Bizarre Delusions and DSM-III-R Schizophrenia

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Objective: Bizarre delusions are assigned greater weight relative to other delusions in the DSM-III-R diagnosis of schizophrenia. The decision to emphasize bizarre delusions was based largely on historical tradition rather than empirical evidence. This study examined 1) the extent to which a history of bizarre delusions contributes to the diagnosis of schizophrenia and 2) whether schizophrenic patients with bizarre delusions constitute a clinically distinguishable subgroup. Method: Two hundred fourteen consecutively admitted psychotic inpatients were assessed for bizarre delusions according to the DSM-III-R criteria. Clinical and demographic correlates of bizarre delusions were examined in subsets of patients diagnosed as schizophrenic according to DSM-III-R, who also received CT scans and neuropsychological testing. Results: With the base prevalence rate for schizophrenia of 0.71, bizarre delusions had a sensitivity of 0.79, a specificity of 0.56, and a positive predictive power of 0.82 for the diagnosis of schizophrenia (N=152) relative to other psychotic disorders (N=62). Clinical, neurobehavioral, CT scan, and premorbid adjustment data on the schizophrenic patients indicated that beyond manifesting more severe positive symptoms, patients with bizarre delusions did not otherwise constitute a clinically distinguishable subgroup. Conclusions: The data suggest that criterion A for the diagnosis of schizophrenia in DSM-IV could be improved by removing the special emphasis that was placed on bizarre delusions in DSM-III-R.

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For decades clinicians and researchers have been seeking disease-specific or pathognomonic indicators of schizophrenia. The markedly strange, fantastic, and idiosyncratic content of certain delusions has been thought by some to be a unique hallmark of schizophrenia. Despite the absence of empirical evidence, these so-called bizarre delusions (defined in DSM-III-R as delusions "involving a phenomenon that the person’s culture would regard as totally implausible") were given greater weight relative to nonbizarre delusions in the DSM-III-R criteria for schizophrenia. As part of the effort to validate symptom criteria for inclusion in DSM-IV, there is a need for systematic investigation of the value of giving special significance to bizarre delusions in the criteria for the diagnosis of schizophrenia.

According to DSM-III-R, the presence of bizarre delusions is by itself sufficient to meet the psychotic symptoms requirement that constitutes criterion A for the diagnosis of schizophrenia. If delusions are not bizarre, the patient must demonstrate at least one additional psychotic symptom to meet this criterion. For some psychotic patients, therefore, the differential diagnosis of delusional disorder versus schizophrenia depends on whether their delusions are judged to be bizarre (1, 2).

From a historical perspective, the concept of bizarre delusions is a vestige of Schneider’s (3) first-rank symptoms, which included delusions of being controlled, thought broadcasting, and thought insertion or withdrawal. Although Schneider suggested that these symptoms should be considered pathognomonic of schizophrenia, subsequent studies have not supported this notion (4). Carpenter et al. (5) found that first-rank symptoms do appear frequently in schizophrenia but are by no means exclusive to schizophrenia. Moreover, they found that frequent diagnostic errors are made if these symptoms are viewed as pathognomonic. Other investigators have reported findings consistent with this conclusion (6, 7). Although there is some evidence that first-rank symptoms may have some discriminative value in distinguishing among psychotic disorders (8),

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TABLE 1. Characteristics of 214 Inpatients With Psychotic Disorders

