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Delusional disorders: boundaries of a concept

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Summary – In 1987, DSM-III introduced the term delusional disorder. In so doing they gave new life to a concept that had predated but was delineated in its modern form by Kraepelin and developed most notably in France in the second and third decades of this century. While the current concept of delusional disorder is defined in a manner that distinguishes it from schizophrenia, a consideration of the evolution of thinking about delusional syndromes in France suggests that current distinctions are based on descriptive convenience rather than any understanding of the mechanisms that might produce phenotypic variations. If the purpose of accurate descriptions is to assist research, this state of affairs would seem unsatisfactory. © 1998 Elsevier, Paris.

delusional disorders / paranoia / misinterpretation / confabulation / bizarre delusions

INTRODUCTION

In 1987, the American Psychiatric Association included the syndrome of delusional disorder (DD) in a revised third edition of their Diagnostic and Statistics Manual (DSM III-R) [1]. The inclusion criteria for and subtypes of this disorder closely resemble older ideas of paranoia, but the dropping of the terms paranoid and psychosis suggest an intention to demarcate the disorder more clearly from paranoid schizophrenia. There are historical precedents for a clear demarcation. There are also historical grounds for arguing that current operational criteria for DD are too restrictive. We will briefly outline aspects of the evolution of thinking on the family of delusional disorders, point out ambiguities in current criteria and propose criteria for delusional disorders other than those at present found in DSM-IV and ICD-10. The current paper does not pretend to be comprehensive in its historical coverage, but we hope it will offer sufficient material to cause those familiar only with the recent literature to pause for thought.

EVOLUTION OF A CONCEPT

Esquirol [13] first distinguished delusional disorders from the main body of insanity under the rubric of monomania. These patients, he argued, were not wholly insane because they were in touch with reality on most things – they were logical, they had accurate memories and a lively curiosity, and where their ideas were odd or eccentric they supported them by an appeal to evidence. There was no thought disorder or dementia to borrow concepts that came later. Before 1850, the term paranoia had connoted a state of complete insanity [24]. In categorising some delusional monomanias as partial insanities, Esquirol began the process that transformed the meaning of paranoia into the more limited disorder of behaviour and the clearly defined syndrome that we now take it to mean. Kahlbaum contributed to the process in 1863 by suggesting that the term paranoia should be used to specifically distinguish one of the partial insanities, namely that composed entirely of a coherent encapsulated delusional system [3].

In the 1860s, the concept of monomania fell apart, partially because it confused symptoms with disorders. Does one set of symptoms, such as an obsessional mania, indicate that the affected person would continue to suffer from that same monomania, or could obsessions transmute into delusions in due course? [2, 15]. From 1860, the example of neurosyphilis, where one pathophysiological lesion was seen to stabilise a succession of symptoms, contributed to the evolution of the monomanias into disease entities of which Kraepelin's manic-depressive insanity and

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dementia praecox were the most notable. However, while Kraepelin described two mental diseases, in the sense of entities that were probably stabilised by biological disturbances, he argued that there were three psychoses – manic-depressive psychosis, dementia praecox and paranoia [19]. He termed paranoia a psychosis on the basis that one of the defining features of a psychosis in the German literature at the time was the presence of delusions. But where others diagnosed paranoia on the basis of the presence of delusions – so that up to 70% of admissions had the diagnosis – and both acute and chronic paranoias were recognised, Kraepelin argued that paranoia was a much less common but distinct illness that could only be diagnosed where there was a "chronic unshakeable system of delusions clearly recognisable from the beginning [which] gradually develops, while presence of mind and the order of the train of thoughts are completely conserved" [22]. He proposed that it hinged on constitutional vulnerabilities of the personality [20], in which "the delusions are largely confined to morbid interpretations of real events, are woven together into a coherent whole, gradually becoming extended to include events even of recent date and contradictions and objections are apprehended and explained".

