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The classification, definition, and ontology of delusion*[1]

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Although delusion is one of the central concepts of psychopathology, it stills eludes precise conceptualization. In this paper, I present certain basic issues concerning the classification and definition of delusion, as well as its ontological status. By examining these issues, I aim to shed light on the ambiguity of the clinical term 'delusion' and its extension, as well as provide clues as to why philosophers are increasingly joining the ranks of psychiatrists, psychologists, and neuroscientists in the effort to come to a comprehensive understanding of delusion.

Key words: Delusion, nosology, metaphysics of psychopathology, DSM-5

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Introduction

Delusion is one of the central concepts of psychopathology. It has been considered 'the basic characteristic of madness' (Jaspers, 1913/1963, p. 93), as well as the main criterion when assessing and diagnosing psychosis. The detection of delusions has profound consequences for diagnosis and treatment, as well as for the prediction of behavior and the attribution of responsibility. Yet, for all its importance, delusion has eluded precise conceptualization. In what follows, I will present the most fundamental theoretical challenges involving the classification and definition of delusion, as well as presenting the more philosophical consideration of whether delusion is a natural kind. In this review article, I aim to show that 'delusion' is a highly ambiguous term, and that the phenomena to which it refers are multi-faceted. Additionally, I aim to shed light on why philosophers have taken an interest in delusions, increasingly joining the ranks of psychiatrists, psychologists, and neuroscientists in the effort to arrive at a comprehensive understanding of the phenomena.

The classification of delusion

Delusions occur in a variety of contexts, including paranoid schizophrenia, bipolar disorder, Alzheimer's disease, Parkinson's disease, Lewy body dementia, epilepsy, and acquired brain injury. Delusions have been grouped in many different ways.

The context of delusion, for example, was once a criterion for dividing delusions into organic and functional. A delusion was called organic if was the result of brain injury, and functional if it had no known organic cause (which usually entailed a psychodynamic, or motivational, explanation). The distinction is now considered to be obsolete, as the development of neuropsychiatry has increasingly lent credibility to the view that all delusions have an organic basis, even though some have not been precisely identified yet.

Delusions are perhaps most intuitively classified according to their content — that is, according to what the delusion is about. Not only pre-twentieth-century inventories bear witness to this characteristic (Berrios, 1996), but it also has made its way into current classifications. For example, the section 'Schizophrenia Spectrum and Other Psychotic Disorders' of the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) states that the content of schizophrenic delusions may include a variety of themes, such as persecutory, referential, grandiose, erotomanic, nihilistic, and somatic. Persecutory delusions involve the conviction that one is being, or is going to be, harmed or harassed by an individual or organization; delusions of reference involve the conviction that certain gestures, comments, and environmental cues are directed at oneself; grandiose delusions involve the conviction that one has exceptional abilities, wealth, or fame; erotomanic delusions involve the conviction that another person, usually of high status or famous, is in love with the patient; nihilistic delusions involve the conviction that a major catastrophe will occur; and somatic delusions focus on preoccupations regarding health and organ function (APA, 2013, p. 87). The thematic families listed in the DSM are some of the most clinically common — especially persecutory delusions and delusions of reference — but the list is not meant to be exhaustive. Indeed, it only scratches the surface of the thematic variety of delusion.

In his lauded *General Psychopathology*, Karl Jaspers effected a shift in the classification of delusions from their content to their formal or structural features, such as their comprehensibility. For Jaspers, the psychiatrist's inability to achieve an empathetic understanding of the patient's experience was the true sign of madness and it was the chief criterion for his distinction between primary delusions (or delusions proper) and secondary delusions (or delusion-like ideas). Jaspers maintained that the former cannot be understood phenomenologically and originate in what he describes as a 'transformation in our total awareness of reality' (1913/1963, p. 95) while the latter originate in understandable ways from experience.