<table>
<thead>
<tr>
<th>Variable</th>
<th>Schizophrenic Disordersa (N=132) %</th>
<th>Delusional Depression Disorderb (N=11) %</th>
<th>Bipolar Disorderc (N=36) %</th>
<th>Delusional Disorderd (N=11) %</th>
<th>Other Psychotic Disorderse (N=4) %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Bizarre delusions present</td>
<td>120</td>
<td>78.9</td>
<td>4</td>
<td>36.4</td>
<td>19</td>
</tr>
<tr>
<td>Male sex</td>
<td>85</td>
<td>56.0</td>
<td>5</td>
<td>45.5</td>
<td>13</td>
</tr>
<tr>
<td>Marital status*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>117</td>
<td>77.0</td>
<td>8</td>
<td>72.7</td>
<td>17</td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
<td>7.9</td>
<td>2</td>
<td>18.2</td>
<td>10</td>
</tr>
<tr>
<td>Previously married</td>
<td>23</td>
<td>15.1</td>
<td>1</td>
<td>9.1</td>
<td>9</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>97</td>
<td>64.0</td>
<td>10</td>
<td>90.9</td>
<td>28</td>
</tr>
<tr>
<td>Black</td>
<td>38</td>
<td>26.7</td>
<td>1</td>
<td>9.1</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>11.3</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
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<tr>
<td>Socioeconomic status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>2</td>
<td>1.4</td>
<td>1</td>
<td>9.1</td>
<td>1</td>
</tr>
<tr>
<td>II</td>
<td>18</td>
<td>11.9</td>
<td>3</td>
<td>27.3</td>
<td>8</td>
</tr>
<tr>
<td>III</td>
<td>49</td>
<td>35.2</td>
<td>2</td>
<td>18.2</td>
<td>19</td>
</tr>
<tr>
<td>IV</td>
<td>40</td>
<td>26.6</td>
<td>2</td>
<td>18.2</td>
<td>5</td>
</tr>
<tr>
<td>V</td>
<td>43</td>
<td>28.0</td>
<td>3</td>
<td>27.3</td>
<td>3</td>
</tr>
</tbody>
</table>

*aIncludes DSM-III-R schizophrenia, schizophreniform disorder, and schizoaffective disorder.
*bIncludes brief reactive psychosis (N=2) and psychotic disorder not otherwise specified (N=2).
*cSignificant difference between groups (χ²=17.18, df=8, p<0.05).

There is considerable variability in estimates of the prevalence of these symptoms in schizophrenia, ranging from as high as 72% (9) to as low as 28% (10). It is important to note, however, that most studies have considered first-rank symptoms collectively, leaving the specific value of the bizarre delusion criterion relatively unexplored.

Findings on the prognostic value of first-rank symptoms have also been contradictory. Taylor (10) and Harrow et al. (11, 12) concluded that schizophrenic patients with first-rank symptoms showed poorer outcome than patients without first-rank symptoms, but Strauss and Carpenter (13) and Hawk et al. (14) found no relation between outcome and the presence or absence of these symptoms. Kendall et al. (15) concluded that Schneider's first-rank symptoms were among the poorest predictors of social and symptomatic outcome when compared to five alternative operational definitions of schizophrenia.

In the present study, we investigated the diagnostic efficiency (16–18) of bizarre delusions and the relation between bizarre delusions and other clinical features of hospitalized schizophrenic patients. In particular, we asked, 1) To what extent does the presence of a history of bizarre delusions contribute to the diagnosis of schizophrenia? and 2) Do schizophrenic patients with bizarre delusions differ from other schizophrenic patients on key demographic and/or clinical features?

METHOD

Subjects were recruited from among psychotic inpatients consecutively admitted to a psychiatric teaching hospital. Thorough screening of new admissions to the hospital was conducted daily. Patients with histories of neurologic or significant medical illness or substance abuse/dependence disorders that might confound diagnosis or clinical presentation were excluded from the study.

The 214 subjects were aged 18–55 years. On the basis of information gathered with the Structured Clinical Interview for DSM-III-R (SCID) (19), the patients had the following diagnoses: schizophrenia (N=119), schizoaffective disorder (N=26), schizophreniform disorder (N=7), bipolar disorder with psychotic features (N=36), major depression with psychotic features (N=11), delusional disorder (N=11), psychotic disorder not otherwise specified (N=2), and brief reactive psychosis (N=2). The mean age was 31.4 years (SD=8.6) for the 152 patients with schizophrenic disorders, 33.1 years (SD=9.6) for the patients with bipolar disorder, 28.4 years (SD=10.4) for the patients with depression with psychotic features, 33.0 years (SD=8.2) for the patients with delusional disorder, and 29.8 years (SD=8.0) for the four patients with other psychotic disorders. Age and other demographic characteristics were essentially equivalent across diagnostic groups, with the exception of marital status (table 1). A higher percentage of the patients with bipolar and other psychotic disorders were currently or had been previously married.

