychotic?

Finally, 16-year-old Marie becomes violent when she sees two classmates, who do not know each other, sitting in the same row at an assembly. She immediately concludes that because they are sitting close to each other they must be gossiping about her. How do we understand the conclusion she made? Is she delusional? Psychotic?

How familiar are these brief vignettes? How often do we encounter variants of these clinical moments, when the chief diagnostic decision we must make is whether or not a patient is psychotic. In all of the examples cited, the patients presented with unusual behavioral signs (including their speech) or shared atypical beliefs and perceptions, raising the question of whether they might be psychotic. In some cases, pathognomic features seemed to be present, whereas in other cases they were absent. For example, Tricia and Didia complained of hearing voices and seeing visions, while Brian spoke so clearly about what sounded like a delusional belief. There was no mistaking that Martin's behavior was bizarre; however, is this alone enough to constitute psychosis? Then there is young Timmy, who used idiosyncratic language and had trouble conveying his ideas in a coherent and organized manner. And what do we make of Marie, who immediately assumed that the physical proximity of two people must mean that a relationship exists between them that has negative implications for how they both feel about her.

Is there a way to sift through the data and understand psychosis in a manner that separates figure from ground? Too often some symptoms are assumed to be pathognomic, or present in every psychotic condition. Symptoms are conflated with syndromes, and terms become used interchangeably, leading to a lack of conceptual clarity and diagnostic confusion. Even among more experienced diagnosticians, it is easy for concepts to become confused and terms to be used in a fuzzy manner.

Reviewing the following definitions and hearing individuals' first-person accounts of their psychoses can help us achieve a more precise

experiential and conceptual understanding. These definitions are by no means novel or new, but, when presented in a simple and straightforward manner, they help set the stage for a richer understanding of different realms of psychotic experience.

Defining Psychosis

The term "psychosis" is derived from the Greek words, *psyche* (mind or soul) and *osis*, (abnormal or deranged). As a general descriptive term, psychosis refers to a mental state characterized by a loss of contact with reality. Losing contact with reality can be either a state or trait-like phenomenon. Psychotic conditions can be brought about by extreme stress or trauma or be the product of psychobiological vulnerabilities. Breaks with reality can be brief and episodic, develop over time, or occur more or less continuously. In some cases, a psychotic state might develop rapidly, occurring as a discrete symptomatic expression for a patient in a catastrophic state of stress. For others, it may creep up in a quiet and sinister manner, laying its experiential groundwork beyond one's conscious awareness. Such was the case with Humpston (2014), who said that the onset of her psychosis was "an insidious one, perhaps because the increase in perplexity was so gradual that even I did not notice it at first. The salience of my surroundings and my own thoughts slowly heightened, each gesture from strangers in the street had become a signal and a message to me" (p. 241). Finally, for some individuals, psychosis becomes a daily reality, eroding the person's sense of self and adaptation to the world.

As a diagnostic term, psychotic disorders are a superordinate class of mental disturbances, characterized by a set of clinical signs and symptoms, some or all of which may be present in a given patient. The most common examples of psychotic disorders include schizophrenia and schizoaffective, bipolar, and delusional disorders. Other psychiatric syndromes may include occasional psychotic states, typically arising under conditions of increased stress (e.g., schizotypal, paranoid, and borderline personality disorders, severe posttraumatic stress disorder, and dissociative identity disorder). Finally, psychotic states may stem from toxic or metabolic factors or occur as a result of neurological damage.

Psychosis can be defined by six overlapping phenomena. Some are observable signs, and others are symptoms reported by the individual. We infer or judge other features to be present from how a patient talks about his experiences. The following six phenomena are hallmark features of psychosis:

1. hallucinations;
2. delusions;

3. thought disorder;
4. disorganized and bizarre behavior;
5. negative signs and symptoms;
6. loss of insight.

Hallucinations

Hearing voices, seeing visions, and feeling, tasting, or smelling things in the absence of sensory information are the defining characteristics of hallucinatory experiences. Beyond clinical definitions, the perceptual experience for the individual is completely real. In Humpston's words, her voices "were my reality. Who is to deny my reality when all I need to do is to perceive. The thoughts and voices were as self-evident as 'reality' would be to any otherwise 'normal' person" (2014, p. 242).