This shift from an extensional to an intensional classification is felt in the distinction between bizarre and nonbizarre delusions — a distinction of some clinical importance, as the DSM treats the presence of bizarre delusions as the heaviest-weighted clinical criterion of schizophrenia. According to the DSM, delusions are deemed bizarre when two conditions are met: first, they are clearly implausible and incomprehensible to same-culture peers; second, they are not derived from ordinary life experiences (APA, 2013, p. 87). Instances of delusion that seem to satisfy these criteria abound in the clinical literature. For example, one patient had the delusion that there was a nuclear power station inside his body (David, 1990); another, that he was both in Boston and in Paris at the same time (Weinstein and Kahn, 1955). Much more common, however, are delusions that do not satisfy the criteria for bizarre delusion; that is, delusions that appear

somewhat understandable and derived from ordinary life experiences. As an example, the DSM alludes to the conviction that one is under surveillance by the police, despite a lack of convincing evidence.

Finally, a recent and useful distinction divides the set of delusions into monothematic and polythematic (Coltheart, 2013). A monothematic delusion is one that is specific to a particular theme. It contrasts with polythematic delusion, in which case patients exhibit many delusions concerning a variety of themes. Monothematic delusions are typically not elaborated and not integrated (or not completely integrated) with the rest of the patient's beliefs, while polythematic delusions are both elaborated and integrated. Monothematic delusions are commonly the consequence of acquired brain injury. Examples of delusions that present as monothematic include those that are referred to as Delusional Misidentification Syndromes, such as Capgras delusion, Frégoli delusion, and reduplicative paramnesia. Polythematic delusions are often and appropriately referred to as delusional systems, being most commonly associated with schizophrenia. Capgras delusion, described by Joseph Capgras and Jean Reboul-Lachaux in 1923, typically involves the conviction that one's loved ones (typically one's relatives or spouse) have been replaced by doubles — impostors which are usually human, but in some cases may be ghosts, aliens, or robots. Frégoli delusion, described by Paul Courbon and Gustave Fail in 1927, typically involves the conviction that strangers are actually familiar individuals in disguise, or that different people are in fact a single person who changes appearance or is in disguise. Finally, reduplicative paramnesia, named by Arnold Pick in 1903 and, in all indication, first described by Charles Bonnet in 1788, typically involves the conviction that a location has been duplicated, existing in two or more places simultaneously, or that it has been relocated to another site.

Perhaps the most famous case of polythematic delusion in psychiatric history remains that of Daniel Paul Schreber, an appellate judge in the kingdom of Saxony who spent thirteen years in mental asylums and wrote of his experiences with schizophrenia in *Memoirs of My Nervous Illness* (Schreber, 1903/2000) — a fame that was due in no small part to the fact that his account was the subject of a major study by Freud, as well as being extensively explored by Bleuler, and offered as an example of schizophrenic incomprehensibility by Jaspers. The core of Schreber's delusional system included the conviction that he had a mission to redeem the world and to restore mankind to their lost state of bliss. In order for this to happen, he insisted, divine forces were preparing him for a sexual union with God by changing him into a woman, so he could give birth to a new race of humanity. Schreber never disavowed what he termed 'my so-called delusions' and died in an asylum in 1911.

The definition of delusion

To provide a definition of delusion that satisfies the needs of both psychopathological theory and clinical practice is a difficult task. The first two editions of the DSM — DSM-I (1952) and DSM-II (1968) — did not provide one, but with the inclusion of the section 'Glossary of Technical Terms' in the DSM-III (1980), the manual came to define delusion as follows:

> A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. (APA, 2013, p. 819)

