

DSM-V and the diagnostic role of psychotic delusions

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Dear Editor,

Delusions are the hallmark of psychotic disorders¹. For many years, they guided the diagnostic of schizophrenia after their inclusion into the first-rank set of symptoms of schizophrenia². However, the special treatment given to Schneider's symptoms in the DSM and ICD systems has been highly questioned over the last years^{3,4}. They have been shown not to be exclusive to schizophrenia, and their reliability in distinguishing bizarre from non-bizarre delusions has been found poor^{5,6}. Schneider's symptoms have been identified in patients with neurotic disorders⁷, manic-depressive disorders⁸, and mood disorders. Peralta and Cuesta⁹ concluded that Schneider's symptoms were highly prevalent in most forms of psychotic disorders. In light of this situation, the DSM-V¹⁰ 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)¹¹. 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 relevance⁴. 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 experiential¹², affective^{13,14}, and cognitive^{12,15} 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^{16,17}. 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^{12,15}. 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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