How to elicit thought disorder during clinical interviews: a practical guide

ARTICLE

Lena Palaniyappan, Oliver Delgaram-Nejad & Eric Yu Hai Chen

SUMMARY

The reliable assessment of formal thought disorder (FTD), a collection of observable signs of suspected problems in generating organised thoughts, is the cornerstone of interviewing a person with psychosis. A significant gap persists between the success of assessments reported in published FTD rating scales and the practical constraints of a clinical interview. Validated rating scales largely focus on operationalised criteria for describing items; the procedural aspects of how to elicit these signs often remain implicit. We synthesise the principles and procedures of FTD assessment embedded in rating scales, translating their design into a framework for routine clinical use. Systematic employment of several manoeuvres can help elicit FTD signs: conversational stimulation, cognitive loading, social modulation and pointed clarifications to stress-test thought, language and communication processes. By making these procedures explicit, we aim to equip clinicians and trainees with a strategic, measurement theory-informed approach to the psychiatric interview when assessing for FTD.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the conceptual framework of formal thought disorder (FTD) as a collection of observable signs requiring specific elicitation procedures
- apply systematic conversational manoeuvres, including thought provocation, cognitive loading and inducing mental state talk, to reliably elicit FTD signs during clinical interviews
- implement a structured, phased approach to FTD assessment that integrates evidence-based techniques from validated rating scales into routine clinical practice.

KEYWORDS

Clinical interview; thought disorder; psychiatry; disorganisation; rating scales.

> 'I am the finest professorship [. . .] This is again the highest activity – double – twenty-five francs – I am double polytechnic irretrievable' (Babette S, in Jung's *Psychology of Dementia Praecox*; Woods 2011)

> 'I love Russian songs. I love Russian speech. I know many Russians who are not Russians, because they speak a foreign language. I know that a Russian is a man who loves Russia. I love Russia. I love France. I love England. I love America. I love Switzerland, I love Spain, I love Italy, I love Japan, I love Australia, I love China, I love Africa, I love the Transvaal. I want to love everybody, and therefore I am God. I am not a Russian and not a Pole. I am a man, not a foreigner and not a cosmopolite. I love the Russian land. I will build a dam in Russia. I know that the Poles will curse me. I understand Gogol because he loved Russia' (Vaslav Nijinsky; Nijinsky 2006)

> ' You know . . . I . . . when I came to England at eleven 102 road, I went to infant school at the time. I was eleven be tweven in December because you know, was still, I was so tiny for my age // . . . I'm them girl in Eastenders . . . Julie crabs' skin and bone and starvation . . . I don't know . . . school with that them . . . them people somehow, they look and the girl face look and I look like that . . . ' (Participant 26AR16 in the Discussing Abstract Ideas in Schizophrenia Corpus: https://reshare.ukdataservice.ac.uk/855021/; Delgaram-Nejad 2023)

Spontaneous segments of speech like those above are rare in routine clinical practice. Yet these are the tell-tale signs of formal thought disorder (FTD) – a disruption in thought/language structure and coherence expressed through speech that represents a core diagnostic feature of severe mental illness (Kircher 2018). The central question facing time-pressed clinicians looking for FTD is: how can we increase the likelihood of eliciting such revealing speech patterns in the clinic?

The challenge of assessing FTD is fundamentally different from assessing many other psychiatric phenomena. Unlike hallucinations, depression or anxiety, which patients descriptively report, FTD must be actively drawn out to be observed during

Lena Palaniyappan, MD, PhD, is Professor of Psychiatry in the Department of Psychiatry, McGill University, Montreal, Canada. He is also an early intervention psychiatrist in the Douglas Mental Health University Institute, Montreal, working with families and young people experiencing psychosis, and Director of the Center of Excellence in Youth Mental Health, affiliated with McGill University, Montreal. His research interests include prevention of youth-onset mental illnesses by understanding the mechanisms of psychopathology and improving treatment outcomes.

Oliver Delgaram-Nejad, PhD, is a psycholinguist whose research focuses on language, cognition and severe mental illness, particularly schizophrenia. An independent researcher in Exeter, UK, he is a co-investigator on the international DIALOG project. His work examines how linguistic structure and use relate to negative symptoms, motivation and lived experience, with an emphasis on clinically meaningful outcomes and inclusive research design.

Eric Yu Hai Chen, MD, is Professor in Psychiatry at the Center for Youth Mental Health (Orygen), University of Melbourne, Melbourne, Australia, and Chair Professor in the Department of Psychiatry, School of Clinical Medicine, University of Hong Kong, Hong Kong. His research interests include the role of memory and language processes in psychosis outcomes, and the long-term impacts of early intervention services and relapse prevention strategies and cognitive enhancement through physical exercise following first-episode psychosis.