Reflection upon and attention to the clinical literature raise a number of difficulties concerning this attempt at a definition (e.g. Leeser and O'Donohue, 1999). Does delusion have to be false? Consider a case of Othello syndrome — the delusion that one's spouse or sexual partner is being unfaithful — discussed by Jaspers, in which the stress provoked by living through the morbid jealousy of her husband causes the patient's wife to find consolation in another man's arms, thereby verifying the patient's delusion. Nothing in the patient's mind has changed: he still holds that his wife is unfaithful without having any evidential justification. So it is not the truth-value of the proposition or propositions held by delusional patients that is epistemologically interesting to the characterization of delusions, but the fact that they are 'sustained despite what constitutes incontrovertible and obvious proof or evidence to the contrary', etc. As Golda Meir is reputed to have quipped after being accused of being paranoid by Henry Kissinger for hesitating to grant further concessions to the Arabs during the 1973 Sinai talks, 'Even paranoids have enemies'.

Does delusion have to be based on inference? As Martin Davies and colleagues (2001, p. 134) observe, a subject might form a delusional belief simply by taking an anomalous perceptual experience to be true, and it is not obvious why this might involve an inferential step. Furthermore, Philip Gerrans has advanced a theory that relieves the emphasis on hypothesis confirmation to which the inferential view alludes, proposing that processes of selective attention and recall exert their effects instead on autobiographical narrative. In his words, 'Someone with a delusion is not a mad scientist but an unreliable narrator' (2009, p. 152). Therefore, the inferential nature of delusion formation is a point of contention. This raises the further question of whether definitions of mental

disorders should include explicitly theoretical elements.

Does delusion have to be about external reality? Consider delusions that concern the subject's own body — such as manifestations of Cotard's syndrome in which the patient affirms that some of her internal organs are missing, or somatoparaphrenia, which involves the denial of ownership of one or more of one's limbs or sometimes an entire side of one's body — or delusions that concern the subject's own thoughts — such as thought insertion, in which the subject reports that another's thoughts occur in her own mind without her volition. Whether it is about "external" or "internal" reality — a terminology so vague as to merit scientific disrepute — is of no consequence to the delusional character of a belief.

Does delusion have to be firmly sustained? While that may be the case in many if not most manifestations, the conviction of delusional subjects is subject to fluctuation. At least some delusional patients show appreciation of the implausibility of their delusional beliefs. Consider, for example, the following excerpt of an interview with a patient who maintained that his house and family had been replaced by duplicates:

> *E*: Isn't that [two families] unusual?
> *S*: It was unbelievable!
> *E*: How do you account for it?
> *S*: I don't know. I try to understand it myself, and it was virtually impossible.
> *E*: What if I told you I don't believe it?
> *S*: That's perfectly understandable. In fact, when I tell the story, I feel that I'm concocting a story ... It's not quite right. Something is wrong.
> *E*: If someone told you the story, what would you think?
> *S*: I would find it extremely hard to believe. I should be defending myself. (Alexander, Stuss, and Benson, 1979, p. 335)

Furthermore, does delusion have to contradict what almost everyone else believes? Or: does the attribution of delusion have to take into consideration the person's culture or subculture? Davies and colleagues (2001, p. 133) object that if a bizarrely implausible belief is formed and sustained in ways that are characteristic of delusions, it seems that it should be grouped together with delusions even if many other subjects believe the same thing. However, as *ad hoc* a clause as it may seem, cultural exemption may make sense of the fact that we do not think that individuals who belong to other cultures which hold peculiar beliefs are delusional. Dominic Murphy reports on the fieldwork done by Wendy James in the Sudan, where it is believed that trees convey information: 'You can learn what they know by burning an ebony twig, dipping it in water and reading the pattern of ashes in the water' (2013, p. 119). The cultural exemption clause encodes into the definition of delusion the fact that we would attribute a delusion to someone in our (Western) culture if they held that they gathered knowledge

about the plans of witches from trees, but not with respect to the Uduk. However, as with the inferential nature of delusion formation, the cultural exemption clause is again a point of contention.

