

Re-envisioning psychosis: A new language for clinical practice

Our language should reflect that psychosis exists on a continuum

"I haven't wanted to call it psychosis yet..."

"I'm not sure if this is psychosis or neurosis."

"I wonder if there's a psychotic process underneath all of this?"

"Psychotherapy won't help psychosis."

In our experience as practitioners in an early psychosis program, the above statements are common among mental health care providers. In our opinion, they are examples of vestiges of an archaic, overly simplistic clinical language that is not representative of current conceptions of psychosis as being on a continuum with normal experience.^{1,2}

The above quotes speak of psychosis as an all-or-none distinction: a "switch," something fundamentally different from other psychological processes. In this article, we highlight common "all-or-none" myths about psychosis and argue for a more fluid, normalized psychosis language, where impairment is defined not by the absolute presence or absence of "weirdness" but instead by distress, conviction, preoccupation, and behavioral disturbance. We challenge the notion that the presence of psychosis mandates a "fast track" diagnosis that ignores the complexity of human experience.

Power of language

The word "psychosis" has enormous power for patients, families, clinicians, and the public. It often is used interchangeably with "craziness," "insanity," or "madness." Mental health clinicians use psychosis to describe many phenomena, including:



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Language of psychosis

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'All-or-none' views of psychosis could lead to oversimplification of persons who have psychotic symptoms

- breaks with reality testing
- odd or delusional beliefs
- abnormal sensations
- catatonia
- bizarre behaviors
- so-called formal thought disorders.

It is likely one of the most heterogeneous symptom terms in psychiatry. DSM-IV-TR notes "the term psychotic has historically received a number of different definitions, none of which has achieved universal acceptance."³

Psychosis myths. In addition to its phenomenological usage, the word psychosis also has various theoretical interpretations and often is used to demonstrate a fundamental pivot point for making qualitative distinctions. For example, clinicians and theorists have used "psychotic" to assume that someone experiencing psychosis:

- is operating on a core or primitive mode of thought, the so-called "primary process"⁴
- has a belief that is beyond understanding, one for which empathy is meaningless and misplaced⁵
- has clear convictions that violate social norms and refuses to accept society's "proper" rules for logic and emotion⁶
- is in a state of "brain toxicity" with an "organic" cause (this comes from discussing psychosis with other clinicians, not from the literature).

Such seemingly disparate definitions share the assumption that psychosis represents a shift in categorical status, whether the category is developmental (advanced vs primitive), interpersonal judgment (able to be empathized with or not), sociopolitical status (conformist or not), or functional brain state (organic or non-organic).

Even the etymological basis for schizophrenia (its Greek roots signify "split mind," which arguably spawned the long-held erroneous view that schizophrenia is a "split personality") exemplifies this stance and reinforces the notion of discrete "all-or-none" categories of experience. In our view, such assumptions do not adequately reflect the reality of psychosis as a continuum of human experience, and could lead to serious, if unintended, stigmatization

and oversimplification of persons who have psychotic symptoms. We argue that such all-or-none thinking reifies 2 clinical "myths" about what psychosis represents:

- Psychosis represents a fundamentally different type of cognitive process.
- Psychosis is so different from normal human experience that mood and anxiety symptoms become "subsumed" by it and treated as "secondary."

Our goal is not to redefine psychosis or present an argument for diagnostically recategorizing schizophrenia, schizoaffective disorder, and bipolar disorder, which others have already done well.⁷⁻¹⁰ Instead we want to reinforce the evidence-based and clinically relevant concept that psychosis exists on a definable continuum of human experience and to offer practitioners a clinical language of psychosis for assessing and treating psychotic symptoms that avoids unsupported all-or-none distinctions.

Defining 'the schizophrenic'

In our experience, an unintended consequence of assuming psychosis is an all-or-none state is the clinician's perpetual search for "real psychosis" as separate from "psychosis for which I have a good explanation." Although this distinction is reminiscent of earlier arguments regarding "neurotic" vs "endogenous" depression, we feel that in this case "real or not" acts at a more basic level: the characterization of person types.