Correspondence: Lena Palaniyappan. Email: lena.palaniyappan@mcgill.ca

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the clinical interview (Palaniyappan 2022). This requires clinicians to serve as architects of conversational conditions that reveal latent cognitive and linguistic vulnerabilities.

Over decades, a number of rating scales have demonstrated that FTD can be measured with high interrater reliability when specific elicitation procedures are followed (Voppel 2025). The authors of these rating scales (Singer 1965; Reilly 1975; Andreasen 1979; Johnston 1979; Harrow 1985; Caplan 1989; Chen 1996; Docherty 1996; Liddle 2002; Bazin 2005; Kircher 2014) universally acknowledge that standardisation of these procedures is essential to achieve good interrater reliability. Yet a paradox persists: despite their psychometric reliability, these scales remain unused in routine clinical practice (Zamperoni 2024a). FTD remains what Sass & Parnas (2017) described as 'a grossly neglected concept', with many psychiatrists in early career stages unfamiliar with its assessment.

Multiple factors have contributed to this decline, including the bewildering array of overlapping terms (e.g. circumstantiality, tangentiality and derailment) used across scales (Sreeraj 2025). Although theoretical clarification of FTD phenomenology and definitional ambiguities lies beyond the scope of this article (see Passby 2017; Sreeraj 2025), we address a more practical gap: bringing forth the reliable but implicit elicitation procedures exploited by these scales (Table 1) for regular clinical use. By extracting these methods, we make explicit a core set of conversational manoeuvres that can be synthesised and flexibly deployed in routine interviews. Our aim is to ground clinical artistry in measurement methodology, providing a practical manual for the FTD-focused interview (Box 1). We do not provide an exhaustive checklist of FTD items; for this, we refer readers to the appendix and supplement of another work (Sreeraj 2025).

Core conceptual framework

The foundational insight for FTD assessment is deceptively simple: FTD comprises subtle but observable signs, not reported symptoms. This distinction has profound methodological implications. Just as eliciting a cardiac murmur requires dynamic auscultatory manoeuvres (e.g. handgrip, the Valsalva manoeuvre, squatting, breath holding or a treadmill stress), detecting FTD demands deliberate conversational techniques. Without proper technique, genuine pathology may go undetected, while improper technique may generate false positives.

Since FTD manifests through conversational speech, our elicitation procedures must themselves be conversational. The clinician becomes an active architect of discourse conditions, strategically varying communicative demands to stress-test linguistic cognition. Rating scale developers realised early that standard symptom-focused interviews are often insufficient. Patients may provide only brief utterances, without enough linguistic material to assess derailment, loosening or other phenomena. Successful scales solve this by systematically manipulating discourse conditions through seven key manoeuvres (Fig. 1 and Box 2). Employing these manoeuvres provides us with a 'treadmill test' for thought, language and communication processes.

Seven key manoeuvres for eliciting FTD

Free and open-ended discourse

The rationale for open-ended discourse draws from a fundamental principle: reducing external guides for organising thoughts allows internal organisational deficits (i.e. mental disorganisation that constitutes FTD) to surface. As social dialogue imposes structure through topic cues, probes and joint attending, plenty of external support is available for organised discourse. In contrast, minimally directed or open-ended speech (soliloquies) strip away this scaffolding.

Associationist and psychodynamic theories that formed the basis of the 'free association' technique, i.e. saying whatever comes to mind freely or induced by a trigger word, have fallen from theoretical favour. But given the importance of observing aberrant semantic associations (Barrera 2005) and first-person narratives in FTD (Elleuch 2025a), a modified form of this approach continues to be important for our purpose. Features such as derailment and perseveration emerge only when patients generate extended linguistic sequences with minimal external constraint. Phenomena like poverty of speech and increased latency become quantifiable through the amount, pacing and pausing of spontaneous output.

Instead of seeking complete Freudian-style free association, contemporary scales operationalise this principle through open-ended prompts. The Bizarre–Idiosyncratic Thinking (BIT) scale (Harrow 1985) makes this explicit: 'more open-ended procedures better lend themselves to eliciting thought-disordered speech' (Marengo 1986: p. 499). The Schizophrenia Communication Disorder Scale (SCD) (Bazin 2005) focuses on everyday life topics – hobbies, family, television – that should elicit natural, elaborated responses. Some authors have resorted to the topic of dreams (Mota 2014). The Clinical Language Disorder Rating Scale (CLANG) (Chen 1996) recommends neutral topics unrelated to psychopathology for this aspect of the interview.

