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Letter to the Editor

Delusional disorders: boundaries of a concept

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Clinical experience certainly justifies the attempts of modern classifications to reserve a separate place for delusional syndromes not attributable to schizophrenia, mood disorders or somatically caused brain dysfunctions. The authors rightly stress, however, that the definition of the bounderies of this category and its subdivision necessitate some improvements, especially concerning the delimitation from schizophrenia. Their proposals require, nevertheless, some critical remarks.

The authors ascribe the widespread abrogation in the past of nonschizophrenic delusional disorders exclusively to the rise of Bleuler's conceptualization of schizophrenia. This contention must be cut down since the schools of Kraepelin and Schneider also share a considerable role in this evolution: Mayer [7] and Kolle [5] recommended the inclusion of Kraepelin's paraphrenias and paranoia in schizophrenia on the basis of catamnestic and family studies, although their data, when critically examined, do not appear fully convincing. Bleuler's school admitted that "accessory symptoms" alone may allow the attribution to schizophrenia under certain, not clearly specified, conditions. Schneider, however, adopted the same standpoint in regard to this "second rank symptoms". Furthermore, Schneider as well as Bleuler expanded the boundaries of schizophrenia through the application of Jaspers' "hierarchical principle" which stipulates that, in the case of a combination of schizophrenic and affective symptoms, the former determine the diagnosis.

The *Diagnostic and Statistic Manual of Mental Disorders* (DSM-IV) criteria for schizophrenia disregard Jasper's principle and combine Kraepelinian, Bleulerian and Schneiderian viewpoints, but ascribe a preeminent diagnostic weight to bizarre delusions. The authors contradict this decision and stress that "bizareness" must not always be based on abnormal underlying experiences but can also appear on the grounds of an "imaginative exuberance". In this perspective, they suggest conceiving an "imaginative subtype" of delusional disorder and recommend this strategy not only to avoid unjustified attributions to schizophrenia but also because they suppose that a subdivision of delusion disorder based on mechanisms of delusion formation is better suited for pathogenetic research than categories founded on content.

The DSM-IV indeed contains an important inaccuracy in its classification of disturbances exhibiting delusions. The criteria for delusional disorder enclose only nonbizarre delusions and require a not markedly impaired functioning. Criterion B for schizophrenia demands, however, a social/occupational dysfunction for a significant portion of time. Where should, then, cases presenting bizarre delusions but not meeting this criterion be placed? This problem could be resolved if the requisite to include only nonbizarre delusions is removed from the criterion A for delusional disorder and if the reference to bizarre delusions is omitted from the note added to criterion A for schizophrenia. The authors' attachment to Schneider's standpoint could then be satisfied if this note would stipulate that the presence of a first rank symptom accomplishes the criterion A for schizophrenia. These modifications could avoid the establishment of a particular set of criteria for confabulatory delusional states since the juxtaposition of fantastic beliefs and relative good social functioning, frequently observed in such cases, could be included in the description of this subtype, and the request that criterion A for schizophrenia has never been met would already be contained in the criteria for the entire group of delusional disorder.

The authors' conceptualization of the imaginative subtype of delusional disorder must not only be called into question because of doubts about the heuristic value of first rank symptoms [1, 2, 6] but also in view of the difficulty to assess "bizarreness" and "imaginative exuberance" reliably [4]. In this perspective, the establishment of this category should be deterred until neuropsychological examinations – eg, those mentioned in the article – have been sufficiently developped in order to fully comprehend these phenomena. If this demand is satisfied, research on the imaginative subtype of delusional disorder may help to clarify whether the assumption of Dupré and Logre [3] that confabulatory delusional states derive from a distinct personality disorder is justified, or whether the inclination to fantasy is only an unspecific pathoplastic factor which would lead subjects endowed with this proneness to develop imaginative inferences, whereas rational individuals would, under the same causal conditions, produce logical convictions.

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