The lifetime histories of bizarre delusions of the 214 patients were determined using DSM-III-R criteria. Three raters, independently and without knowledge of final diagnoses, reviewed written transcripts of relevant data collected in the SCID interviews and determined whether or not each reported delusion qualified as bizarre. The kappa coefficient for the three independent raters was 0.78. For the final data analysis, discrepancies between ratings were resolved through discussion.
TABLE 2. Diagnostic Efficiency* of Bizarre Delusions in Differentiating Schizophrenic Disorders From Other Psychotic Disorders

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Patients With Schizophrenic Disorders (N=152)</th>
<th>Patients With Other Psychotic Disorders (N=62)</th>
<th>Total (N=214)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence</td>
<td>120(a)</td>
<td>27(b)</td>
<td>147</td>
</tr>
<tr>
<td>Absence</td>
<td>32(c)</td>
<td>35(d)</td>
<td>67</td>
</tr>
</tbody>
</table>

*For the calculations, patients with delusional disorder (N=111) were included in the group with other psychotic disorders. Base prevalence rate of schizophrenic disorders = number of schizophrenic patients/total number of patients; 152/214 = 0.71. Sensitivity/specificity of a/b or (1-c/d) of 0.56. Positive predictive power = a/(a+b) = 0.63/0.17 = 0.82. Negative predictive power = d/(c+d) = 0.35/0.67 = 0.52. Meehl and Rosen's (16) index of diagnostic efficiency: prevalence (P)L-1-P(low positive rate)/(true positive rate) = 0.1/(1.0-0.71) = 0.35/0.125 = 2.8.

until a consensus judgment was obtained; additional opinions of senior clinicians were used when necessary. From the group of 119 patients diagnosed as having DSM-III-R schizophrenia, a subset of 81 patients was included in the intensive clinical assessment study. These patients were predominantly single (74.1%, N=60), and their mean age was 31.8 years (SD=9.0); 67.1% (N=50) were white, 29.6% (N=24) were black, and 8.6% (N=7) were “other.” They came from a broad distribution of socioeconomic strata: 12.3% (N=10) from levels I and II (upper and upper-middle class), 30.9% (N=25) from level III (middle class), 27.2% (N=22) from level IV (lower-middle class), and 29.6% (N=24) from level V (lower class). The following clinical dimensions were assessed: 1) the global level of current functioning, with the Global Assessment Scale (GAS) (20); 2) the severity of general symptoms, with the Brief Psychiatric Rating Scale (BPRS) (21); and 3) the severity of specific positive and negative symptoms, with the Scale for the Assessment of Positive Symptoms (22) and the Scale for the Assessment of Negative Symptoms (23). We also used the Cannon-Schoor Premorbid Adjustment Scale (24) to assess levels of social, sexual, academic, and occupational functioning at various developmental stages prior to the onset of illness. The interviews for this scale were conducted with each of the patients near the time of discharge. When available, family members were interviewed to provide additional information on the patients’ premorbid adjustment.

Neurobehavioral tests and CT scans were done on patients (N=65) who qualified for study on the basis of the following criteria: no known systemic or neurologic illness by history and by physical examination, no prior ECT, no history of head trauma or substance dependence, and no significant substance abuse within 1 month before testing (and for eye movement measures, no lithium or benzodiazepines within 2 weeks before testing). Neurobehavioral assessments included 1) a battery of neuropsychological tests (Wisconsin Card Sorting Test, Rey Verbal Learning Test, Block Design, Benton Judgment of Line Orientation, F-A-S Verbal Fluency, Finger Tapping, Trail-Making, and Ammons’ IQ test), 2) pursuit eye movement testing, and 3) a CT scan for calculating the ventricle-brain ratio (VBR) of the lateral ventricles and frontal horns, by procedures reported elsewhere (25).

RESULTS

A history of bizarre delusions was documented for 78.9% (N=120) of the 152 patients with “broad-band” schizophrenic disorders (i.e., schizophrenia, schizoaffective disorder, and schizotypal disorder) (table 1). Prevalence rates were essentially equivalent for the patients with schizophrenia (79.0%, N=94), schizoaffective disorder (80.8%, N=21), and schizotypal disorder (71.4%, N=5) (x^2=0.29, df=2, n.s.). A history of bizarre delusions was present in 43.5% (N=27) of the patients with nonschizophrenic psychotic disorders, a significantly lower prevalence rate than that for the group with broad-band schizophrenic disorders (x^2=24.04, df=1, p<0.0001).