In France, the concept of paranoia was developed further. A clear demarcation was drawn between the chronic delusional disorders and dementia praecox, in that while both were chronic, subjects with delusional disorders did not "dement" [30]. From within the body of chronic delusional disorders, Serieux and Capgras in 1909 carved out a misinterpretative delusional disorder (délire d'interprétation), which corresponded closely to Kraepelin's paranoia. This was a disorder of "false reasoning originating in the misinterpretation of a correctly perceived fact, to which logical but erroneous inferences lend misconstrued subjective meaning consonant with personal inclinations and preoccupations" [33]. They argued that emotion can fix an idea and remove it from the realm of rational analysis, leading to persecutory, grandiose, hypochondriacal, erotomanic, jealous, or mystical delusions (essentially the same subtypes as are found in DSM-IV's DD).

Capgras postulated that what was involved in a misinterpretative delusional disorder was a hypertrophy of attention, that could bring particular issues to the fore to the exclusion of others, with a consequent loss of contextualisation. This mechanism cut across delusional contents and in its absence delusions per se would not trigger the diagnosis, thus avoiding the criticism levelled at Esquirol that prominent symptoms were being mistaken for distinct disorders. An alternative mechanism for essentially the same condition was put forward by Kretschmer in 1919 [23], who proposed that the development of these psychoses was predicated on the existence of a sensitive or vulnerable point in the constitution of the affected person.

Other delusional syndromes were subsequently described based on this template. In 1910 Ballet argued for the existence of a delusional disorder secondary to prominent hallucinations, and in 1911 Dupre and Logre described a confabulatory or imaginative delusional disorder. Capgras went on in 1923 to describe the first of what are now known as the delusional misidentification syndromes (DMS) [5]. The Capgras syndrome was initially seen as a misinterpretative delusional disorder stemming from the marked suspiciousness and extreme concern with minor details to which the paranoiac personality is typically prone. In this case an "agnosia" through over-attention results in an inaccurate interpretation of physiognomic details or too closely observed clothing for instance. Thereafter the Fregoli syndrome [8] and the syndrome of intermetamorphosis were described [9].

Far from being related to dementia praecox, there was initially a tradition that linked these delusional syndromes to the obsessive-compulsive and hypochondriacal disorders [15]. All of these states, it was argued, involved a hypertrophy of attention leading to checking behaviours, whether monitoring physical symptomatology or checking through underwear, for instance, with an inability to be reassured. In the case of all three disorders, there is frequently a great deal of secrecy, such that it may be many years before the full extent of the pathology is discovered [25, 33].

Developments in the psychopathology of the delusional disorders, however, were abrogated by the rise of the schizophrenia concept. The Bleulerian concept of schizophrenia, as is now clear, was a very loose one capable of almost infinite expansion. From the 1920s through to the 1960s, it progressively swallowed disorders, even ones as distinctive as manic-depressive disorder. Against this background, it was all but inevitable that disorders characterised by the presence of delusions would be diagnosed as schizophrenic [36, 37].

CURRENT AMBIGUITIES

The dominance of Bleuler's schizophrenia was brought to an end by DSM-III, which reinstated in its place a neo-Kraepelinian dementing disorder. Serieux and Capgras' syndrome was resurrected by DSM III-R in 1987, complete with jealous, somatic, erotomanic, persecutory and grandiose subtypes. Genetic studies suggest differences between this delusional disorder and schizophrenia [14]. The authors have recently published studies on attentional, attributional and reasoning processes in a series of patients with DD,

where the mean age of onset of the disorder and the lack of an obvious "dementing process", negative symptoms or schizotypal features was inconsistent with a diagnosis of schizophrenia [16, 17, 18, 34]. Using an emotional Stroop Test we found a "hypertrophy" of attention biased toward emotionally salient material, a finding which was potentially consistent with either the mechanism proposed by Capgras or that offered by Kretschmer. Scores on the Beck Depression Symptom Inventory and measures of attributional style furthermore indicated that the subjects were not depressed. These results offer further support for the validity of distinguishing a "psychotic" group or groups from the manic-depressive and schizophrenic groups.