We assume that every clinician—ourselves included—who has worked with seriously mentally ill patients has heard an individual with schizophrenia referred to as "a schizophrenic." Although the problem of defining a person as an illness is not unique to psychosis, we think that you will agree that the phrases "a depressive," "a bipolar," or "a generalized anxiety" [sic] are rare.

DSM-IV-TR specifically avoids using expressions such as "a schizophrenic...and [instead uses]...an individual with schizophrenia."¹¹ But we believe that DSM-IV-TR accidentally encourages the distinction of a "psychotic person type" by making

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Table 1

The ‘logic’ of schizoaffective disorder applied to anxiety and OCD

Symptom course	‘Primary’ feature	‘Secondary’ feature	Diagnosis
2 weeks of ≥2 psychotic symptoms outside of a major mood episode plus a manic or depressed episode	2 weeks of psychotic and negative symptoms	2 weeks of low mood or anhedonia or 1 week of elevated or expansive mood	Schizoaffective disorder
1 month of social anxiety and avoidance outside of a major mood episode plus a manic or depressed episode	1 month of social anxiety and avoidance	2 weeks of low mood or anhedonia or 1 week of elevated or expansive mood	‘Socio-anxious-affective disorder’*
1 month of obsessions and compulsions outside of a major mood episode plus a manic or depressed episode	1 month of obsessions and compulsions	2 weeks of low mood or anhedonia or 1 week of elevated or expansive mood	‘Obsesso-compulso-affective disorder’*

OCD: obsessive-compulsive disorder

*These diagnoses are hypothetical disorders used to illustrate how the criteria used to define schizoaffective disorder subsume other types of symptoms

schizoaffective disorder—a disorder that suggests a continuum—use Criterion A for schizophrenia as its defining feature. The implicit assumption is that “something categorical”—in this case defined by Criterion A—identifies a “psychotic person type,” as opposed to a person who simply has psychotic symptoms. If we see evidence of Criterion A, then the person is naturally moved into the realm of “schizophrenia and other psychotic disorders.” In other words, Criterion A *subsumes* other types of symptoms. In contrast, the presence of 1 month of social anxiety or obsessions and compulsions does not subsume other symptoms into primary anxiety disorders. To make this example explicit, we have developed a set of criteria for hypothetical disorders that overlap major categories of DSM-IV-TR (*Table 1*).

A continuum approach

As a way out of this inductive logic trap, we suggest the following statements as evidence-based and clinically realistic ways of approaching psychosis assessment.

‘Normal sadness’ and ‘normal psychosis’ are equivalent. The DSM-IV-TR description of major depressive disorder, states that “periods of sadness are inherent aspects of the human experience.”¹² However, descriptions of psychosis rare-

ly reflect that psychotic-like experiences are quite common¹³⁻¹⁹ and easily induced in otherwise healthy people.²⁰ Psychotic symptoms are widely described as being genetically linked to normally distributed personality traits.²¹⁻²⁴ Finally, research on risk for developing chronic psychosis has identified that most patients who develop attenuated psychotic symptoms do not experience them chronically.²⁵⁻²⁸ Together, these data argue strongly for a concept of psychosis as common and continuously distributed across large groups.

A psychosis screen can be much more than ‘+/- AH/VH/PI.’ We reject the idea that psychotic phenomena are fundamentally different from “normal” occurrences such as imagined or inner speech, perceptual fluctuations, distorted or rigid beliefs, or inability to accurately express one’s emotional state. Yet abnormal perception, affect flattening, and delusions often are viewed as “really weird,” which suggests most people never experience these phenomena, only “affected” people. This easily can lead to cognitive errors that associate psychosis as a state of mind that is fundamentally different from non-psychosis. In fact, DSM-IV-TR categorizes the presence of persistent psychotic symptoms as evidence of disorder until proven otherwise.³