Seven of the 214 patients met the DSM-III-R psychotic symptom criterion for schizophrenia solely on the basis of the presence of bizarre delusions. Thus, 3.3% of all of the psychotic patients and 4.6% of all of the patients with DSM-III-R schizophrenic disorders would have failed to qualify for a diagnosis of schizophrenia if bizarre delusions had not been a “sufficient” psychotic symptom in the DSM-III-R criterion A for schizophrenia. If bizarre delusions had not been given special emphasis in the diagnosis of schizophrenia, two of these seven patients would have met the DSM-III-R criteria for delusional disorder. They did not show a pattern of bizarre behavior, and although chronically psychotic, they had demonstrated intact functioning until shortly before admission. The remaining five patients would have been assigned to the DSM-III-R category of psychotic disorder not otherwise specified. Of the seven patients who would no longer be considered schizophrenic, six had experienced their first psychotic episode within the previous 12 months.

Compared to the base prevalence rate for schizophrenia of 0.71 in this sample (table 2), a history of bizarre delusions had a diagnostic sensitivity of 0.79 and a specificity of 0.56. This symptom showed a relatively high positive predictive power of 0.82, indicating that 82% of the patients with histories of bizarre delusions received the DSM-III-R diagnosis of schizophrenia. The negative predictive power of 0.52 indicates that 52% of the patients who did not have this symptom received DSM-III-R psychotic disorder diagnoses other than schizophrenia.

As one approach to assessing the diagnostic efficiency of the bizarre delusion symptom, we used Meehl and Rosen’s base-rate-corrected evaluation of classification accuracy (16). This index (footnote to table 2) indicates whether a certain symptom or test value improves the classification accuracy above and beyond reliance on the base rate alone. In this sample, the index of diagnostic inaccuracy (the false positive rate 0.44) divided by the true positive rate 0.79, i.e., 0.56 was exceeded by

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TABLE 3. Psychiatric Scale Scores at Admission for a Subgroup of 81 Schizophrenic Patients With and Without Bizarre Delusions

<table>
<thead>
<tr>
<th>Scale</th>
<th>Patients With Bizarre Delusions (N=64)</th>
<th>Patients Without Bizarre Delusions (N=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale for the Assessment of Positive Symptoms*</td>
<td>Mean 11.6 SD 3.1</td>
<td>Mean 7.6 SD 3.4</td>
</tr>
<tr>
<td>Scale for the Assessment of Negative Symptoms</td>
<td>Mean 14.0 SD 3.6</td>
<td>Mean 15.3 SD 3.0</td>
</tr>
<tr>
<td>BPRS*</td>
<td>Mean 33.2 SD 9.9</td>
<td>Mean 48.2 SD 8.4</td>
</tr>
<tr>
<td>GAS*</td>
<td>Mean 25.0 SD 5.7</td>
<td>Mean 29.2 SD 5.9</td>
</tr>
</tbody>
</table>

*Significant difference between groups (t=4.62, df=73, p<0.001).

The index of prevalence (the positive base rate of schizophrenia in the sample [0.71] divided by the negative base rate [0.29], which is equivalent to 2.45) indicates that the accuracy of diagnosis when present or absence of a history of bizarre delusions was used exceeded the base rate of the disorder in our sample (footnote to Table 2). A z test of the significance of the difference in proportions indicated that the efficiency of diagnosis based on the symptom criterion (0.82) was statistically greater in magnitude than that attained using the base rate alone (0.71) ([z=2.38, p<0.009).]

Because according to the DSM-III-R criteria, a patient with delusional disorder cannot have bizarre delusions, the preceding analyses may have yielded an artificially high estimate of the diagnostic specificity of bizarre delusions. For this reason, a second analysis was conducted in which patients with DSM-III-R delusional disorder were excluded from the group with nonschizophrenic psychoses. In this case, bizarre delusions were found in 52.9% of the patients with nonschizophrenic psychoses—still a significantly lower prevalence than for the broad-band schizophrenia group (x^2=12.93, df=1, p<0.0003). With the revised, now higher, base rate of 0.75 for schizophrenia, the specificity of bizarre delusions dropped from 0.56 to 0.47, and the negative predictive power dropped from 0.52 to 0.43. Using the revised base rate in the computation of the Meehl and Rosen index, we found that the bizarre delusion criterion still added meaningfully to diagnostic classification beyond the base rate alone in identifying cases of DSM-III-R schizophrenia.

