

# DSM-V and the diagnostic role of psychotic delusions

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## Dear Editor,

Delusions are the hallmark of psychotic disorders<sup>1</sup>. For many years, they guided the diagnostic of schizophrenia after their inclusion into the first-rank set of symptoms of schizophrenia<sup>2</sup>. However, the special treatment given to Schneider's symptoms in the DSM and ICD systems has been highly questioned over the last years<sup>3,4</sup>. They have been shown not to be exclusive to schizophrenia, and their reliability in distinguishing bizarre from non-bizarre delusions has been found poor<sup>5,6</sup>. Schneider's symptoms have been identified in patients with neurotic disorders<sup>7</sup>, manic-depressive disorders<sup>8</sup>, and mood disorders. Peralta and Cuesta<sup>9</sup> concluded that Schneider's symptoms were highly prevalent in most forms of psychotic disorders. In light of this situation, the DSM-V<sup>10</sup> has eliminated the special treatment of Schneiderian symptoms, and with it, the special treatment of delusions as a key diagnostic input. Apart from the elimination of the subtypes of schizophrenia, the DSM-V proposes: 'the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing)'<sup>11</sup>. This decision has two main consequences within a diagnostic context. First, it means that delusions will be treated like any other symptom in terms of diagnostic relevance<sup>4</sup>. Second, it makes really obscure the exact diagnostic role of delusions within the DSM system, as it is not clear what they would be a symptom of.

There are good reasons to think that, at least, the elimination of the special treatment of delusions is not the best way to deal with the lack of discriminability of Schneiderian symptoms. Delusions involve a number of experiential<sup>12</sup>, affective<sup>13,14</sup>, and cognitive<sup>12,15</sup> alterations that do not seem to be present in such high rates in other symptoms. In addition, the adoption of psychotic delusions occurs within a context in which the whole experience of the subject and the world is rarefied<sup>16,17</sup>. Although delusions are not exclusive to schizophrenia; they still are a fundamental sign of profound breakdowns within the patients' mind, breakdowns that might distinguish them from other relevant symptoms. In consequence, I think delusions should not be treated equally to other symptoms that do not involve all the abnormalities they do. Here it is important to note that not even all delusions should be treated equally. Delusions vary considerably in content and phenomenological features. Some of them are bizarre and some of them are accidentally possible<sup>12,15</sup>. Some delusions involve the presence of weird ideas about the world ('I've been followed; people are constantly looking at me'), while others involve the distortion of ego-boundaries ('thoughts are inserted into my mind' – Thought Insertion), and even the disintegration of one's own feeling of being alive ('I'm dead' – Cotard Delusion). All these differences in content and phenomenological features are determined by different aetiological routes. This is not something that should be ignored when weighing the diagnostic role of delusions. Differences in the type of abnormalities and doxastic contents they involve make delusions worthy of a more specific treatment within clinical diagnosis. The open problem challenge is to define such a treatment in a conceptually clear and empirically well-informed

way. It follows that the clarification and serious consideration of the aetiological, content-related, and phenomenological differences between delusions might help to clarify their diagnostic role. Let's hope the next version of the DSM system incorporates these issues in order to offer a better and clearer view on the particular role of delusions in clinical diagnosis.

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## References

1. Jaspers K. General Psychopathology. 7<sup>th</sup> edition. Manchester: Manchester University Press; 1963.
2. Schneider K. Clinical Psychopathology (trans. By M.W. Hamilton). New York: Grune & Stratton; 1959.
3. Flaum M, Andreasen NC, Widiger TA. Schizophrenia and other psychotic disorders in DSM-IV: final overview. In: Widiger TA, Frances AJ, Pincus HA, et al. (Eds.), DSM-IV Sourcebook. Vol. 4. Washington D.C.: American Psychiatric Association, 1998.
4. Tandon R, Gaebel W, Barch DM, Bustillo J, Gur RE, Heckers S, et al. Definition and description of schizophrenia in the DSM-5. Schizophr Res. 2013;150(1):3-10.
5. Mullen R. Delusions: the continuum versus category debate. Aust N Z J Psychiatry. 2003;37(5):505-11.
6. Bell V, Halligan PW, Ellis HD. A cognitive neuroscience of belief. In: Halligan PW, Aylward M (eds.). The power of belief. Oxford: Oxford University Press; 2006.
7. Carpenter WT, Strauss JS, Mukh S. Are there pathognomonic symptoms in schizophrenia? An empiric investigation of Schneider's first-rank symptoms. Arch Gen Psychiatry. 1973;28(6):847-52.
8. Wing J, Nixon J. Discriminating symptoms in schizophrenia. A report from the international pilot study of schizophrenia. Arch Gen Psychiatry. 1975;32(7):853-9.
9. Peralta V, Cuesta MJ. Diagnostic significance of Schneider's first-rank symptoms in schizophrenia. Comparative study between schizophrenic and non-schizophrenic psychotic disorders. Br J Psychiatry. 1999;174:243-8.
10. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Arlington, VA: American Psychiatric Publishing; 2013.
11. American Psychological Association. Report: Highlights of Changes from DSM-IV-TR to DSM-5. USA: APA; 2013.
12. Coltheart M, Langdon R, McKay R. Delusional belief. Annu Rev Psychol. 2011;62:271-98.
13. Marwaha S1, Broome MR, Bebbington PE, Kuipers E, Freeman D. Mood instability and psychosis: analyses of British national survey data. Schizophr Bull. 2014;40(2):269-77.

14. Ellis HD, Young AW, Quayle AH, De Pauw KW. Reduced autonomic responses to faces in Capgras delusion. *Proc Biol Sci.* 1997;264(1384):1085-92.
15. Coltheart M. Delusions. In: Scott R, Kosslyn S (eds.). *Emerging Trends in the Social and Behavioural Sciences*. Hoboken: John Wiley & Sons; 2015.
16. Conrad K. *Die beginnende Schizophrenie*. Stuttgart, Germany: Thieme Verlag; 1958.
17. Fuchs T. Delusional mood and delusional perception – a phenomenological analysis. *Psychopathology.* 2005;38(3):133-9.