The nature and content of the voices may vary considerably. For one individual, they may be abusive, threatening, and controlling, while for another person they may provide encouragement and comfort. Still others may experience both positive and negative voices, or a shift in the quality of the voices over time. In a moving first-person account of her experience with psychosis, Lampshire (2012) spoke poetically about her experience as a person hearing voices, which provided both a sense of comfort and a source of torment: "Madness can be an enticing siren, calling from many ragged shores with a promise of tranquility hidden amongst the rocks; unfortunately, we are just as likely to find ourselves shattered and impaled on the rocks as we are to find a safe and serene harbour" (p. 139). Just as with Tricia, Lampshire's voices offered comfort and safety but also could turn on her in an intrusive and taunting manner.

Delusions

Whereas hallucinations represent sensory-perceptual experiences, delusions are ideational phenomena that reflect an individual's beliefs. The defining feature of a delusional conviction is that it is held as an irrefutable truth that cannot be disconfirmed. Delusions are essentially efforts to explain something that is confusing, threatening, or anxiety-provoking. More than 100 years ago, Freud concluded that Schreber's delusion about being turned into a woman was not only an effort to explain confusing internal experiences but that by alleviating anxiety it became a restorative process (Freud 1958). Delusional explanations may decrease anxiety by explaining the source or nature of the voices that an individual has begun to hear. In any case, the reduction in anxiety is achieved at the expense of a regressive shift in reality-testing.

Humpston called her delusions "an instinctive search for meaning in the face of the confusion," describing psychosis as "an unfortunate

endpoint of one's desperate search for explanations and understanding. The psychotic person is perpetually trapped in a cul-de-sac" (2014, p. 241). Later, Humpston shared that her delusional beliefs occurred after she began hearing voices, as a desperate means of explaining her sense of perplexity.

Also writing from a first-person perspective, Chadwick (2014) described his "shift to psychosis" in terms of his delusional thinking: "As psychosis approached in the summer of 1979, the verificationist tendency (confirmation bias) also started to gallop and in madness was unstoppable. I could always confirm my delusions but not refute them" (p. 485).

Then there was Nick Lotz, whose story of psychosis was told in the *New Yorker* (Marantz, 2013). As a college student, Nick grew increasingly anxious and self-conscious. He went out and drank nightly to the point of having blackouts. Friends seemed to stop returning his calls. He stayed up all night, snorting Adderall and Focalin, worrying that people might be posting embarrassing videos of him online. Like Brian, he began to suspect that people were tracking him online. He anxiously searched internet sites looking for coded messages about him, though he could not find any. Then, one night, while at a concert, he heard the Dave Matthews Band sing the lyrics "One year of crying and the words creep up inside." At that instant, it all became clear; Nick had solved the puzzle of his life. He concluded that since starting college he had been the star of a reality-TV show. In this clarifying moment, everything made sense to him.

Whereas a patient who hears voices may not be psychotic, the delusional patient has become psychotic. While not all psychotic patients may demonstrate clear delusional beliefs, once a patient becomes delusional, he or she may reasonably be considered to be psychotic.

Thought Disorder

Suffice it to say that thought disorder may or may not signify the presence of a psychotic disorder. We may regard thought disorder in two ways: objectively, as a formal characteristic of how individuals express their ideas through their speech or writing (disorganized speech and linguistic peculiarities) and inferentially, as the silent way in which they reason, form concepts, and make connections between their observations and ideas (leading to errors in thinking and reasoning). In this regard, Chadwick (2014) reflected on his confusing cognitive processes during his prepsychotic and psychotic states. He focused on his tendency to collapse boundaries between different categories. "This—perhaps through overconnectivity of thought—leads to categories merging and coalescing into a totality rather than being separated and distinct. The result is enhanced similarity perception and hence the often mentioned overinclusive thinking

of thought disordered patients" (2014, p. 484). Chadwick also described how the blurring of boundaries resulted in his being unable to write up research from Ph.D. studies because "every topic I had worked on seemed to *merge* and blend with every other topic" (2014, p. 484).