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TABLE 1 Overview of major formal thought disorder (FTD) rating scales and their elicitation procedures

Scale (Acronym; Year)	Key stimuli and tasks
Procedures to test	
Singer & Wynne's Communication Deviance (CD) (Singer 1965: p. 190)	Viewing and responding to TAT and Rorschach cards; corresponds to everyday situations in which 'two people see a series of different kinds of reality'
Reilly's Loosening of Association and Disordered Speech (LADSP) (Reilly 1975)	Free verbalisation of non-mental health topic (7 min) and mental health topic (7 min) to induce potential stress, with prompts only to encourage flow
Andreasen's Thought, Language and Communication scale (TLC) (Andreasen 1979)	Open interview on neutral and standard clinical topics; two phases: uninterrupted speech, then introduce some interruptions[a]
Holzman & Johnston's Thought Disorder Index (TDI) (Johnston 1979)	Rorschach inkblots; WAIS subtests (Comprehension, Similarities); inquiry into all deviant verbalisation
Harrow's Bizarre–Idiosyncratic Thinking Index (BIT) (Harrow 1985)	Gorham Proverbs Test and WAIS Comprehension subtest with inquiry into odd responses
Caplan's Kiddie Formal Thought Disorder Rating Scale (KFTDS) (Caplan 1989)	Story Game: retelling audio stories and generating original stories from prompts; non-directive prompts during the game (e.g. 'Can you say more?')
Docherty's Communication Deviance Index (CDI) (Docherty 1996)	Open-ended questions on neutral topics (family, religion, politics); no active provocation
Chen's Clinical Language Disorder Rating Scale (CLANG) (Chen 1996)	Combination of spontaneous speech, open questions (e.g. 'Why believe in God?'), cognitive tests and narrative tasks
Liddle's Thought and Language Index (TLI) (Liddle 2002)	Sequential description of eight TAT pictures (1 min each), followed by structured inquiry for clarifications and to follow logic of thought
Hardy-Baylé & Bazin's Schizophrenia Communication Disorder Scale (SCD) (Bazin 2005)	Adversarial interview with specific constrained tasks (e.g. resolve ambiguity after a distractor mathematics task) where clinician deliberately creates conversational challenges
Kircher's Thought and Language Dysfunction Scale (TALD) (Kircher 2014)	50 min exploration, with open-ended start, then semi-structured clinical questions; emotional topics (about delusions) deliberately raised and subjective aspects directly questioned

TAT, Thematic Apperception Test; WAIS, Wechsler Adult Intelligence Scale.
a. Andreasen described a 50 min interview for scoring the TLC, but researchers have applied numerous variations, ranging from a set of 6 questions in a 5–10 min interview (Muralidharan 2018) to using very brief recordings of free speech (~1.5–3 min) (Tang 2023) or snippets from videos of ~1.9 min average length (Krell 2022).

BOX 1 Diagnosing formal thought disorder: key learning points

- Formal thought disorder (FTD) is a collection of observable signs that must be actively elicited through systematic conversational manoeuvres, not passively awaited.
- Seven key elicitation techniques can be derived from validated rating scales: free and open-ended discourse, thought provocation, cognitive loading, affective reactivity, inducing mental state talk (manipulation of perspectives), systematic targeted clarification and assessing subjective dimensions.
- A structured, phased approach to FTD assessment integrates these techniques across a 15–20 min interview: open discourse, structured provocation and social–cognitive–emotional challenge.
- The clarification technique is critical for differentiating occasional slips from genuine thought disorder – individuals without FTD can usually clarify their meaning or repair inconsistencies when prompted.
- Cultural context, linguistic factors and differential diagnoses (e.g. aphasia, intellectual disability, anxiety) must be carefully considered to avoid misidentifying normal variations or other conditions as FTD.

Clinical application

Initiate the interview with 5–7 min of minimally constrained discourse, asking the patient to speak freely and telling them you will not interrupt. A prompt: 'Tell me about your favourite TV show' or 'Thinking back, can you tell me a story about something important that happened to you in your life?'. The key is establishing permissive conditions to initiate the free-flowing thoughts with a first-person perspective.

Thought provocation through stimuli

Open-ended discourse removes external constraints, whereas thought provocation actively introduces interpretive demands. This procedure coincided with the shift from free association to projective techniques in the pre-DSM-III era, as ambiguous stimuli were seen as amplifying subtle cognitive aberrations. By requiring the patient to impose meaning on ambiguity, we can stress-test the integrity of their conceptual organisation.