To determine whether schizophrenic patients with bizarre delusions represent a clinically distinctive subgroup, we examined the demographic and clinical characteristics of 81 of the 119 patients with DSM-III-R schizophrenia for whom extensive clinical assessments were available. This group included 64 patients with and 17 patients without histories of bizarre delusions. Comparisons of the demographic characteristics of these two groups showed no significant differences in age, sex, marital status, race, or socioeconomic status.

We determined the relation between a history of bizarre delusions and admission ratings of symptom severity (the scales for positive and negative symptoms and the BPRS) and global functioning (the GAS). The results (Table 3) indicated that patients with histories of bizarre delusions showed significantly more severe positive symptoms, as measured by the sum of the global ratings from the Scale for the Assessment of Positive Symptoms. Hallucinations and delusions, as assessed on the global scales from that instrument, were significantly more severe among the patients with bizarre delusions (t=4.48, df=78, p<0.001, and t=2.54, df=79, p<0.02, respectively). Patients with histories of bizarre delusions also had more severe general psychopathology on admission (as measured by total BPRS scores) than those who did not have histories of bizarre delusions. At admission no significant differences between groups were found on the negative symptom dimensions of the Scale for the Assessment of Negative Symptoms. Global functioning at admission, as measured by the GAS, was poorer for the patients with histories of bizarre delusions when compared with the other patients.

Results of neurobehavioral assessment revealed that the patients with histories of bizarre delusions had fewer perseverative errors on the Wisconsin Card Sorting Test (t=2.03, df=64, p<0.05), a trend for smaller VBR of the frontal horns (t=1.93, df=64, p<0.05) but not the body of the lateral ventricles, and higher IQs (t=3.49, df=64, p<0.01). There were no significant differences on other neuropsychological tests or in gain of pursuit eye movements.

Finally, we investigated the relation between a history of bizarre delusions and clinical factors often considered to be prognostic indicators (age at onset, number of previous hospitalizations, duration of illness, premorbid adjustment, and length of stay during the index hospitalization). The results (Table 4) indicated no significant differences between the two groups, with a single exception: patients with histories of bizarre delusions had a significantly shorter hospital stay.
Discussion

The nosological changes introduced by DSM-III-R gave greater weight to bizarre delusions than to nonbizarre delusions in the differential diagnosis of schizophrenia. The assessment of lifetime histories of bizarre delusions among patients with psychotic disorders revealed that bizarre delusions are characteristic of a sizable majority (79.9%) of patients with schizophrenic disorders but are also found with relatively high prevalence (43.5%) in patients with other DSM-III-R psychotic disorders. These findings are consistent with previous studies that disputed the pathognomonic character of these symptoms on the basis of prevalence data obtained for various psychotic disorders (5–8).

With use of the Mehl and Rosen index of classification accuracy, the bizarre delusion symptom proved more “efficient” than the schizophrenia base rate alone in accurately classifying cases in our sample into the schizophrenia and non-schizophrenia categories. (On the basis of the ratio of false positives to true positives for our sample, Mehl and Rosen’s index of classification accuracy indicates that use of the bizarre delusion symptom would yield more accurate classification than that obtained by using the base rate alone in settings with a base rate for schizophrenia, among psychotic disorders, of 36% or more.) This indicates merely that patients with bizarre delusions were more likely to have schizophrenia than any other psychotic disorder, even with a correction for the base rate of the syndrome.

A more stringent criterion of efficiency is reflected by the number of cases in which the diagnosis of the target disorder would change with a change in the presence or absence of the criterion symptom. In the case of the bizarre delusion symptom criterion, we found that elimination of the extra emphasis on bizarre delusions in criterion A of the DSM-III-R definition of schizophrenia would result in only a relatively small number of changes in diagnosis (3%–4%) among a heterogeneous group of patients with psychotic disorders. All but one of the patients diagnosed as having schizophrenia on the basis of meeting this criterion were first-hospitalization patients in the early phase of illness. Although bizarre delusions may offer an advantage for earlier detection of schizophrenia, it is not clear whether all such patients would go on to meet the other diagnostic criteria for schizophrenia. Examination of the patients in our sample who had been ill for 3 years or longer and had histories of bizarre delusions revealed that all of them also had histories of other psychotic symptoms. Therefore, it is possible that over the course of the illness, the diagnosis may become less contingent on the presence of bizarre delusions alone. This suggests that, from a nosological point of view, the bizarre delusion symptom criterion could be dropped as a sufficient psychotic symptom without significantly changing clinical diagnostic practice. The possible cost of delaying the diagnosis of schizophrenia in a small percentage of first-episode patients would be offset by the lack of evidence that this diagnosis is suitable for such individuals.

