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Conceptual Frameworks and Diagnostic Judgment: How Psychiatrists Decide What Counts as a Delusion

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ABSTRACT

Background: Diagnostic categories in psychiatry often derive from heterogeneous conceptual traditions. When applied to concrete cases, clinicians must resolve potential ambiguities between these frameworks in order to make practical diagnostic decisions. Delusion is a paradigmatic example, as it has been defined differently across phenomenological, operational (DSM-based), and epistemic–motivational approaches. Little is known about which conceptual criteria psychiatrists rely upon in everyday diagnostic reasoning and how these frameworks affect clinical judgment.

Method: We conducted semi-structured interviews with eight psychiatrists working in specialized psychosis services. Participants evaluated three standardized clinical vignettes designed to generate situations in which different definitional criteria for delusion could lead to different diagnostic interpretations. Interviews explored diagnostic judgments, confidence, perceived usefulness, anticipated inter-rater agreement, and ethical considerations. Data were analyzed using descriptive qualitative analysis.

Results: A consistent gradient emerged across cases. Clinicians expressed highest diagnostic confidence and clarity when the vignette supported criteria associated with phenomenological descriptions of delusion. Operational DSM-based criteria were often used as initial anchors but were regarded as provisional, dependent on contextual and longitudinal information. Situations compatible with epistemic–motivational interpretations generated the greatest diagnostic uncertainty, prompting requests for additional information and concerns about potential over-pathologization. Psychiatrists did not rely on competing definitions of delusion in an interchangeable way. Instead, their diagnostic judgments reflected a preference for conceptual criteria that reduced ambiguity and supported confident, communicable, and ethically prudent decisions in practice.

Conclusions: Examining how clinicians resolve conceptual differences in real cases provides a way to assess the practical validity of diagnostic definitions in psychiatry.

1 | Introduction

Diagnostic practice in psychiatry frequently requires clinicians to apply categories whose definitions originate in heterogeneous theoretical traditions. Although diagnostic manuals aim to standardize terminology, psychiatrists often face situations in which the criteria for applying a concept are not self-evident, requiring interpretive judgment in real clinical contexts. As a result, diagnostic decisions may depend not only on observable clinical features, but also on the implicit conceptual framework guiding the clinician's interpretation. Recent discussions on clinical judgment in psychiatry have emphasized that diagnostic reasoning cannot be reduced to the mechanical application of operational criteria, but instead involves the organization of ambiguous information, the formulation of provisional hypotheses, and the integration of

contextual and longitudinal considerations into clinical decision-making [1]. In this sense, psychiatric diagnosis depends not only on descriptive classification, but also on forms of clinical judgment that mediate between general diagnostic frameworks and individual cases.

The concepts and terms used in contemporary psychopathology have diverse origins and serve different functions depending on their historical and methodological contexts. In the nineteenth century, many emerged with a descriptive–clinical purpose, aimed at establishing a shared vocabulary for naming and classifying clinical manifestations [2]. Later, the phenomenological approach developed by Jaspers sought to understand these phenomena from the patient's subjective perspective [3]. With the rise of diagnostic operationalism in the second half of the twentieth century a more empirical and largely atheoretical strategy was adopted, privileging observable and replicable criteria, often at the expense of experiential meaning and conceptual coherence [4, 5].

Conceptual analysis has also been used to examine the validity, internal coherence, and practical function of psychopathological concepts [6, 7]. From the second half of the twentieth century onward, this approach has often adopted a revisionist role, critically assessing whether inherited concepts adequately capture the phenomena they are intended to describe and effectively serve clinical and scientific aims. Authors such as Wakefield [8], Cooper [9], and Fulford [10] have explicitly employed conceptual analysis to reassess foundational notions—most notably that of mental disorder itself—by examining their theoretical coherence, normative presuppositions, and practical consequences within diagnostic systems.

Psychopathology is situated at the intersection of empirical science, clinical judgment, and philosophical reflection [11]. As a result, central concepts often adopt different meanings depending on the theoretical framework in which they are used, generating terminological ambiguity and variability in clinical application [12]. The concept of delusion provides a particularly suitable example of this diagnostic difficulty, as it is defined differently across phenomenological, operational, and epistemic–motivational frameworks.

Jaspers' [3] classical formulation remains foundational, defining delusion in terms of absolute subjective certainty, resistance to counterargument or experiential correction, content that is impossible or extraordinary relative to shared reality, and, crucially, psychological non-understandability—understood as the impossibility of deriving the belief meaningfully from the person's situation. This last criterion distinguishes delusion from overvalued ideas or culturally shaped beliefs.