FTD scales operationalise this strategy through a variety of complex stimuli with varying degrees of ambiguity in visual and auditory modalities. At the most ambiguous end, Rorschach inkblots, used in the Thought Disorder Index (TDI; Johnston 1979) and the test procedures to elicit Communication Deviance (Singer 1965), offer minimal perceptual structure. The Thematic Apperception Test (TAT; Murray 1943), used by the Thought and Language Index (TLI) (Liddle 2002) and CLANG, provides recognisable scenes but leaves narrative connections unstated. Recorded stories (e.g. in the Kiddie Formal Thought Disorder Rating Scale, KFTDS; Caplan 1989) present less ambiguous content but require interpretive commentary.

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FIG 1 Techniques to elicit formal thought disorder. This figure was generated using Google's NotebookLM.

BOX 2 Good practice points in eliciting evidence of formal thought disorder (FTD)

- Allocate at least 15 min for dedicated FTD assessment, beginning with neutral, open-ended topics before progressing to more demanding tasks.
- Systematically request clarification for any unclear, illogical or tangential statements, and verify whether the patient has subjective experiences of disrupted thought flow and dynamics.
- When working with interpreters, brief them on the assessment goals and ensure they can convey speech structure and coherence, not just content.
- Balance assessment of observable FTD signs with direct inquiry about the patient's subjective experience of their thinking processes.
- With the patient's consent, consider recording verbatim (preferably via audio recording) portions of clinical interviews for more detailed analysis rather than simply noting 'disorganised speech – present or absent'.

Simple verbal provocation offers a more practical clinical approach. Abstract questions – 'Why do you think some people believe in God?' (CLANG) – demand sustained, organised argument. Proverb interpretation (CLANG, BIT) and comprehension items from the Wechsler Adult Intelligence Scale (Wechsler 2008) used by the TDI and BIT ('Why does land in the city cost more than land in the country?') assess the ability to extract and articulate abstract meaning via monologues of extended utterances.

These tasks share a common feature: they require the patient to generate and sustain a coherent response to an interpretive challenge induced at abstract or metaphorical levels on neutral topics that a casual open-ended conversation might conceal. Although less abstract topics, such as 'What would someone have to do if they wanted to smoke a cigarette/wash their hair/do their laundry?' (Just 2023) or 'Tell me the story of Cinderella' (Fradkin 2024), can also serve as a prompt, abstract topics perform better in identifying features of FTD, without the need to wait for a full story to unfold.

Clinical application

Deploy prompts requiring extended interpretive responses in standard mental state examination tests: 'What does it mean to say too many cooks spoil the broth?'. Follow with non-directive encouragement if the verbal output is insufficient, for example 'Can you say more?'. Include complex visual stimuli (preferably featuring human figures as in the TAT; see 'Inducing mental state talk' below for the rationale) to provide interpretive challenge.

Cognitive loading

Executive dysfunction figures prominently in theoretical models of FTD, with cognitive disorganisation or dyscontrol representing a major factor across multiple analyses (Roche 2015; Zamperoni 2024b). Yet surprisingly few scales explicitly tax executive resources during assessment.

The SCD takes the most direct approach, embedding deliberate semantic ambiguity into prompts. Polysemic words such as tie, pumps and rags appear in contexts that activate multiple meanings, forcing executive systems to maintain appropriate semantic selection while suppressing competing interpretations. This dual-task demand can unmask subtle FTD. Of note, ambiguity can also increase the likelihood of expressing delusional ideas (for examples, see the Discussing Abstract Ideas in Schizophrenia Corpus (DAIS-C; Delgaram-Nejad 2023); this has been the basis of Rorschach inkblots and other projective tests. Several models argue that delusions are formed to explain an experienced ambiguity (Denecke 2024).

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An alternative approach which introduces memory load was originally used by Bleuler (the story of a donkey that soaked its cotton load from Aesop's fables (Bleuler 1950)); this is also utilised by contemporary scales like the CLANG. Story recall taxes memory, executive control and narrative organisation simultaneously. This differs fundamentally from using stories as thought-provoking stimuli (as in the KFTDS), as the cognitive demand of recall creates the stress test, likely taxing the processes required for coherent retelling.

Clinical application

Ask the patient to read an 8–10 sentence short story and retell it in their own words. The resulting discourse reveals how cognitive demands tax organisation of thoughts.