Does delusion have to occur in the face of incontrovertible and obvious proof or evidence to the contrary? Consider the case of mirrored-self misidentification — the delusion that one's reflection in the mirror is not one's own. It sometimes is accompanied by the conviction that whoever the person in the mirror is, he or she is following the subject around. Now, are these patients in possession of 'incontrovertible and obvious proof or evidence' that, although they fail to identify the face in the mirror, it is nevertheless theirs? Consider that just as not all hallucinatory symptoms lead to delusion, an otherwise normal subject presented with the anomalous experience of not recognizing oneself in the mirror would presumably not arrive at the belief that, say — although the mirrored person is waving just like I am, wearing the same clothes, sporting the same hairstyle, etc. — that person is not me. In addition to these overriding facts (which point to the great plausibility that there is something wrong with *me*), the testimony of each and everyone of one's epistemic peers would also weigh in heavily in the reasoning of a person whose thoughts did not mark the presence of some deficit, or bias, or both. So imperviousness to evidence does indeed seem to be a central feature of delusion.

Indeed, delusion is often not only impervious to evidence that tells against it, but it also persists in spite of bad consequences — even self-perceived harmful and imprudent consequences. A final observation of the inadequacy of the DSM definition is that it captures exclusively epistemological features, failing to take the disruption of day-to-day functioning into account (McKay et al., 2009) — that which is typically the focus of clinical concern and treatment. It ultimately ignores the fact that, as George Graham sums up, 'Living through a delusion *hurts* a person' (2010, p. 203, my emphasis).

The ontology of delusion

The fact that the standard definition of delusion has proved so problematic raises the question of whether delusion can ever be given a proper definition in terms of necessary and sufficient conditions. Put another way, it raises the question of whether all the various types of delusion we have discussed share a common essence, something to which we could refer in order to ultimately decide if something is or is not a delusion. Is delusion a class of things akin to quarks, noble gases, and tigers, in their suitability for the purposes of scientific investigation? Does delusion as a kind "carve nature at its joints," latching on to a

real distinction in nature? In other words, is delusion a *natural kind*?

'Natural kind' is philosophical jargon and, therefore, the question 'Is delusion a natural kind?' merits further analysis. Beyond depending on an investigation of the characteristics of delusions as a whole, an answer to it will be determined by one's view of what requisites a class of things should fulfill in order for it to be considered a natural kind. The traditional account of natural kinds is represented by various forms of *essentialism*, which usually involves three main tenets (Ereshefsky, 2009). First, all and only the members of a kind share a common essence. Second, that essence is a property, or a set of properties, that all the members of a kind must have. And third, a kind's essence causes the other properties associated with that kind. So, for example, the essence of gold is gold's atomic structure, and that atomic structure occurs in all and only pieces of gold. That structure is a property that all gold must have as opposed to such accidental properties as being valuable to humans. And the atomic structure of gold causes pieces of gold to have the properties associated with that kind, such as readily dissolving in mercury at room temperature, conducting heat and electricity, and being unaffected by air and moisture.

As essentialism holds that natural kinds exist independently of our classifications, it behooves scientists to discover their inherent essences and classify them accordingly. The conceptualization of scientific kinds as essentialistic natural kinds has indeed been applied with success, especially in physics and chemistry, but is it applicable to psychiatric kinds, or even biological kinds? Can psychiatric disorders and symptoms be exhaustively defined by fixed and inherent properties? Can delusion, in light of the fact that the conditions in its standard definition are not necessary or even jointly sufficient?

On the other hand, assuming that there is no essential criterion or set of criteria for being a delusion does not, by itself, entail that delusion as a kind is nothing but an arbitrary clustering of properties. 'Delusion' picks out reasonably stable, nonarbitrary patterns, and application of delusion as a classification seems justified by its usefulness for clinical purposes (Bell et al., 2006). In consonance with these observations, Peter Zachar (2000) has proposed that mental disorders be conceptualized as *practical kinds*. As an example, Zachar (2014, pp. 154-5) alludes to the distinction between an adult and a child. Although the kinds 'adult' and 'child' are not in themselves sharply demarcated, the uses for which we deploy them will determine where their boundaries should be drawn. Consequently, many distinctions between adults and children are context-dependent. For example, if our aim is to decide who is able to vote, engage in consensual sex, get married, be sent to prison, drink alcohol, or enter into a legal contract, each of those considerations will result in different ways of demarcating adulthood (Horwitz and Wakefield, 2012, p. 53).

