Classification/diagnosis of Schizophrenia

In most countries 1% of the population over 18 possibly have schizophrenia. DSM – signs must be present for at least 6 months whereby one month symptoms are constant. ICD- only 1 month. At least one or 2 under 2, should be present for at least 1 month.

1.) Thought echo, insertion, withdrawal or broadcast
   A.) Delusions of control
      B.) hallucinatory voices
      c.) Hallucinations that are impossible
   2.) Persistent hallucinations, half formed delusions.
   b.) neologisms break in train of thought
   c.) catatonic behaviour
   d.) negative symptoms

Crow- distinguish between positive (added) and negative (loss of) symptoms.

Develops early in adult life, men/women equal, for women 5-10 years later than men, hasn’t been explained. Episodic illness, symptoms occur after prodromal period of week of months change in mood/behaviour evident to people close to the sufferer, specific symptoms not yet appeared. Suffer low mood, difficult in social relationships, can’t concentrate in work/study. Active phase of disorder may last from 1-6 months can extend to a year.

Early psychologists believed schizophrenia was impossible to recover from. Longitudinal studies found 2/3 can recover from schizophrenia. Affected by biological, psychological factors. Depression can occur co-morbidly with schizophrenia, 10-15% Schizophrenic patients suffers commit suicide.

About 1/3 have an episode of schizophrenia and then recover, most likely to recover if schizophrenia occurs quickly rather than a long time for development.

Type 1 mostly positive symptoms, later onset greater chance of recovery, evidence it may involve biochemical abnormalities

Type 2 mostly negative symptoms, structural abnormalities.

Sub types have been devised to help diagnose schizophrenia however validity has been questioned. Later re-categorised when more symptoms develop. Only use in Britain if there is close similarity to the category. Valid classification system should be able to predict outcome and response to treatment. Difficult to predict either with accuracy, wide individual variation.

Sub-Types: According to DSM-IV-TR
Paranoid- Delusions, hallucinations
Catatonic- unusual motor activity, marked agitation, postural immobility, rare
Hebephrenic-begins early age, incoherent and illogical speech, flat and/or inappropriate behaviour.

Undifferentiated-Don’t fit in another category but clearly less symptoms of Schizophrenia, seen as early signs of later sub-types

Residual- last signs of schizophrenia expire, symptoms persist, no longer prohibiting, show prominent signs of disorder.

Issues with diagnosing and classification:
America more broader definitions in their classification system. 20% diagnosed in 1930’s 80% in 1950’s, In London it remained at 20%. attempts made to bring the diagnostic systems more in line with each other.

Several other diagnostic systems developed other than ICD & DSM, to help clinicians diagnose schizophrenia, can improve reliability. Farmer et al found high reliability when using PSE. Use different criteria make it difficult to conduct research studies, difficult to compare data on individuals who have been diagnosed using different criteria.

Szasz questioned concept of mental illness, suggested process of diagnosing is a form of sanctioned social control. Other

Other critics suggest it’s stigmatising to attach a ‘label’ to Schizophrenic patient’s. Scheff believed that if people are given a label then they will conform to that label, then becomes a self-fulfilling prophecy. Inadequate explanation it is true that the label sticks to the individual than the illness.

Often difficult to define the boundaries between disorders. Such as mood disorders can be helped by using drug induced psychosis, however it is difficult with mood disorders.

ICD and DSM tried to address system overlap by proposing mixed disorder categories but the validity of categories has been questioned.

Co-morbidity- suffers two or more disorders, Schizophrenic patients often show signs of this, sim et al 142 Schizophrenic patients 32% had additional mental disorder. Symptoms overlap, creates problems of reliability.

Evidence to use continuity approach rather than the categorical approach. Tested by using questionnaires that refer to +/- symptoms of SZ, some on schizotypy, Chapman-normal individuals, high scores, likely to develop psychosis. Findings support continuity hypothesis. Blurred boundaries between the two diagnosis reduces the reliability with which Schizophrenia is diagnosed.

Rosenhan: challenged suffers can be diagnosed with high reliability/validity. 8 individuals tried gaining admission to 12 psychiatric hospitals, complained of hearing voices, “empty”, “hollow” only symptom they reported, 7 were admitted and diagnosed. After the