Since the publication of DSM-IIIR, there has been a reawakening of interest in the delusional disorders and in the mechanisms that might lead to this disorder. The monosymptomatic hypochondriacal delusions, for instance, have attracted attention [27, 28], as have disorders such as delusional infestation [26, 31], body dysmorphic disorder [29] and the misidentification syndromes [6, 7, 10, 12]. Thus it would seem that the validity of DD rigorously defined has regained a measure of acceptance. The extent of the category of delusional disorders has also become the subject of some debate as it did in the early years of this century in France. However, at present interest focuses more on the interface between delusional and obsessional disorders [4, 29, 32] rather than on delineating types of delusional disorders other than the classic form described by Kraepelin, Serieux and Capgras. Somewhat remarkably, perhaps, neither DSM III, III-R or IV or ICD-10 have a separate diagnostic category, or even an index listing, for either delusional misidentification syndromes or Capgras syndrome or any indication where these conditions might be categorised, suggesting that the final word in this area has not been spoken.

Regarding a further fundamental revision of the classification of delusional disorders, it can be noted that the inclusion criteria for DSM-IIIR and DSM-IV explicitly require that the delusional system in DD be non-bizarre. The presence of bizarre delusions automatically satisfies criterion A for schizophrenia. This is consistent with criteria set out by Serieux and Capgras [5] but consider the following extracts from Dupre and Logre [11]: "the ... imaginative individual spurns logic and the evidence of his own senses alike and expresses ideas, narrates tales and affirms facts he staunchly and unshakeably believes to be true, without regard for experience or reasoning, the ... interpretative and the ... imaginative individual are opposite in temperament and mental make-up: one is a reasoner and the other a rambunctious intuitive" [see 30].

Or the following: "... imaginative subjects are not worried by what they see in the outside world. They do not feel an urge to embark on elaborate logical proofs of what is there. Instead they express ideas or recount stories without caring whether they conform with reality. They proceed by intuition, autosuggestion and invention ... misinterpretation is a cognitive process, ... imagination a poetic process".

While the language and perhaps even the concepts here are somewhat archaic, distinctions of this kind have a face validity which could be explored further with an instrument such as the Magical Ideation Scale. If this point is conceded, however, we plunge into a classificatory crisis by simply inserting the word delusionally in front of imaginative and interpretative, as Dupre and Logre did. We do so because delusionally imaginative individuals will almost inevitably have bizarre delusions.

Dupre and Logre [11] argued for the existence of an imaginative psychosis to be found in individuals who "proceed by intuition, autosuggestion and invention. The point of departure for their mistaken view of the world is not an idea about some external event, exact or inexact, or a false way of reasoning, or a false perception, but a fiction of endogenous origin, a subjective creation. Misinterpretation is a cognitive process, confabulation a poetic process". Or again: "There is a temperamental difference between individuals who rely on reasoning, who are prone to misinterpretations and those who rely on intuition who are prone to confabulations. Delusions based on misinterpretations grow because the subject continually consolidates the system by noting further instances and making further inferences. Delusions based on imagination are enriched by further fictions and their most distinctive feature is the richness and creative imagination, particularly the tendency to fabricate in an extempore manner".

There is a logic to the Dupre and Logre proposal. In the 1899 edition of his textbook Kraepelin noted that there were German advocates for notions of confabulatory paranoia. He did not favour distinguishing this from paranoia but Kraepelin was not hampered by an operational criterion which would have prevented him from classifying individuals presenting with bizarre delusions under the rubric of paranoia. He subsequently recognised more explicitly that paranoia could occur in a fantastic form [21].

In contrast, however, at present within DSM-IV (ICD-10 is silent on the issue), the mere presence of bizarre delusions forces a diagnosis of schizophrenia regardless of any mechanism that may underpin either a delusional disorder or schizophrenia. The problems this poses have been recognised and attempts have been made to specify more clearly the operational

meaning of the term bizarre but without great success [35]. There is no a priori reason to suppose that "imaginative" individuals cannot contract a delusional disorder but as things stand, individuals with bizarre delusions, not based on an abnormal underlying experience, who do not show evidence of a dementing process as indicated by social or occupational dysfunction, are essentially unclassifiable. They may be classified as schizophreniform disorder but only if the disorder clears up within 6 months, which it is unlikely to do if it is a delusional disorder. Even if something clears up, the imaginative style of the patient may impede a recognition that there has been a recovery and the default is likely to be toward a diagnosis of schizophrenia.