Affective reactivity and emotional topics

Some people with psychosis show more pronounced symptoms when negative affect is aroused. This thought–affect interface has been observed for features of FTD (Docherty 1994; Cohen 2004). Some scales formalise this observation by deliberately introducing emotional arousal as a probe: for example the Thought and Language Disorder (TALD) scale (Kircher 2014) states 'Since some phenomena occur solely under situational stress (delusions, hallucinations, emotional life events), emotional topics should be raised'. This procedure operates under the assumption that if capacity to organise thoughts is marginal, emotional arousal may precipitate decompensation into manifest FTD. For some, describing delusional or hallucinatory content may be the only context where FTD becomes manifest.

Of note, many healthy individuals show transient speech disorganisation when intensely emotional – a phenomenon that forms the basis for Main's Adult Attachment Interview to identify disorganised attachment (George 1985). The SCD acknowledges this caveat and takes the approach of advocating 'shielded' assessment that avoids discussion of symptoms entirely. This methodological choice also addresses another concern – that of 'symptom leakage' or contamination, for example awareness of a patient's bizarre delusions or hallucinations may bias an observer to rate speech as more illogical or loose than it actually is (Palaniyappan 2022). The ideal solution – although difficult in clinical practice – involves separate assessment contexts: one shielded from symptom content (early part), another deliberately engaging emotional reactivity (later part). Comparing discourse across contexts provides the most informative picture.

Clinical application

After establishing baseline patterns through neutral discourse (the first three manoeuvres above), gradually introduce personally relevant emotional topics, such as health-related topics (symptoms or treatment). Monitor for structural deterioration: Does logical sequencing fragment? Do referential connections become unclear? Does coherence collapse under emotional load and then recover?

Inducing mental state talk

A growing body of literature on social cognition and FTD indicates that issues with theory of mind (i.e. perspective-taking) may explain some of the features of FTD (Minor 2015; Achim 2022; Hardy-Baylé 2003). The closest approximation to testing this aspect appears in the SCD's assessment of perspective-taking: 'In your opinion, what does your father/mother/friend/doctor think about your problems?'. This requires modelling others' mental states – a social cognitive demand revealed in 'mental state talk' (Kim 2021)' (e.g. 'She knows that he is going to leave her'). Picture description tasks featuring human figures also involve implicit social demand modulation. Describing what characters are doing, thinking or feeling requires theory of mind operations that engage social cognition alongside language organisation. Furthermore, the need to generate syntactically more complex clauses (e.g. when describing who did what to whom) in stories also increases the likelihood of grammatical errors associated with FTD (Elleuch 2025b). The integration of these demands can unmask deficits not apparent in non-social narratives.

Clinical application

Impose perspective-taking demands: 'If I asked your colleague/best friend about you, what would they say?'. This requires adopting another's perspective while maintaining narrative coherence. Use of TAT pictures with human characters or cartoon storyboards (Achim 2022; Alonso-Sánchez 2022; Cho 2026) may also enforce perspective-taking and mental state talk.

Targeted clarification

Of all the techniques derived from rating scales, seeking targeted clarification is one the most important for clinical judgement. When explicitly requesting clarification for an unclear or illogical statement, the patient's response helps us to differentiate accidental slips or drifts (successfully clarified) from more pervasive thought disorder (further confabulation or tangentiality). This should be practised at all phases of the interview.

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BOX 3 Interview questions for assessing subjective aspects of formal thought disorder

1. **Initiative**: Is thinking too much of an effort for you these days? Do you feel that you have the mental energy you used to have?
2. **Slowing**: Does your thinking feel slowed down, as if it is a heavy drag?
3. **Blocking/fading**: Does your train of thought ever just suddenly stop mid-sentence, like hitting a wall? Do your thoughts sometimes just slowly fade away?
4. **Poverty**: Have you noticed fewer new ideas or thoughts coming to you than before?
5. **Pressure**: Have you experienced too many thoughts coming at once, like you can't control them?
6. **Interference**: Do you find it hard to stay focused because other thoughts keep jumping in, or things around you keep pulling your attention away?
7. **Rumination**: Are there certain thoughts or worries that you can't seem to stop thinking about, even when you try to move on to something else?
8. **Reception**: When people are talking to you, can you follow along and understand them as easily as before? Do you find some words or sentences confusing?
9. **Expression**: How about expressing yourself – do you feel that you can say what you mean as clearly as you used to? Do you find some words or phrases hard to come by?

The questions should be organised in a natural conversational flow, starting with energy and speed and moving through specific domains of thinking, attention and communication. These subjective items are modified from Kircher's Thought and Language Disorder Scale (Kircher 2014).