By contrast, the DSM relies on a descriptive and pragmatic logic. It defines delusions as false beliefs based on incorrect inference about external reality, held despite clear contradictory evidence and not shared by a relevant cultural group. Unlike Jaspers, the DSM-5 [13] does not require impossibility or phenomenological incomprehensibility; thus, false but plausible beliefs may qualify as delusional depending on context and clinical course. Within this framework, the specific content of the belief and the accompanying subjective experience are of secondary importance; what matters diagnostically is the persistence and resistance of the belief to evidence or reasoning, particularly for the purposes of reliability and operational consistency.

A third influential approach—the motivational or epistemic account of delusions [14]—emphasizes their negative epistemic features, such as lack of justification and resistance to counterargument [15], while proposing that some delusions may serve motivational or affective functions by helping individuals maintain coherence or manage psychological distress [16]. In these cases, delusions may be psychologically understandable.

The coexistence of these divergent definitions illustrates that delusion is not a single, stable concept but a polysemous construct whose meaning varies with theoretical assumptions, diagnostic conventions, and intended purposes. Although these definitions do not necessarily originate in clinical practice, they nonetheless shape clinical reasoning once incorporated into diagnostic frameworks. This plurality is not merely terminological: it influences how clinicians assess severity, determine treatment needs, and interpret patients' subjective reports [17]. To understand how clinicians resolve these conceptual divergences in practice, it is useful to examine how psychiatrists engage with concrete clinical cases using structured case comparisons, a method that has been employed to study conceptual judgments in applied contexts [18].

In this context, establishing the clinical validity of diagnostic concepts requires examining how they function in everyday psychiatric reasoning—how they guide judgments, support confidence, and shape decisions in real clinical encounters [19]. Accordingly, the present study examines how practicing psychiatrists evaluate three structured clinical vignettes—each designed to create situations in which different diagnostic criteria for delusion could plausibly be applied—focusing on their judgments about whether the reported beliefs should be diagnosed as delusional and on the perceived clinical and ethical implications of those judgments.

2 | Methods

We conducted a qualitative study using semi-structured interviews and clinical vignettes. The study design used structured case comparisons to examine how clinicians make diagnostic judgments when conceptual criteria may lead to different interpretations [18, 19].

2.1 | Participants

We recruited eight psychiatrists with clinical experience in psychosis, working in outpatient or inpatient psychiatric services at the Hospital del Salvador de Valparaíso, Chile. Participants were required to have at least 2 years of independent clinical practice after completing medical and psychiatric training. Interviews were conducted until informational saturation was reached, defined as the point at which no substantively new descriptive insights relevant to the study aims emerged. Saturation was observed after the seventh interview, and one additional interview was conducted to confirm the stability of the descriptive categories.

2.2 | Materials Clinical Vignettes

Three clinical vignettes were developed to represent:

1. *Carla*: A phenomenological description of delusion (impossibility and break with shared reality)
2. *Marta*: A DSM-based operational description (false, fixed belief not shared by a cultural group, without requiring impossibility)
3. *Tomás*: A motivational/epistemic definition (beliefs potentially understandable in terms of psychological needs or contextual meaning)

Each vignette presented a brief and neutral clinical description without diagnostic labels (see Supporting Appendix 1).

2.3 | Procedure

Participants completed a 60-min audio-recorded interview. For each vignette, they were asked:

- Whether the case should be classified as a delusion
- What clinical features supported their judgment
- How confident were they in the diagnostic decision
- Whether additional information would change their assessment
- Perceived ethical implications of applying the definition

2.4 | Qualitative Analysis

Data were analyzed following the principles of descriptive qualitative analysis, as outlined by Sandelowski [20]. This approach aims to produce clear, faithful, and well-organized descriptions of participants' perspectives, remaining as close as possible to their own words and to the manifest content of their accounts, while avoiding high-level theoretical interpretation.

All interviews were transcribed verbatim. The research team engaged in repeated readings of the transcripts to achieve familiarization with the data and to gain an overall understanding of clinicians' responses.During this phase, preliminary observations were noted, maintaining a descriptive stance focused on content rather than interpretation.

An initial low-inference descriptive coding was then conducted. Text segments were coded openly to capture clinicians' explicit judgments and reasoning regarding each vignette, particularly in relation to perceived conceptual clarity, clinical applicability, usefulness, inter-rater reliability, and ethical neutrality of the different definitions of delusion. Codes were intentionally kept simple and closely aligned with participants' language.