Comparison of the clinical characteristics of patients with and without histories of bizarre delusions revealed that patients with bizarre delusions had more severe psychotic symptoms at the height of the index episode. Several explanations may account for the more severe positive symptoms in these patients. In patients who presented with bizarre delusions during the target hospitalization, the bizarre character of the delusions might have accounted for the severity of the positive symptom ratings. However, global ratings of hallucinations were also higher for patients with histories of bizarre delusions, suggesting that the elevated global positive symptom ratings were not attributable to bizarre delusions alone. This suggests that schizophrenic patients with histories of bizarre delusions tend to become more acutely psychotic during exacerbations of illness.

Other than the more florid positive symptoms during acute exacerbations, there were no significant differences between schizophrenic patients with and without bizarre delusions in demographic characteristics, premorbid adjustment, or age at onset of illness. Patients with histories of bizarre delusions actually stayed fewer days in the hospital. From the neuropsychological assessment data, there was no indication that a history of bizarre delusions was associated with a more severely disabling illness. In fact, trends in the data were for patients with bizarre delusions to manifest fewer neuropsychological and neuroanatomic impairments. Thus, in terms of factors often thought to be associated with a poorer course of illness (such as premorbid adjustment, age at onset, length of hospital stay, negative symptoms, and neuropsychological and neuroanatomic abnormalities), patients with bizarre delusions were not clinically distinguishable from those without bizarre delusions. In sum, these data do not support the notion that a history of bizarre delusions is prognostic of a more severe form of illness.

Another important issue in evaluating the utility of bizarre delusions as a diagnostic criterion for schizophrenia is the extent to which delusions can be reliably classified as bizarre. Many investigators have noted that it is often difficult to reach agreement among even the most experienced of practitioners (26, and personal communication from K. Kendler, 1990). The DSM-III-R definition of “bizarre,” based as it is on implausibility rather than physical impossibility, was intended to enhance the clarity of the definition and thus to increase potential interrater agreement on its presence or absence. Nonetheless, there still remains some lack of clarity about what constitutes an implausible delusion. For example, a Hispanic patient who reports spirit possession, or a fundamentalist Christian professing to be controlled by Jesus, or an anxious city dweller who avoids use of the subway because he is convinced that exposure to the electromagnetic field is giving him cancer could present problematic determinations for the clinician. Given the diversity of ethnic and cultural belief systems, and advances in modern technology that tend to blur the distinctions between science fiction and physical fact, it is often difficult to come to a categorical
determination of the implausibility of a belief. Nevertheless, the relatively high kappa rate obtained in this study (0.78) demonstrates that a reasonable degree of reliability can be achieved with use of the current operational definition. However, it is likely that our interrater reliability estimate approaches an upper limit, because our assessment team met regularly over a period of years and conducted weekly live interviews and consensus reviews of diagnostic data.

In summary, although bizarre delusions are often presented by patients with schizophrenia, psychotic patients in other DSM-III-R categories also show a high prevalence of these delusions. Few patients in our sample met the psychotic symptom criterion for schizophrenia solely on the basis of the presence of a history of bizarre delusions. Patients with bizarre delusions showed more severe positive symptoms at admission; however, on demographic, premorbid adjustment, neurocognitive, and all other clinical measures, there was no evidence that the presence of a history of bizarre delusions reflected a more pathological form of illness. Whereas there may be merit in retaining the bizarre delusion symptom in the exclusion criteria for the diagnosis of delusional disorder, retaining it in the inclusion criteria for schizophrenia appears to add an unnecessary level of complexity to the diagnosis of schizophrenia, with little obvious benefit for clinical practice. Taken as a whole, our data suggest that criterion A for DSM-IV could be improved by removing the special emphasis that was placed on bizarre delusions in DSM-III-R.

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