Many factors can produce unclear speech – anxiety, unfamiliarity with medical settings, limited education or simply the universal difficulty of converting complex thoughts into linear language. Seeking clarification involves asking patients to access and re-present the thought they just expressed. If the thought is intact but expression was poor, clarification succeeds. If the thought is disorganised, clarification may reveal further drift. Successful clarification after prompts indicates effective conversational scaffolding; the ability to repair unclear speech with clinician support may suggest milder FTD compared with cases where scaffolding fails to improve coherence.

Several scales incorporate this principle. The TDI instructs raters to 'inquire into all deviant verbalizations, percepts, slips, and reasoning' (Johnston 1979). The BIT requires inquiry into 'all unclear or odd words or responses' (Harrow 1985). The TLI structures this as systematic follow-up after picture descriptions (Liddle 2002). The SCD goes a step further and marks 'the inability to clarify a speech corpus' as a marker of deficit in the integration of contextual information (Bazin 2005). The consistency across scales reflects recognition that clarification requests are not optional add-ons but essential diagnostic manoeuvres.

Clinical application

When an unclear or illogical statement occurs, resist the urge to move on. Instead ask: 'I want to make sure I understand – what did you mean by that?' or 'Can you explain that in a different way?'. Successful clarification weakens the case for FTD. Progressive confusion, tangential drift or bizarre elaboration strengthen it.

Assessing subjective dimensions

Formal thought disorder encompasses both observable signs and subjective experiences. Observable signs are the external manifestations of disrupted thought organisation, including disturbances in the structure of speech (e.g. derailment, tangentiality, incoherence) and in its dynamics (e.g. pressure of thought, flight of ideas); these are what clinicians directly observe, and what FTD rating scales such as the Thought, Language and Communication scale (TLC; Andreasen 1979) and TALD (Kircher 2014) are designed to capture. Subjective experiences are patients' first-person awareness of their own thinking processes, such as thoughts that feel blocked, racing or out of control (Kircher 2014). These two dimensions do not always correlate perfectly (Kircher 2014): many patients with profound objective disorganisation report minimal subjective awareness. Direct questions about patients' internal experiences therefore complement, rather than substitute for, observational techniques (Box 3). Notably, subjective features of dysfunctional thought and language organisation may phenomenologically overlap with the cognitive/psychomotor slowing of a depressive episode (Palaniyappan 2025), with common elicitation procedures as we describe here. A list of these, adapted from the TALD (Kircher 2014), is provided in Box 3 for clinical application.

An integrated clinical approach

A sensitive clinical assessment of formal thought disorder needs to follow a structured, phased approach, and we suggest the following (Fig. 2).

Phase 1: Open discourse (5 min) – start with minimal restrictions to establish baseline patterns. Ask open-ended questions about neutral topics (hobbies, daily life, interests) to encourage natural speech without structure. This phase shows spontaneous organisation, speech quantity and pacing, and baseline coherence before introducing more demands.

Phase 2: Structured provocation (5 min) – introduce interpretive and narrative demands for more goal-directed thoughts. Story generation,

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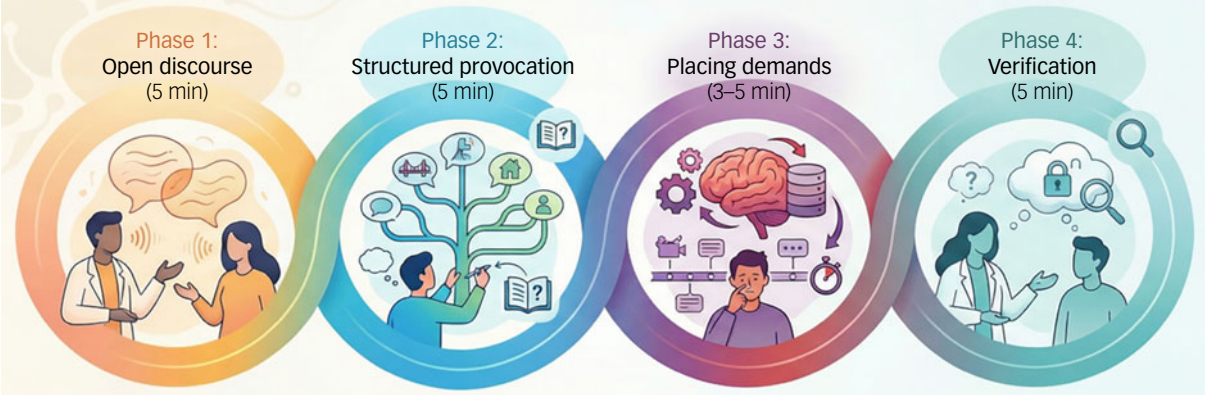


FIG 2 An integrated clinical approach to eliciting formal thought disorder. This figure was generated using Google's NotebookLM.

proverb interpretation, abstract questions and complex picture descriptions all need organising around external prompts. This phase shows how organisational processes work when needed for specific communication goals.

