Construct validity or validity based on the construct?: Comments to Soler et al.☆

¿Validez de constructo o validez basada en el constructo?: comentarios a Soler et al.

Dear Editor,

Recently a paper was published that had the aim of validating a borderline personality disorder instrument[1] which gave excellent information on the measurement of this personality disorder. Nevertheless, a brief remark should be made about the concept of *construct validity* used by the authors of the paper, which leads to an interesting debate.

Validation is the process by which a measurement instrument is shown to be valid. Validity is classically therefore held to be ''that which measures what it aims to measure''.[2] However, things are not as simple as they sound. The concept of validity has changed significantly during history[3]: these changes started in the 1950s in disciplines close to the area of healthcare, and they were drawn up by technical committees who were designing regulatory manuals.[4] The area of healthcare is now included in this initiative, and there is a guide to selecting measuring instruments within this field.[5]

Validity is currently understood to consist of the degree to which evidence and theory make it possible to interpret the scores of a test that was created with a purpose,[6] and based on this definition five sources of evidence are postulated: validity based on the relationship with other variables, on response processes, on the consequences, and on internal content and structure.[6] The latter source of validity refers to the use of factorial analysis as the means of checking the amount of factors and whether an item pertains to a factor.

It is due to this reason that an instrument is not validated in itself, but rather that validation takes place of the interpretations arising from the instrument. Note that the paper in question talks of validation of the construct, when the correct thing would be to talk about validity based on the construct (in contemporary classification validity based on internal structure). Finally, this difference seems to be trivial and insignificant; nevertheless, it contains a modification in how the concept of validity is understood, a viewpoint that has recently arisen as a debate in the area of healthcare.[7]

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The comprehensive treatment of delusional disorder☆

El tratamiento integral del trastorno delirante

Dear Editor,

The ethical principles which govern medical practice, in this case psychiatry, underline the need for patients to be treated as comprehensively as possible, as is demanded by the principles of care, dignity, integrity and justice.[1] In spite of the fact that the prevalence of delusional disorder (DD) stands at 0.18% of the population[2] there are no clinical practice guides (CPG) for DD which guide its treatment, so that the information from the schizophrenia CPG is used instead. This may be due to the fact that its place in psychiatric hospital care has not been clearly defined to date, as it has varied between being considered a schizophrenia subtype,[3] an affective disorder[4] or a separate entity.[5] It is now defined in the CIE-10[6] as a psychosis involving persistent delirious ideas, although functioning is relatively well conserved, while there may also be a few other psychotic symptoms such as negative symptoms and

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minor hallucinations. Nevertheless, recent studies not only contribute to establishing this disorder as a differentiated entity,[7–11] as they also rule out the possibility that it is a monosymptomatic disorder[12] and emphasise the existence of different dimensions of the same, as well as its high comorbidity. Although the delirious symptom is not specific to DD, which therefore justifies its inclusion within the psychotic spectrum,[13] it has been shown to have certain specific qualities and characteristics which differentiate it from schizophrenia. Thus while DD would display fewer delirious ideas than is the case in schizophrenia, they would be more intense. There would also be certain qualitative differences respecting schizophrenia. The predominance of somatic or jealous delirious ideas would be intrinsic to DD in comparison with those profiles which predominantly display religious delirious ideas that would be characteristic of schizophrenia.[7] The other dimensions of DD underline not only the role of delirious ideas but also the relevant importance of affective symptoms, especially depression,[8,9,13] cognitive symptoms[9,13,14] or the risk of suicide as a comorbidity.[15] Likewise, poorer awareness of the disease has also been detected, or even a worse response to antipsychotic drugs than is the case in schizophrenia.[7] All of these factors mean that this disorder has its own peculiarities and profile which make it necessary treat it more widely than the delirious symptom alone or merely to extrapolate from data on schizophrenia treatments.

Pharmacological treatment is currently considered to be standard for the treatment of DD, and antipsychotic drugs are the cornerstone of this. A recent systemic review of descriptive studies which cover 385 DD patient cases treated using drugs[16] has shown these to be effective, as there is a $\geq$50% improvement over the basal situation in 33.6% of cases, while first generation antipsychotics (FGA) are superior to second generation ones (SGA) (FGA 39% vs SGA 28%; $\chi^2 = 5.2595$; $P \leq .02$; RR: 1.40; IC 95%: 1.04–1.88), while no specific individual antipsychotic is superior any other. More data are required on the latest antipsychotic drugs, given that the majority of the data on SGA refer to Risperidone or Olanzapine, while it would be of interest to determine the role of antipsychotic drugs which have an outstanding mood regulating function, as is the case for Quetiapine, or good tolerability such as Aripiprazol. Antidepressive drugs too may play a promising role in treatment, given the importance of the above-mentioned depressive dimension and other symptoms such as anxiety or irritability, as well as the good overall response to them which has been found. This is better than the response to antipsychotic drugs (response $\geq$50% in 50% of cases), although the sample size was small. They may be especially useful in the somatic subtype.[16] Patient lack of awareness of the disease and possible lack of adherence also suggest a role for prolonged liberation parenteral drugs as well as the possible role of psychoeducation and psychological therapies aimed at improving the capacity for introspection, awareness of the disease and adherence. Cognitive-behavioural therapy has also been shown to have a moderate effect in improving secondary variables such as the social self-esteem of these patients.[17] It would also be necessary to study the potential of treatments of this type or other psychological treatments such as metacognitive training on the cognitive traits underlying the delirious ideas which characterise DD, or cognitive repair[18] of the cognitive symptoms existing in the disorder. To conclude, we emphasise that given that the intrinsic profile of the disorder is becoming increasingly consolidated, studies and especially clinical trials or large-scale naturalistic studies are necessary to study the treatment of DD as a differentiated entity rather than a schizophrenia sub-group under the heading of ''other psychoses''.

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