Issues surrounding classification and diagnosis of schizophrenia

- Schizophrenia is cognitive and emotional disruption characterised by positive and negative symptoms, whereby factors such as delusions, hallucinations, disordered thinking, affective flattening, alogia (poverty of speech) and avolition (reduction of ability to persist in goal directed behaviour) persist over at least a month period.
- **Reliability** is the extent to which psychiatrists can agree on diagnoses when independently assessing individuals, so consistency of measuring instrument.
- DSM and ICD; different diagnostic criteria, ex. DSM 5 subtypes of sz, but ICD 7 types. Not consistent across world so cultural bias highlighting inconsistency of diagnosis.
- **Validity** extent a diagnosis represents something real and a classification system measures what it claims to measure issues.
- Sz is not understood enough to diagnose accurately. Stigmatisation consequences and mistreatment raising ethical concerns. Labelled as in remission and not as cured affecting employment and social interaction in future.
- No **conclusive physical cause**- Relying on patients ability to report symptoms which might not be accurately described (if schizophrenic not a full mind set). **Objective diagnosis**.
- **Subjective interpretation**- Individuals ability in diagnosis varying between health care professionals.

- Whaley- intrarater reliability between diagnosis as low as 0.11. Diagnosis rarely consistent. DSM tool unreliable.
- Rosenhan- reliability of diagnosis. Normal people presented to us hospitals as claiming to hear voices and all admitted and labelled schizophrenic. No staff noticed they were normal during stay so ethical issues. Follow up, said we are bad, pseudopatients for them to detect, none sent but 21% detection rate. Reductionist understanding of zS, lacking validity.
- Schneider- developed first rank symptoms distinguishing Sz from other disorders, belief was that it would make diagnosis more reliable and thus valid. But symptom overlap such as dep. And bid, Ellason and Ross showed that. Dissociative identity disorder actually have more symptoms of Sz than people diagnosed with it.
- **Comorbidity**- symptoms appear to fit with Sz, yet might be due to combination of illnesses that resemble. So diagnosis and treatment difficult and possibly invalid and ineffective.
- People diagnosed rarely share same symptoms, or same outcomes will occur ie. 20% recover from previous level of functioning, 10% significant and lasting improvement and 30% improvement with relapses (predictive validity)
- Reductionist tools as not fully understood as disorder varies between individuals (individual differences).
- Cause- still not known, so how can treat when don’t fully understand.
- **Cultural differences**- Copeland description given to US and British psychiatrists, 69% of US diagnosed with Sz, only 2% from Uk. Normality in one culture varies to the next.

US and UK both westernised.
- Religion focussed societies, such as hearing voices of god.