Phase 3: Placing demands (3–5 min) – deliberately stress neural systems supporting linguistic cognition. Story recall increases memory load. Emotional content engages the thought–affect interface. Inducing mental state talk via perspective-taking taxes social cognition. Not all patients need this phase (e.g. someone with pressured speech in a manic episode does not) – but when earlier phases yield ambiguous results, stress-testing can be crucial.

Phase 4: Verification of subjective phenomena (5 min) – finally, enquire about subjective aspects of thought disorder. Throughout all phases of the interview, systematically seek clarification for any deviations, unclear statements or illogical connections noted.

Practical considerations and limitations

It is important to note that not all seven elicitation manoeuvres are equally specific for diagnosing FTD. Findings from affective provocation should be interpreted cautiously. Transient disorganisation can occur in healthy individuals under anxiety or strong emotion, in patients with limited formal education or familiarity with clinical settings and in those speaking a second language. Spontaneous disorganisation (phases 1 and 2) that worsens with cognitive loading or perspective-taking demands (phase 3), and disorganisation that cannot be repaired through targeted clarification (phase 4), provide stronger evidence for genuine FTD. Clinicians should seek convergent evidence across multiple manoeuvres and prioritise recurring instances over isolated findings from the various phases of the interview. Broader controversies and ongoing debates regarding interpretation and diagnostic thresholds are summarised in Box 4.

BOX 4 Controversial issues and ongoing debates regarding formal thought disorder (FTD)

- The theoretical basis of FTD remains debated: is it primarily a disorder of associations, executive control, semantic memory or communication pragmatics?
- The specificity of FTD to psychotic disorders is questioned, as similar phenomena occur in mania, dementia and even normal individuals under stress or fatigue.
- Whether FTD should be understood as a categorical sign (present/absent) or a dimensional phenomenon existing on a continuum remains unresolved.
- The role of the listener in identifying speech as 'disordered' is increasingly recognised, raising questions about the objectivity of FTD assessment.
- Emerging computational linguistics and natural language processing approaches may provide objective, automated FTD assessment, but their clinical utility and ecological validity remain to be established.
- The relationship between observable FTD and subjective experiences of thought disorder (racing thoughts, thought blocking) is complex and not fully understood.

Time constraints

Starting with free, open-ended discourse, followed by visual and abstract prompts to induce thoughts, increasing processing load via recall demands or emotional content, and finally inducing social complexity to elicit mental state talk provides an optimal set of approaches to elicit FTD in a clinical setting (Fig. 1). Although there are several other approaches (e.g. showing videos of emotional

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stimuli and then asking standardised questions (Huang 2026), clinical reality often complicates idealised assessment procedures. Individuals with negative symptoms may lack the motivation for extended discourse. Guarded individuals may resist procedures perceived as testing their sanity. Children may find formal assessment threatening. Assessing FTD in a gamified manner with picture descriptions, story-telling and collaborative exploration as laid out above ('Inducing mental state talk'), or with playful word associations (that help assess semantic priming) shifts the focus from evaluation to shared activity with the clinician. Such gamification can reduce the Hawthorne effect on verbal behaviour and ensure engagement for the 15–20 min of discourse needed for a reliable assessment (Caplan 1989).

FTD may manifest in written material (letters, texts, emails) and does not always co-occur with spoken FTD. Clinicians should review written samples when available, although care is needed when interpreting FTD in text messaging, because of format-specific conventions.

Significant others

A growing body of evidence from individuals with lived experience of FTD highlights a crucial yet often overlooked dimension: the listener's role in co-constructing what clinicians call disordered speech (Hodgins 2022; also see Galletly 2011). Communication is inherently dyadic: what one person finds incoherent may be understood by another. This insight challenges assumptions about the objectivity of FTD assessment and highlights the value of underutilised assessment strategies, such as systematic observation of conversations with others (third parties). But such strategies face practical constraints in a clinical setting. Enquiring about conversational difficulties encountered by people (significant others) who spend considerable time with the patient will be a valuable source of information.

Cultural and linguistic considerations

Assessing FTD across different cultural and linguistic contexts requires additional care. What appears to be loose associations or circumstantiality may reflect cultural narrative styles or translation difficulties. Some languages have features that complicate assessment. For instance, Tamil has no formal definite (the) or indefinite (a/an) articles, but relies on context and demonstratives. A native Tamil speaker may miss such nuances in English, and this needs to be accommodated in assessments. Another example is Cantonese, where the same phonetic sound can map onto multiple words; these frequent homophones and puns should not be considered pathological. Whenever possible, involve clinicians familiar with the patient's cultural background and primary language. When using interpreters, ensure they understand the assessment goals and can convey not just content, but also the structure and coherence of the patient's speech.