Next, related codes were grouped into descriptive categories reflecting recurrent patterns across interviews. These categories did not aim to generate abstract constructs or theoretical explanations, but to organize clinicians' reported criteria for identifying delusions, the difficulties encountered when applying each definition, and the perceived differences among phenomenological, DSM-based, and motivational/epistemic frameworks.

The resulting categories were then reviewed and refined to ensure internal coherence, clarity, and fidelity to the data. Discrepancies in coding or categorization were discussed among the investigators and resolved through re-examination of the transcripts, enhancing analytic rigor through investigator triangulation.

Preliminary descriptive findings were subsequently discussed in a focus group composed of four senior psychiatrists with clinical experience in psychosis who were not part of the original interview sample. The session lasted approximately 90 min and focused on the clarity, plausibility, and clinical relevance of the descriptive categories identified during analysis. Feedback from this discussion was incorporated only to refine category descriptions, clarify ambiguities, and enhance the descriptive coherence of the findings. The focus group did not function as an independent analytic dataset, nor was it used to generate new categories or establish interpretive consensus. Rather, this procedure was intended to strengthen descriptive credibility and analytic transparency while maintaining the descriptive orientation of the study.

Finally, a narrative descriptive synthesis was produced, summarizing clinicians' perceptions of how the three definitions of delusion function in real-world clinical reasoning. The synthesis aimed to accurately portray how participants understand and apply the concept of delusion in practice, maintaining minimal interpretation and prioritizing clarity, transparency, and proximity to clinicians' expressed reasoning.

3 | Results

Overall, respondents described clear differences among the three vignettes. Carla's vignette was most often judged to present a delusional belief, characterized by ideas considered implausible or absurd, firmly held, and resistant to correction. Marta's vignette elicited more variable judgments: several clinicians considered that the presentation could be delusional but emphasized the need for additional contextual information and longitudinal observation, whereas others indicated that it might not reach diagnostic threshold: “At first presentation, I would probably leave it as a working hypothesis rather than a definitive delusion” (CT). Tomás's vignette generated the greatest uncertainty, with frequent requests for collateral data and follow-up before assigning a diagnostic label. Illustrative comments included: “It is clearly a delusion” (UR); “It would be rather unusual, but it is not impossible that this could actually happen” (CS).

3.1 | Conceptual Clarity

Judgments regarding conceptual clarity varied across vignettes. Carla's case showed the highest level of agreement, with clinicians consistently identifying features such as irreducible

conviction, implausibility or bizarreness of content, and a rupture with shared reality. For Marta's vignette, clarity was intermediate and contingent upon contextual factors and functional impact. One clinician noted: "It could be a delusion, but I would need to understand better how this belief developed and how much it affects her functioning before being certain" (MP). Tomás's vignette showed the lowest clarity, with many clinicians noting that the belief could be psychologically understandable within a life history or interpersonal context. "In this case, it is difficult to determine where understandable suspiciousness ends and delusion begins" (AR).

3.2 | Clinical Usefulness

Perceived clinical usefulness also differed across cases. Carla's vignette was described as providing clear guidance for initiating treatment, typically involving pharmacological and psychosocial interventions. As one clinician stated, "This is the kind of case where you already have a fairly clear idea of how to proceed clinically" (CS). Marta's vignette was viewed as moderately useful, with decisions dependent on clinical course and additional information. One participant commented: "I would probably need to follow the case over time before feeling confident about the diagnosis" (MP). In Tomás's vignette, usefulness was considered limited at first presentation: approximately half of the clinicians regarded a delusional hypothesis as potentially useful if held provisionally, while others advised against applying that categorization at the initial assessment. Representative statements included: "Clearly to initiate pharmacological and psychosocial treatment" (CS) and "It could help if considered as something provisional" (UR).

3.3 | Etiological Considerations

Across vignettes, clinicians emphasized that etiological inference could not be established based on the vignette format alone. Nonetheless, Carla's vignette was more frequently associated with a primary psychotic process, particularly because of the perceived rupture with shared reality and the bizarreness of the belief content. One clinician stated: "This seems more compatible with a primary psychotic phenomenon than with a reaction understandable from the person's circumstances" (CS). In contrast, Tomás's vignette prompted more references to reactive or contextual explanations, including stress-related or personality-related factors. As one participant noted, "At times it gives the impression of being a reactive response" (CT). Marta's vignette elicited more mixed responses, with some clinicians favoring a primary psychotic explanation and others suggesting a potentially understandable response requiring longitudinal observation before drawing a definitive diagnostic conclusion.