Is Zachar right in arguing that psychiatric kinds are practical kinds that pick out mind-dependent distinctions? Or do they pick out mind-independent distinctions in nature? Importantly, what is the relevant sense of mind-independence with regard to the characterization of natural kinds? Richard Samuels argues that it is what Sam Page (2006) calls *individuative independence*: 'Roughly put, a kind, K, is individuatively independent if it is circumscribed by boundaries that are totally independent of where we draw the lines. In other words, individuatively independent kinds are the sorts of kinds whose existence does not (metaphysically) depend on how we categorize things' (Samuels, 2009, p. 54). Page illustrates his concept by alluding to the individuation of the night sky into constellations: 'Though it is *prima facie* plausible that reality is individuated intrinsically into stars, reality is not individuated intrinsically into constellations, since it is people who divide the night sky into constellations' (Page, 2006, p. 328). Furthermore, although the International Astronomical Union divides the celestial sphere into 88 official constellations, there can be as many different star maps as there are people willing to point out a few stars and name clusters of stars.

With respect to individuative independence, then, Zachar's practical kinds model has the import of making psychiatric kinds out to be akin to constellations rather than stars. However, since psychiatric kinds are manifold and differ greatly with respect to validity, it is possible for some to be mind-dependent kinds, and for others to turn out to be mind-independent — and, among those that are merely mind-dependent kinds, some may be practical kinds in Zachar's sense, while others may not even rise to such a status. With regard to the specific case of delusion, three considerations put pressure on the assumption that it constitutes a mind-independent kind. First, delusions may be an artifact of our folk psychology, our commonsense mode of thought about mental states and processes, as Murphy (2006) proposes:

> Whether or not something is a delusion is a matter of how it strikes us, and that depends on how well it comports with our understanding of what people are like, both in general terms and within our culture. It does not depend on some psychological mechanism or a formal property of beliefs. (p. 180)

Murphy's observation that being a delusion is a response-dependent property stems from reflection on the attribution of delusion. He argues that a delusion is attributed to a subject when our explanatory resources run out and we cannot make sense of how and why someone has a certain belief: 'a delusion is a belief that is acquired in ways that defeat our expectations about belief acquisition' (2013, p. 117).

Second, as I have pointed out when discussing the cultural exemption clause in the DSM definition of delusion, what is considered a delusion in one place (or at

one time) may not be considered in another. This ties neatly with Murphy's theory of delusion attribution as a failure of folk epistemology to account for someone's acquiring a belief, as what will count as a reason for holding a belief will ultimately depend on the context of attribution. Consider again the example of Sudan's Uduk-speaking peoples. Believing that ebony trees can eavesdrop on conversations and that information about such conversations can be read off from them through divination will count as a reason for refusing to conduct a conversation near an ebony tree (Boyer, 2001, p. 69). In Uduk society, in contrast with Western society, this kind of reasoning will be understandable. To the extent that what is a delusion depends on what beliefs are socially prevalent in the context of attribution, cultural relativity suggests that being a delusion is a response-dependent property.

Third, delusions are normatively assessable: to be deluded usually (if not necessarily) means that something is *wrong*. While this does not necessarily entail mind-dependence, if the norms to which the assessment of delusion is subject are in any way social, then the very existence of delusions would turn out to depend on our cultural modes of thought. In other words, the boundaries of delusion would be at least partly dependent on where we draw the lines. Hence, delusion would not be an individuatively independent kind. But are the norms that govern delusion social?