THE FAMILY OF DELUSIONAL DISORDERS

This state of affairs should be unsatisfactory to anyone who believes that enhancing the clarity of phenotypic descriptions will increase the probability of discovering underlying pathological mechanisms. There would seem to be two options. One is to return to a more inclusive form of delusional disorder which would not exclude individuals with fantastic subforms. The other is to establish a broader family of delusional disorders within which the current delusional disorder would be one category and an imaginative or confabulatory form would be another less frequent form.

Descriptive criteria for delusional disorder – imaginative subtype in DSM-V (ICD-11) might look something like the following: A) the subject is chronically deluded and the delusional themes are fantastic or bizarre and show an imaginative exuberance; B) criterion A for schizophrenia (DSM-V) has never been met. Particular care must be taken to exclude subjects with bizarre delusions stemming from an underlying abnormal experience (ie, Schneiderian first rank symptoms [35]); C) apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behaviour is not obviously odd or bizarre. Indeed there should be something of a paradoxical co-existence of fantastic beliefs and relatively good social functioning; D) and E) as for 297.1.

The syndrome outlined here was classified as paraphrenia in France in the 1950s and afterward and links with Dupre and Logre's original descriptions were clearly recognised [30]. Paraphrenia, however, has disappeared from DSM-IV and while ICD-10 subsumes it within the category of persistent delusional disorders, yet the utility of doing this without offering criteria for its diagnosis is debatable as while it may lead French psychiatrists to classify delusional disorders with bizarre delusions under this rubric it is likely to be interpreted by English speaking psychiatrists as referring to a form of late onset schizophrenia that it would seem meaningless to resurrect.

It might be argued that the discriminative validity of Schneiderian first rank symptoms, the delusional elaborations of which are ordinarily bizarre, is so poor that subjects with first rank symptoms but without "dementing" features could be classified in the proposed category, but while often fantastic there is a relative consistency in these delusional elaborations, that in the absence of a more general imaginative exuberance, would warrant exclusion from the category.

Whichever option, to lump or to split, is chosen, it is unarguably the case that an explicit place should be found for the delusional misidentification syndromes. At present, it seems unlikely that the various DMS will have a single neuropsychiatric basis and accordingly the better classificatory option would be to distinguish rather than combine syndromes. If this option is taken for the DMS, it possibly makes sense to take the same approach for the entire group of delusional disorders.

The issue we have raised may seem esoteric but it is likely to come to the forefront in the near future as clinical studies with a new generation of antipsychotic agents will almost certainly involve some companies targeting the delusional disorders for clinical trials, as well as other research and educational programmes in a manner that has happened in the antidepressant fields with the syndromes of panic disorder and social phobia. It would be unfortunate if a lack of awareness of an older literature were to lead to a great deal of research initiative being dissipated in reinventing the wheel.

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COMMENTARIES

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The nosological state of delusional disorders has been always a point of controversy. In the past, three main views have emerged about this topic. Paranoia was considered to be a subtype of schizophrenia [4, 14, 24], a subtype of affective illness [7, 8, 25], or a distinct nosological entity [10, 15, 17]. Recently, a fourth view was mentioned by some authors, who proposed delusional disorder – especially somatic and jealous types – to be related to obsessive compulsive spectrum disorder [19].

Course and outcome data, as other empirical data derived from genetic and family studies, give a bulk of evidence suggesting that delusional disorder is a distinct nosological entity [11, 12].

This was taken into account in modern diagnostic manuals, ie, DSM-III-R/IV and ICD-10 [2, 3, 27, respectively] where delusional disorders are classified in a separate diagnostic category. However, certain ambiguities still remain. One major point of criticism, on which we focus in our comment and that is mentioned by the authors, concerns the term "bizarre delusion".

In DSM-III-R/IV the term "bizarre delusions" plays a major role in the diagnostic criteria for schizophrenia and delusional disorder. The presence of "bizarre delusions" alone satisfies the A criterion for diagnosis of schizophrenia. For a diagnosis of delusional disorder, the delusions must be "non-bizarre". Non-bizarre delusions are defined as "involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, having a disease, being deceived by one's spouse or lover". In contrast to this definition bizarre delusions are characterised as "involving a phenomenon that the person's culture would regard as totally implausible".