3.4 | Expected Inter-Rater Agreement

Clinicians anticipated different levels of inter-rater agreement across vignettes. Carla's case was expected to yield high agreement, Marta's moderate agreement, and Tomás's lower agreement, reflecting greater diagnostic variability. These expectations were attributed to differences in the clarity of diagnostic thresholds across cases.

3.5 | Perceived Neutrality

Differences were also observed in perceived diagnostic neutrality. Carla's vignette was considered least vulnerable to subjective or value-laden interpretation. Marta's case raised some concern insofar as judgments depended on context and clinical course. Tomás's vignette generated the greatest caution, with several clinicians expressing concern about potential bias or over-interpretation, particularly in early clinical encounters. One participant noted: "In this case, there is a risk of being subjective or influenced by environmental factors" (UR). At the same time, some clinicians emphasized the importance of considering contextual meaning and the patient's perspective before drawing categorical conclusions.

3.6 | Cross-Domain Patterns

Across evaluated domains—conceptual clarity, clinical usefulness, expected inter-rater agreement, and perceived neutrality—a consistent gradient was observed. Carla's vignette showed the highest convergence across domains, Marta's intermediate convergence, and Tomás's the greatest dispersion of views. Although clinicians acknowledged that all three situations could potentially be considered delusional, judgments regarding clarity, usefulness, and confidence varied substantially depending on the vignette.

4 | Discussion

The present study examined how psychiatrists evaluate the clinical validity of three clinical situations in which different conceptual criteria for diagnosing delusion may come into play when applied to standardized clinical vignettes. Taken together, the findings reveal a consistent gradient across definitions in terms of perceived diagnostic clarity, clinical usefulness, inter-rater stability, and ethical safety. The phenomenological vignette elicited the highest level of diagnostic confidence and consensus, the DSM-based vignette showed intermediate and course-dependent validity, and the epistemic–motivational vignette generated the greatest diagnostic uncertainty. This pattern suggests that psychiatrists did not treat competing definitions of delusion as clinically interchangeable. Instead, different vignette structures appeared to orient clinicians toward different diagnostic thresholds and degrees of confidence.

Across interviews, clinicians' judgments recurrently referred to three features when diagnosing delusion: irreducible conviction, impossibility or bizarreness of content, and a rupture with shared reality. Crucially, however, it was the combination of a rupture with shared reality and psychological non-understandability that appeared to carry the greatest diagnostic weight, while the remaining features functioned primarily as supporting indicators. This pattern indicates that clinicians privilege criteria that provide clear thresholds for distinguishing pathological beliefs from understandable reactions to life circumstances. From this perspective, delusions are not defined merely by falsity or poor epistemic justification, but by their experiential quality and psychological non-understandability—that is, by the fact that they cannot be meaningfully derived from the individual's biography, affective state, or situational context. Several clinicians appeared

to rely on contextual and biographical plausibility when differentiating understandable reactions from delusional experiences. The prominence of these considerations in clinicians' judgments suggests that phenomenological concepts continue to play a central role in contemporary diagnostic reasoning, even in settings where operational criteria formally dominate [21].

The vignette based on DSM criteria illustrates this point clearly. Participants recognized that DSM definitions allow a belief to be classified as delusional even when its content is not impossible or bizarre, provided that it is false, firmly held, and resistant to counterargument. This pragmatic formulation was regarded as useful for structuring initial assessment and supporting diagnostic reliability. However, clinicians frequently treated such judgments as provisional, emphasizing the importance of functional impact and broader clinical context. This finding is consistent with previous discussions in psychiatry noting that contemporary diagnostic systems have primarily emphasized the standardization of assessment through operational criteria, often leaving broader processes of clinical judgment comparatively underexamined [1]. This helps explain why diagnostic agreement for the DSM-based vignette was intermediate rather than high, with the DSM definition commonly functioning as a working hypothesis rather than a definitive diagnostic anchor at first presentation.

By contrast, the epistemic–motivational vignette—broadly aligned with accounts that emphasize the psychological intelligibility and potential adaptive functions of some delusional beliefs—posed the greatest challenges for clinical decision-making. Although interviewees acknowledged that psychologically understandable beliefs may be delusional, many reported difficulties distinguishing such beliefs from non-pathological emotional reactions, stress-related responses, or interpersonal conflicts, particularly in early clinical encounters. This diagnostic ambiguity was repeatedly described as clinically problematic, as it undermines confidence in labeling and complicates decisions regarding treatment initiation.

Importantly, clinicians framed this uncertainty not only in epistemic terms but also in ethical ones. Several participants expressed concern that applying a delusional label to beliefs that remain psychologically understandable or contextually grounded risks over-pathologizing non-pathological experiences or imposing culturally normative judgments as markers of psychopathology. In this sense, broader definitions that relax the criterion of psychological non-understandability were perceived as introducing ethical vulnerability into the diagnostic process when applied without sufficient contextualization or longitudinal evidence.

