

## Towards a More Egalitarian Approach to Communicating Psychopathology

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In the initial interviews with patients who suffer psychotic symptoms, the usage of the terminology of descriptive psychopathology rests upon an arbitration of knowledge of the 'truth' by using terms like "delusions" or "hallucinations" (with their definitions as "false beliefs" or "false perceptions") (Casey & Kelly, 2007). These terms can have a profound negative impact on patients' experience, which may produce an initial strain on the egalitarian patient-doctor relationship. In an era where deference to experts is dead, it might be worthwhile agreeing on the phenomenology of these psychotic experiences prior to labeling them. Some delusions cannot be objectively detected and described, because they evolve and exist within subjective and interpersonal dimensions. Severe psychopathology symptoms are statistically deviant, and thus can be labeled as 'unshared'. Symptoms may be perceived by others as objectively 'distressing' and by patients as subjectively 'disabling', as evidenced by 'dysfunctional' behavior (Adams & Sutker, 2004), but what is understandable by the person not experiencing the unique inner world of the suffering other?

Jaspers considered the lack of understandability of how a patient reached a particular conclusion to be the defining factor of a delusional idea. The notion of defining 'delusion' as "false belief" was challenged by Jaspers. Sims (1991) gives the example of a man who believed his wife was unfaithful to him "because the fifth lamp-post on the left was unlit". What makes it a delusion is the methodology, not the conclusion, which may in fact be right (Sims, 1991).

Some delusions might be mundane in their content, and others may not be falsifiable. Dereistic thinking is not based on logic but rather on feelings. It is possible to find ways to evade falsification (e.g. ad hoc hypotheses). Delusional elaboration may build upon delusional and/or hallucinatory foundations which may then have convergence with the more understandable concepts embedded in or reasonably sustaining the ad hoc hypothesis. Absence of verification from the patient's side does not lead to deductive falsification (Casey & Kelly, 2007).

The criterion for demarcation between what is real and what is pathologic may be different in the patient-doctor relationship. The assertion on the clinician's part of the falsity of a belief or experience can carry the risk of dogmatism. Discussion of the statistical deviance of symptoms, their distressing nature, disabling consequences, the resultant dysfunctional behavior, and apparent leaps from evidence to conclusion may be more helpful starting points. Such sensitivity is more in line with the essence of medicine as 'ars

medicina' (art of healing). Empathic identification with patients in their suffering may serve as an egalitarian platform prior to naming the symptoms.

The clinician's usage of terms like 'dysfunctional unshared belief', or 'distressing auditory perception', or other related terms that address the secondary effect of a pathologic experience may be more helpful, and may be more logically plausible and philosophically coherent. Taylor and Vaidya (2009) mention that it is often helpful to 'normalize', but that this is not equivalent to minimizing or being dismissive of patients' delusional beliefs. (Taylor & Vaidya 2009).

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