Delusions may be subject to at least two kinds of norms, namely, medical norms and norms of rationality (Samuels, 2009). On the one hand, it is difficult not to accept that delusions are typically, if not always symptomatic of pathology — and even the least socially laden theories of mental disorder accept that the notion of harm should be understood in sociocultural terms (Wakefield, 1992). On the other hand, it is hard to avoid the conclusion that some, if not all, delusions are epistemically irrational — although whether norms of rationality are even partially socially constructed is much more controversial.

Against these threats, Samuels (2009) has argued that the line of reasoning present in the mind-dependence objections to the natural kind status of delusion conflates the metaphysics of delusion with its epistemology:

> The relevant metaphysical issue concerns the *nature* of delusions: roughly, what is it to be a delusion. The relevant epistemic question concerns the *evidential basis* for our judgements about delusion: roughly, the sorts of evidence we invoke in judging that someone is deluded. (p. 68, my emphases)

However, even if such evidential basis were necessarily linked to culture-bound folk epistemologies and mind-dependent norms, Samuels argues, there remains the modal point that this alone would not establish a necessary link between what it is to be a delusion and our judgments about what it is to be a delusion — the connection may be a contingent one.

Ultimately, the importance of investigating what kind of thing delusion is lies in determining if it constitutes an appropriate category for the purposes of scientific

inquiry, such as inductive generalization, empirical discovery, and mechanistic explanation. Toward that end, the essentialist demand that all and only members of a kind share intrinsic properties as a matter of metaphysical necessity may be overly restrictive, since many kinds that successfully figure in scientific practice, such as biological taxa, do not meet these conditions. Partly for this reason, the predominant opinion in philosophy of science is that such a *sortal* notion of essence should be replaced by a merely *causal* notion that entails only the existence of a set of empirically discoverable causal mechanisms that explains the covariation of the characteristics or symptoms co-instantiated by instances of a kind. Such a refined (if mitigated) essentialism is exemplified in Richard Boyd's (1991) *homeostatic property cluster* account, the most widely accepted model of natural kinds.

Settling the dispute about whether delusion constitutes a practical kind or a natural kind in the liberal sense will depend, then, on ascertaining through exploratory research whether delusion as a kind is individuated by a causal essence. A strong indication that this is the case would be for explanations of delusion to exhibit some kind of unity. So far, such unity remains a distant goal and the options are all still on the table, including the possibility that delusion as a generic kind picks out a merely practical distinction while some of its subtypes possess the individuative independence and causal unity required of natural kinds. However, even if the investigation of the neurobiological causes of delusion reveals that delusion as such is not nondisjunctively characterizable in the vocabulary of biological neuroscience, explanatory unity may be found at other levels of explanation. Causal explanations of delusion have mostly focused on computational processes at the cognitive level. Ultimately, however, given that many factors are implicated in delusion development, and the contribution of each in individual cases varies, seeking an explanation that *integrates* the various levels of description — from neurobiological to phenomenological — may turn out to be our best chance to arrive at a unified theory of delusion (Gerrans, 2014).

Conclusion

Through the preceding examination of foundational problems involved in determining the nature of delusion, I have tried to show some of the reasons why philosophers have been progressively disregarding disciplinary boundaries and contributing to the debates outlined above. Especially, I have made an effort to justify the engagement of philosophers with the clinical literature on delusion, and the collaboration between philosophers and psychiatrists, which ideally is a two-way street: while philosophers profit from psychiatry inasmuch as the clinical literature provides real-life, as opposed to merely imaginary, cases for

philosophy of mind to engage with, philosophers can contribute not only by clarifying concepts and working out the implications of empirical results, but also in building explanatory models of delusion and suggesting new avenues for empirical research (e.g. Davies et al., 2001; Gerrans, 2014). The best way for philosophers to contribute to the understanding of the relevant phenomena, I suggest, is for us to heed Louis Sass's (2004, p. 71) advice and resist the tendency to formulate issues and arguments in overly polarized terms and then to rely uncritically on these formulations in exploring the domain of inquiry, so as not to actually hinder our understanding of phenomena which are fraught with ambiguities and complexities that defy standard conceptualizations.