In contrast, the phenomenological vignette was widely regarded as ethically safer. The clear rupture with shared reality and the implausibility of the belief content were seen as justifying diagnosis without intruding upon the patient's personal interpretive space or pathologizing plausible– but not common - beliefs. Clinicians noted that this clarity has direct clinical consequences, including greater confidence in treatment recommendations, clearer communication with patients and families, and a more judicious use of diagnostic authority. These considerations help explain why the phenomenological definition was associated with higher perceived inter-rater stability and clinical usefulness.

Taken together, these findings suggest that, in everyday clinical practice within specialized psychosis services, judgments about delusional diagnosis continue to rely primarily on the classical phenomenological definition. While DSM-based criteria are valued for their operational clarity and reliability, they are often applied provisionally and supplemented by phenomenological judgment and longitudinal observation. Definitions that emphasize psychological intelligibility and motivational function, although theoretically informative and potentially valuable for understanding patients' experiences, were not regarded as sufficient grounds for firm diagnostic decisions at initial presentation.

From a broader clinical perspective, these results illustrate how psychiatrists must pragmatically resolve conceptual ambiguities when making diagnostic decisions in real cases, despite the coexistence of multiple theoretical frameworks [1, 22, 23]. Recent discussions in philosophy of psychiatry and clinical decision-making have emphasized both the legitimacy of conceptual pluralism and the difficulty of capturing delusional phenomena through any single definition. The present findings suggest that clinicians navigate this plurality pragmatically, assigning different degrees of diagnostic legitimacy to different definitions according to their perceived clarity, action-guiding capacity [24], and ethical implications [25]. In this sense, diagnostic reasoning appeared to rely less on the direct application of fixed operational criteria than on provisional and revisable forms of clinical judgment adapted to the uncertainties of individual cases [1]. Conceptual divergence is therefore not merely an abstract theoretical issue, but one that directly shapes diagnostic reasoning, treatment decisions, and the moral stance adopted in clinical encounters.

In conclusion, this study demonstrates how structured case comparisons can be used to examine how psychiatrists operationalize core diagnostic concepts in real clinical situations. Although multiple theoretical definitions of delusion coexist in contemporary psychiatry [26], clinicians do not treat them as diagnostically equivalent in practice. Clinicians appeared to privilege definitions that provided clearer diagnostic thresholds and greater practical confidence in clinical decision-making. DSM-based definitions function as useful operational tools but often require longitudinal confirmation, whereas broader epistemic–motivational accounts were experienced as clinically and ethically more uncertain at initial presentation. These findings suggest that the practical validity of psychiatric concepts depends not only on definitional coherence, but also on how effectively they support clinical judgment under conditions of uncertainty. In this sense, the present findings are consistent with Feinstein's classical view of clinical judgment as a form of reasoning oriented toward practical decisions regarding prognosis and treatment [27].

5 | Limitations

As a qualitative study focused on clinicians' reasoning rather than diagnostic accuracy, the findings should be interpreted as

describing patterns of conceptual use in practice. Several limitations should be considered when interpreting these findings. The sample was small and drawn from a single specialized psychosis service, which is appropriate for an in-depth qualitative exploration but limits the scope of transferability to other clinical settings. In addition, all participants were psychiatrists practicing within the Chilean public mental health system. While this shared training and institutional context may have contributed to the coherence of the judgments observed, diagnostic reasoning may differ in other cultural, health-care, or legal contexts. The vignette-based design also necessarily abstracts from the complexity of clinical encounters; however, this format was chosen to allow controlled comparison of conceptual frameworks under standardized conditions. The use of written vignettes necessarily excludes non-verbal, affective, and interactional dimensions that may influence diagnostic judgments in actual practice. Future studies involving clinicians from diverse countries, professional backgrounds, and clinical settings would help clarify the extent to which the observed patterns generalize across contexts.

Ethics Statement

This study was reviewed and approved by the Ethics Committee of the Faculty of Medicine, Universidad de Valparaíso. The study involved psychiatrists as participants and did not include patient data or clinical records.

Consent

All participants provided written informed consent prior to participation. Interviews were anonymized, and no identifying information was recorded.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

De-identified qualitative data that support the findings of this study are available from the corresponding author upon reasonable request, subject to approval by the relevant ethics committee and institutional regulations regarding confidentiality and participant protection.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.
Supporting File: jep70513-sup-0001-vignettes.docx.