Documentation

Detailed documentation should specify the discourse context in which FTD was observed or absent (neutral concrete, neutral abstract, emotional, psychosis-related topics). Record verbatim examples whenever possible (e.g. using embedded dictation systems), including the elicitation method used (e.g. picture description, proverb interpretation) and whether clarification attempts were successful. This provides a richer source for longitudinal comparison and assessment of treatment effects and allows other clinicians to understand the basis for your assessment.

Implications for training

The impression of decline in FTD assessment skills among psychiatrists (Tucker 1998; Sass 2017) reflects, in part, inadequacies in current training (Zamperoni 2024a). Traditional teaching often portrays FTD assessment as a passive observation rather than an active elicitation skill. Medical students and trainees can be explicitly taught the manoeuvres described here, with practice and feedback opportunities. Reviewing clinical interview recordings and discussing them provides valuable learning. Transcribing interview portions helps analyse speech patterns and sharpens observational skills. Workplace-based assessments could evaluate trainees' ability to elicit FTD using these techniques. Exposure to validated rating scales, even if not used clinically, provides frameworks for understanding FTD phenomenology. The publicly available DAIS-C (Delgaram-Nejad 2023) schizophrenia speech corpus, including participants with advanced FTD, and the interviewer being an expert with lived experience of psychosis (Delgaram-Nejad 2024, 2025) can be a useful training aid for clinicians reviewing recent interactions. FTD itself is not a single natural kind of psychiatric object; it is a clinical entity constituted for practical purposes (Palaniyappan 2026). Sharpening our training to reliably elicit all its constituents is key to its utility in the psychiatric clinic.

Conclusion

Babette's 'double polytechnic irretrievable', Nijinsky's stream of disconnected statements and the

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more recent example from participant 26AR16 from DAIS-C all represent the dramatic end of the FTD spectrum. But FTD exists on a continuum, from subtle loosening detectable only through systematic probing to profound disorganisation that overwhelms routine communication. Mastering the clinical skills of stress-testing, clarification and verification of individuals' subjective experience of FTD will improve how we measure, document and understand thought disorder as it unfolds in front of us in our clinics.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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Author contributions

L.P. conceived the article, wrote the first draft, provided overall supervision and critically revised the manuscript. O.D.-N. and E.Y.H.C. contributed to the conceptual development of the article and critically revised the manuscript. All authors approved the final version and agree to be accountable for all aspects of the work.

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MCQ answers
1 b 2 c 3 b 4 d 5 c

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MCQs

Select the single best option for each question stem

1 Which of the following best describes the conceptual basis for assessing formal thought disorder (FTD)?

a FTD is a subjective symptom that patients will spontaneously report if present
b FTD is a collection of observable signs that requires active elicitation
c FTD can only be reliably assessed using standardised rating scales
d FTD assessment should focus exclusively on the patient's written communication
e FTD is best evaluated through passive observation during routine clinical conversation.

2 What is the primary purpose of requesting clarification when a patient makes an unclear or illogical statement?

a To demonstrate to the patient that their communication is problematic
b To fill time during the interview when uncertain how to proceed
c To differentiate between poor expression and genuine thought disorder
d To test the patient's frustration tolerance and emotion regulation
e To allow the interviewer time to formulate their diagnostic impression.

3 Which of the following is an appropriate application of cognitive loading in FTD assessment?

a Asking rapid-fire questions without allowing time for responses
b Reading a brief story and asking the patient to retell it in their own words
c Conducting the interview in a noisy environment with multiple distractions
d Requiring the patient to write their responses rather than speaking to them
e Repeatedly interrupting the patient mid-sentence to test their frustration tolerance.

4 When assessing FTD across different cultural and linguistic contexts, which approach is most appropriate?

a Applying standardised Western assessment criteria uniformly across all cultural groups
b Avoiding assessing FTD in non-native speakers, as it cannot be done reliably
c Focusing only on non-verbal behaviours when working with interpreters
d Ensuring interpreters can convey speech structure, not just content
e Relying exclusively on self-report measures, to avoid cultural bias.

5 The recommended phased approach to FTD assessment typically requires what minimum duration?

a 3–5 min
b 7–10 min
c 15–20 min
d 30–45 min
e 60 min or more.

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