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Resumos

(A classificação, definição e ontologia do delírio)

Apesar de o delírio ser um dos conceitos centrais da psicopatologia, ainda escapa à conceptualização precisa. Neste artigo, apresento alguns problemas fundamentais a respeito da classificação e definição do delírio, bem como sobre seu estatuto ontológico. Por meio do exame desses problemas, tenho como objetivo

esclarecer a ambiguidade do termo clínico "delírio" e sua extensão, bem como fornecer pistas sobre o motivo de filósofos cada vez mais se juntarem a psiquiatras, psicólogos e neurocientistas na tarefa de chegar a uma compreensão global do delírio.

Palavras-chave: Delírio, nosologia, metafísica da psicopatologia, DSM-5

(Classification, définition et ontologie du délire)

Bien que le délire soit l'un des concepts centraux de la psychopathologie, il échappe encore à la conceptualisation précise. Dans cet article, je présente quelques problèmes fondamentaux concernant la classification et la définition du délire, ainsi que son statut ontologique. Par le biais de l'examen de ces problèmes, je cherche à faire la lumière sur l'ambiguïté du terme clinique « délire » et son ampleur, ainsi qu'à fournir des indices sur la raison pour laquelle les philosophes se joignent de plus en plus aux efforts des psychiatres, psychologues et chercheurs en neurosciences pour parvenir à une compréhension globale du délire.

Mots clés: Délire, nosologie, métaphysique de la psychopathologie, DSM-5

(La clasificación, definición y ontología del delirio)

Aunque el delirio sea uno de los conceptos centrales de la psicopatología, este aún se escapa de la conceptualización precisa. En este artículo, presento cuestiones fundamentales relacionadas a la clasificación y definición del delirio, así como también acerca de su estado ontológico. A través del examen de estas cuestiones, mi objetivo es dilucidar la ambigüedad del término clínico 'delirio' y su extensión, así como proporcionar pistas sobre por qué los filósofos se unen cada vez más a los psiquiatras, psicólogos y neurocientíficos en el esfuerzo por llegar a una comprensión global del delirio.

Palabras claves: Delirio, nosología, metafísica de la psicopatología, DSM-5

(Klassifizierung, Definition und Ontologie des Wahns)

Obwohl der Wahn eines der zentralen Konzepte der Psychopathologie ist, konnte ein genauer Begriff bisher nicht erstellt werden. In dieser Arbeit stellen wir grundlegende Probleme bezüglich der Klassifizierung und Definition des Wahns, sowie seinen ontologischen Status dar. Unsere Problemuntersuchung hat zum Ziel, die Mehrdeutigkeit des medizinischen Begriffs „Wahn" und seine Erweiterungen zu erläutern, sowie mögliche Antworten auf die Frage zu finden, warum Philosophen sich zunehmend Psychiatern, Psychologen und Neurowissenschaftlern anschließen, um ein umfassendes Verständnis des Wahns zu erlangen.

Stichwörter: Wahn, Nosologie, Metaphysik der Psychopathologie, DSM-5

（谵妄症的分类，定义及其存在）

虽然谵妄症是精神病症的主要概念，但是它的概念依然不是很清楚。本论文对谵妄症的分类和定义方面的一些基本问题进行探讨，并且分析了它的本体论的一些问题。通过调查分析这些问题，作者尝试澄清谵妄症这个临床术语的模糊性和它的外延，了解驱使精神分析学，心理学，神经科学，众多学科的学者联合起来，试图对谵妄症进行一个全面的理解的哲学背景。

关键词：谵妄症，疾病分类学，精神病理学的形而上学，DSM-5

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