The difficulty of the term "bizarre delusion" is that its definition is far from precise and can be interpreted in different ways.

From a historical perspective, the concept of bizarre delusions in DSM-III-R/IV is based on Schneider's first-rank symptoms, which included delusions of being controlled, thought broadcasting, and thought insertion or withdrawal. However, in contrast to Anglo-American concepts, the German traditional psychopathology called these symptoms "Ich-Storungen" (disturbances of the ego-boundary), and were a psychopathological dimension apart from delusions. Thus, the essence of the symptom "thought insertion", for example, is not only the delusional conviction of a

subject – that his thoughts are not his own and that his mind is being intruded upon – but is primarily the immediate, sometimes bodily experience of the process of thought insertion.

Although, Schneider suggested that these symptoms should be considered pathognomonic of schizophrenia, subsequent studies have not supported this notion [6, 13, 20]. Further, studies have shown that the reliable assessment of "bizarre delusions" is far from optimal [9, 21, 26]. Taking these points into account, the validity of the concept of bizarre delusions in establishing the boundary between schizophrenia and delusional disorder seems somewhat unclear.

In this context the authors of the article propose their descriptive criteria for "delusional disorder - imaginative subtype" and intend in doing this to introduce an older diagnostic concept, which was classified as "paraphrenia in France in the 1950s", in the DSM-IV. Criterion A of the disorder is "the subject is chronically deluded and the delusional themes are fantastic or bizarre and show an imaginative exuberance". Criterion B is "Criterion A for schizophrenia (DSM-V) has never been met. Particular care must be taken to exclude subjects with bizarre delusions stemming from an underlying abnormal experience (ie, Schneiderian first rank symptoms [26]).

In our opinion, there are several shortcoming concerning the proposed criteria. First, the proposed criteria implicate two different kinds of "bizarre delusions": one that is connected with the German concept of "Ich-Storungen" and another that includes delusions with fantastic or bizarre themes which are not based on an underlying abnormal experience. From our point of view, this differentiation might cause further unwanted problems and makes the meaning of "bizarre delusions" no clearer.

Further, the authors do not bear in mind that there is a generally recognised confusion about the concept of paraphrenia.

Kraepelin classified the non-affective psychosis into dementia praecox, paranoia and a third paranoid psychosis, paraphrenia. He regarded paraphrenia as lying between dementia praecox and paranoia; in paraphrenia, the patient has unremitting systematised delusions, but does not progress to dementia. The main difference from paranoia was that the patient with paraphrenia has hallucinations [16]. Mayer [18] followed up Kraepelin's series of 78 paraphrenic patients and found that 50 of them had become schizophrenic. He found no difference in original clinical presentation between those who became schizophrenic and those who did not. Bleuler and others regard paraphrenia as a late-onset schizophrenia [5]. According to British tradition, paranoid psychoses of old age have been conceptualised as late paraphrenia that were in a different category from schizophrenia [23]. However, internationally there has not been a clear differentiation between late-onset schizophrenia and late paraphrenia; both terms were widely synonymous. Thus, results on so-called late-onset schizophrenia are in fact based on populations with late paraphrenia or on mixed diagnostic groups.

A differentiation of both diagnosis, based on psychopathological features as proposed by the authors, seems to be questionable because most studies addressing this topic have failed to show major differences [22]. Almeida et al [3] noted that patients with late paraphrenia display typical schizophrenic symptoms. Delusions were similar in frequency type and severity to the delusional features reported for schizophrenia. In summary, they concluded that the current trend to include "late paraphrenia" into the diagnosis of schizophrenia or delusional disorder has poor empirical and theoretical bases. However, in the absence of more definitive studies, the authors moved for the retention of the separate diagnosis of late paraphrenia and against subsuming patients with this disorder into the diagnosis of either schizophrenia (DSM-IV) or persistent delusional disorder (ICD-10).

Keeping these points in mind, the introduction of operatinalised criteria in the way that is proposed by the authors seems somewhat premature.