We feel that this simplistic language describing psychosis as inherently patho-

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Psychotic-like experiences are common and easily induced in otherwise healthy people



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Approaching psychotic symptoms as expressions on a continuum allows for a therapeutic alliance that focuses on patient recovery

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Table 2

Revising the clinical language of psychosis to separate presence from pathology

Symptom	Continuum	Attenuated experience	Pathological experience ('disorder')	Psychotherapeutic intervention
Paranoid ideation/delusions	Schematization and testing of environmental information	<ul style="list-style-type: none"> • referential thinking • suspiciousness • negative attitudes of others • confusion about accuracy of thoughts • feelings of special purpose or meaning • loss of control over own thoughts 	<ul style="list-style-type: none"> • frequent • preoccupying • leads to maladaptive behaviors 	<ul style="list-style-type: none"> • encourage curiosity about beliefs, evidence gathering, and alternative hypothesis testing • design new and adaptive safety behaviors • develop individual formulation of experience
Hallucination	Higher order sensory processing and self/other discrimination	<ul style="list-style-type: none"> • perceptual changes • increased sensitivity to light and sound • senses 'playing tricks' 	<ul style="list-style-type: none"> • frequent • intrusive • distressing • conviction about external source • leads to maladaptive behaviors 	<ul style="list-style-type: none"> • discuss phenomenon as exaggeration of normal brain function • focus on socially appropriate coping skills (eg, talking into cell phone to have a 'conversation') • develop individual formulation of experience
Disorganized speech/'thought disorder'	Social pragmatics and conceptual linking	<ul style="list-style-type: none"> • difficulty 'getting point across' 	<ul style="list-style-type: none"> • little insight • little attentional control 	<ul style="list-style-type: none"> • emphasize social appropriateness of linearity and tangentiality • encourage circumstantial thinking as a creative outlet

Source: For a bibliography, see this article at CurrentPsychiatry.com

logical ignores the clinical richness of psychotic experience. In our experience, many individuals who have been diagnosed with chronic psychosis have never been asked:

- about the timing, intensity, and character of their abnormal sensory experiences²⁹
- how their beliefs and schemas affect day-to-day behavior and choices
- if their psychotic symptoms are both-ersome or troubling.

We worry that a person experiencing impairing psychotic symptoms could become overshadowed by all-or-none assumptions about the symptoms themselves.

We propose *Table 2* as a guideline for approaching psychotic symptoms as expressions along a continuum of experience, one that shares much in common with recent well-developed biopsychosocial models of psychotic phenomena.³⁰ In

our view, this allows for a therapeutic alliance that focuses on patient recovery, as opposed to seeing psychotic symptoms as the only treatment targets. By moving beyond all-or-none myths and approaching psychosis as a continuum with normal experience, we believe that patient recovery can become a realistic goal.

Re-envisioning psychosis

We conclude with a reiteration of recovery in the language of the US Surgeon General almost 10 years ago: "...hope and restoration of a meaningful life are possible, despite serious mental illness... Instead of focusing primarily on symptom relief...recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society."³¹ We see no reason why people cannot live mean-



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We envision a landscape in which psychosis is seen as a 'normal' part of outpatient psychiatric practice

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Related Resources

- Bentall R. *Madness explained: psychosis and human nature*. London, United Kingdom: Penguin Books; 2003.
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ingful lives while also having symptoms of psychosis. Data from well-designed studies³² and accounts from individuals who have experienced or continue to experience psychosis³³ suggest that this is realistic.

By dispelling all-or-none myths, revealing the flawed logic of psychosis as “subsumer” of mood and anxiety, and describing the continuum of psychotic symptoms, we hope to encourage clinicians to be more positive and proactive in their approach to people experiencing impairing psychotic symptoms. Through assertive alliance and informed clinical technique, we envision a landscape in which psychosis is seen as a “normal” part of outpatient psychiatric practice.

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