Along with hallucinations and bizarre behavior, psychotic individuals may or may not also demonstrate these disturbances in how they formulate or express their ideas. For example, a person may talk about delusional beliefs in a clear and coherent manner. Conversely, an individual may speak in a disorganized, distracted, and loose manner yet not have lost contact with reality.

Disorganized and Bizarre Behavior

Oddities of behavior may be a sign of psychosis. The patient's manner of dress and grooming, facial expressions, posture, and social and psychomotor behavior may deviate considerably from conventional norms. Patients may behave in socially inappropriate ways, crossing normative boundaries that threaten those around them. They may dress or adorn their body in a peculiar manner. Such was the case with Martin, who was found on his hands and knees in the middle of a busy street, covered with green paint.

Some individuals may speak at an inappropriate volume or not speak at all. However, like hallucinations and disturbances in reality-testing, bizarre behavior is not necessarily associated with psychosis. Someone may behave bizarrely and not be psychotic. Conversely, some suffering from a psychotic disorder may not behave in floridly bizarre ways.

Negative Signs and Symptoms

If hallucinations, delusions, disordered speech and thinking, and bizarre behavior are considered the "positive" or florid signs and symptoms of psychosis, "negative" features are those that reflect an absence of various psychological functions. In some psychotic disorders, absences, or deficits, are apparent in cognitive functioning, speech, emotional expressiveness, and social relatedness. Typically, negative signs and symptoms are identified by a series of words that begin with the letter "a," including *apathy*, *anergia*, *alogia*, *avolitionality*, and *anhedonia*.

Subjective accounts of negative symptoms call into question the deficit hypothesis and raise questions about the defensive function of negative symptoms. For example, Longden (2012) described her withdrawal from the world as a coping strategy: "My own experience of this reflected a fundamental need to disconnect from a world with which I had ceased to identify or desire to know. Or, at other times, it protected me from the shocking, unsettling impact of voices or flashbacks" (p. 185).

Impaired Insight

Essentially, impaired insight reflects a lack of understanding or a denial of one's symptoms. It may reflect a failure to grasp cause and effect, an inability to "see within," and an inability to see oneself through others' eyes. Insight into the abnormal nature of one's psychotic symptoms and the awareness that one has an illness are related to specific attributes such as self-awareness, self-reflection, and the general ego function of reality-testing, which involves correct attribution of the source and location of one's experiences (i.e., as products of internal or external stimuli).

The essential question regarding reality-testing has to do with whether or not an individual can distinguish the products of his own mind and imagination (i.e., what is inside) from what is objectively perceived and consensually verifiable in the external world. While avoiding a philosophical discussion about who gets to decide what is reality, we feel that mental-health professionals generally agree that there is a meaningful distinction between fantasy and reality. Impaired insight implies that an individual cannot determine the nature, source, or locus of her psychotic experiences and, by extension, know whether she has a mental illness and if the symptoms are "real" or abnormal. Impairment in insight is also associated with willingness to undergo treatment, which, in turn, may influence prognosis for recovery.

In this regard, consider the experiences of Ms. G., an attorney who has been treated for many years for heightened anxiety that colleagues are removing things from her desk and "listening" to her thoughts. In fact, Ms. G. used the term "broadcast thinking" to describe this experience. Clearly, her anxiety-ridden worries are capable of rising to a delusional level. However, Ms. G. has managed to stay out of the hospital for more than 20 years with a regimen of weekly individual psychotherapy and neuroleptic medication. In addition to the beneficial effects of her treatment and other restorative influences in her life, Ms. G's stability can be tied to her recognition that her delusional thinking is a symptom of a disorder that is effectively reduced by compliance with prescribed medications and ongoing psychotherapy.

As with other phenomena associated with psychosis, loss of insight is not pathognomic of psychosis. While most patients who have "broken with reality" have lost insight into the nature of their symptoms and beliefs, not all uninsightful patients have broken with reality. Thus, loss of insight is a phenomenon associated with a variety of nonpsychotic conditions.

With these clinical features and conceptual issues in mind, let us return to the patients at the beginning of this chapter and see if we can sharpen our diagnostic focus. Assuming there was no basis to doubt the credibility of her reports, Tricia's hallucinatory symptoms should make one