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Fear, KcMonagle and Healy propose to reconsider the diagnostic category of (chronic) delusional disorders as described in DSM-IV and ICD-10. In their view this class should be extended and include an "imaginative" subtype, and also find room for the delusional misidentification syndromes. They attribute the shortcomings of the present classifications to their reliance on "descriptive convenience" and to their inability to understand "the mechanisms that might produce phenotypic variations". They find arguments in the history of psychiatry, especially of the French school, since the beginnings of this century. The brevity of their paper excuses "the lack of comprehensive coverage" they recognise, but their selection of facts does not do justice to the relative importance of the concepts successively developed or adopted in France.

1. Starting with the classical Kraepelinian tripartite division: manic-depressive psychosis/dementia praecox/paranoia, the German psychiatry has adopted generally a model, expressed in its most systematic form by Kurt Schneider: the bipartite subdivision of the "endogenous psychoses" in manic-depressive psychosis and schizophrenia, the rejection of paranoia in the class of "psychological developments". The proposal made "tentatively" by Kraepelin in the 8th edition of his textbook, to single out of dementia praecox the new category of "Paraphrenias", with their four forms (expansive, systematic, confabulatory and fantastic), on the basis of their slow and even non-existent evolution towards a "psychic enfeeblement" met in Germany with no success.

2. The French initial – and enduring – position was based on the exclusions of a large number of patients with a (chronic) delusional syndrome from the paranoid form of dementia praecox - later of schizophrenia. The three types described before the first World War, Serieux and Capgras' *Délires d'interprétation*, Gilbert Ballet's *Psychose hallucinatoire chronique* (PHC) and Dupré and Logre's *Délires d'imagination* had in common their definition by an alleged psychological mechanism, respectively interpretative, hallucinatory and imaginative. The "délires d'imagination" had been largely inspired by Kraepelin's Paranoia – Serieux was the introducer of Dementia praecox in France, and the concept was immediately accepted, as was the chronic hallucinatory psychosis, whereas the "délires d'imagination" occupied then a minor position.

3. From the 20s on, although all French psychiatrists agreed on the existence of a large class of (chronic) non-schizophrenic delusional disorders, important development took place.

The description of various misidentification syndromes, mentioned by the authors, did not play a role in this history. In the French textbooks currently in use they are mentioned as special memory disturbances and presented as symptoms occurring eventually in mania, schizophrenic or organic disorders.

The three conceptions which had a lasting influence were:

a) De Clerambault's proposal to split up the "délires d'interprétation" in two radically distinct classes, the interpretative delusional disorders proper and the "délires passionnels" whose type was erotomania, and which included also pathological jealousy and to which were associated the "querulous" variety (délires de revendication). The délires passionnels have a starting point, Clerambault's "delusional postulate" (in the case of erotomania "he-or-she loves me") and in their evolution new emerging facts or ideas, delusional or not, are used only as confirmations of the initial postulate ("délire en secteur"). On the contrary, in the interpretative delusional type proper, the delusional system extends by incorporating unrelated elements (such as new themes and new persons) forming progressively a complex web ("délire en réseau").

b) Kretschmer's "Sensitive Beziehungswan", mentioned by the authors, influenced much more the French than the German psychiatric thought. It became, under the name of "paranoia sensitive" a standard French category.

c) In the 30s the role of the alleged mechanisms – interpretative, hallucinatory, imaginative – was contested. A revision took place in which Henri Ey was to play a leading role. It was originally affirmed that the criteria for the definition of the delusional entities should be the "structure" of the delusional system (which was "coherent" or not), the structure of the underlying personality ("dissociated" or not) and the interrelations of delusions and personality. Three types were described. On the one side the "paranoide" (incoherent delusional system and dissociated personality) belonged to schizophrenia. On the other, the two types of the non-schizophrenic chronic delusional disorders were the "paranoiaque" (coherent, delusional system interwoven with a non-dissociated personality) and the "paraphrénique" (fantastic delusions contrasting with an otherwise normally functional personality). (Mention must be made here that the French psychiatric language makes a sharp distinction between "paranoiaque" (paranoia-like) and "paranoide" (only used in relation with schizophrenia) whereas in the present English usage, paranoid tends to be more or less a synonym for "delusional".) The paraphrenic form was in its name and its description inspired by Kraepelin's fantastic paraphrenia and in the tradition of Dupré and Logre's "délires d'imagination". The striking point was the disappearance of the chronic hallucinatory psychosis, condemned because its definition was not "structuralistic" but relied on a "mechanistic" psychology which postulated that the hallucinations were the primary phenomenon and the basis of the subsequent delusional construction, an idea implicitly admitted by Gilbert Ballet, and systematically developed by de Clerambault.

4. However, after the end of the second World War, Ey revised this initial model and in the 50s and 60s, through his influential textbook, constituted the "French doctrine" which has persisted until today. The existence of the chronic hallucinatory psychosis, assimilated to Kraepelin's systematic paraphrenia, was recognised. Accordingly the (chronic) non-schizophrenic delusional disorders include now three types: the chronic hallucinatory psychosis, the "systematised" (also called "paranoiaques") and the parphrenic, the second type being further subdivided in paranoia proper ("délires d'interprétation"), "délires passionels" and "délires de revendication", and "paranoia sensitive".

Many French psychiatrists will observe with satisfaction that the suggestions of the British authors are based on French concepts little known outside of their country of origin. But, leaving aside the already mentioned case of the delusional misidentification syndromes, the "resurrection" of categories concerns only the fantastic-paraphrenic type. This would lead to a bipartite division of the (chronic) non-schizophrenic delusional disorders in practice identical to the short lived scheme proposed in France in the 30s. Two basic elements of the French conception are lacking. Among the "paranoiaques" delusional disorders, only the original Serieux and Capgras' "délire d'interprétation" is mentioned whereas, for more than a half-century, the tripartite sub-division in interpretative, "passionnels" and sensitive subtypes based on their respective psychological mechanisms is the generally accepted view. Also striking is the absence of any direct reference to the chronic hallucinatory psychosis. The patients receiving this diagnosis constitute the largest group of those excluded, as delusional disorders, from schizophrenia. In fact, the authors evoke it through a problem of terminology. They note that, while the term paraphrenia has disappeared from the DSM-IV, it still exists in the ICD-10 among the "delusional disorders" but without diagnostic criteria. According to them, such a situation may confuse both the French (because of their category of paraphrenic-fantastic disorders) and the English speaking psychiatrists (because the term has been used by them to describe "a form of late paraphrenia it would seem meaningless to resurrect"). The ambiguity of the term paraphrenia is evident. In addition to the original meaning given by Kraepelin, and to its present form in France, it has been used by English-speaking psychiatrists to describe "a paranoid psychosis in which there are conspicuous hallucinations often in several modalities. Affective symptoms and disordered thinking, if present, do not dominate the clinical picture and the personality is well preserved". This definition of paraphrenia – involutional paranoid states and late paraphrenia being given as synonyms – is quoted from the Glossary of ICD-9 published in English in 1969, and it is practically identical to the Glossary of ICD-8 prepared by a purely British Committee under the chairmanship of Sir Aubrey Lewis. A detailed clinical description had been given in 1952 by Roth and Morrisey. Any French reader will be struck by the similarity with his chronic halucinatory psychosis. The authors consider the ressurection of this syndrome as meaningless. But, despite the disappearance of this specific category in the DSM-IV which has engulfed it in the schizophrenias, this manual observes that "(in late-onset cases) the clinical presentation is more likely to include paranoid delusions and hallucinations and less likely to include disorganisation and negative symptoms". The authors point out

rightly that the whole issue of the delusional disorders is likely to come to the forefront in relation with the appearance of new antipsychotic agents. It is in this connection worthwhile mentioning that the DSM-IV, among the specific characters of late-onset schizophrenia, stresses that "it is often quite responsive to antipsychotic medications in lower doses".

Despite its concentration on very selected aspects of the French psychiatric history of the chronic delusional disorders, this paper may hopefully contribute to a general revision of the class. The fact that a nosological concept is of ancient origin and has been retained by a national school is not in itself an argument for its general adoption. Its validity must be demonstrated empirically by adequate scientific methods – the genetic and experimental studies mentioned by the authors are examples. But a knowledge of the existence of such concepts may, by stimulating new research, lead to an improvement of the nosological systems.