**Discuss issues associated with the classification and/or diagnosis of schizophrenia. (8 + 16 marks)**

One issue surrounding the classification and diagnosis of schizophrenia is that inter-rater reliability is poor. For example, Beck et al (1962) found that agreement on a diagnosis of SZ between two psychiatrists was only 54%. This was blamed on the ‘vague’ criteria used for diagnosis. This is an issue because it suggests that diagnosis is subjective, which could lead to the same patient receiving different diagnoses from different doctors. This could lead to in appropriate treatments being given.

However, it should be noted that the two psychiatrists in the Beck study interviewed the patients separately, so they may have received different information on each occasion, which could explain their lack of agreement. It should also be noted that this research is now 50 years old, meaning that classification systems have been revised several times since, which should have improved the inter-rater reliability of diagnosis.

Rosenhan’s classic study brought into question the ability of psychiatrists to diagnose schizophrenia. He found that, of 8 pseudo patients who presented to hospital saying they could hear single words like ‘thud’, all were admitted to hospital (7 with a diagnosis of schizophrenia, 1 with a mood disorder). This was despite the fact that none of them were suffering from any mental disorders. This is worrying because it means that people who are not mentally ill could be labelled as schizophrenic. Even if this diagnosis is later revised, the stigma may still remain. For example, they may have to declare their past ‘illness’ on job interviews, et In the second part of Rosehnan’s study, a teaching and research hospital challenged him to send more pseudo patients, saying that they would be able to recognise them. During a three month period, the hospital staff identified approximately 10% of their regular intake as being pseudo patients. However, Rosenhan revealed that he had sent no new patients, demonstrating that the doctors could not reliably identify those who were not schizophrenic. This is an issue because it means that some people who are schizophrenic may be refused treatment because the doctors do not recognise their condition. This could mean that their condition worsens and they become a danger to themselves or others. Although it is rare for people with schizophrenia to be violent, this could occur if delusions /hallucinations are left untreated. The risk of suicide may also increase. However, the classification system in use at the time this study was carried out (1973) was the DSM 2, whereas the current system is DSM 4 (the 5th edition is due to be published next year). Over time, the systems have been improved in light of experience, which should mean that Rosenhan’s results would not be replicated today.

A further issue is that there are two different diagnostic manuals that can be used to diagnose schizophrenia. The DSM is widely used in the UK and America, whereas the ICD is commonly used in the rest of Europe. There are several differences between the systems which could mean that a patient in the UK receives a different diagnosis to those in the US, even when their symptoms are exactly the same. For example, the DSM uses a multi axial system, meaning that it takes other factors, such as social and occupational functioning, into account when making a diagnosis. It also requires continuous signs of disturbance to be present for a continuous period of at least 6 months (including one month of characteristic symptoms), whereas the ICD only requires one month of symptoms for a diagnosis of schizophrenia to be made. There are several potential issues with this. Firstly, a patient may be misdiagnosed using the ICD because one month of schizophrenia like symptoms could be due to a short term stressor in their life, such as the death of a family member. However, there could also be a problem with using the DSM, in that a patient with severe schizophrenic symptoms may not receive prompt and appropriate treatment if they do not meet the criteria of having suffered with at least six months of previous signs of disturbance.

Another issue is that classifications systems use subtypes as a way to group certain symptoms together. For example, a patient with paranoid delusions may be classified as a ‘paranoid type’ schizophrenic. The addition of subtypes was originally intended to improve the validity and reliability of diagnosis, with the aim of developing specific treatments for different subtypes. However, subtypes will be removed from DSM 5 because they have not been found to predict the outcome of the disorder or allow doctors to predict the response to treatment (poor predictive validity).

Finally, Thomas Szasz suggested that there is no such thing as schizophrenia, and therefore it cannot, and should not, be classified and diagnosed. He argued that labelling people as mentally ill can be used as a form of ‘social control’, in which certain sections of society which are seen as damaging or undesirable by the ruling classes (e.g. unwed mothers in the 1960s) are given the label of ‘mad’ in an attempt to remove them from mainstream society. However, it could be argued that it is necessary to classify mental illness to prevent the individual suffering and to protect wider society from those who could potentially be harmful.

**Examiner comment**

**A01 = 8** A wide range of issues are identified and explained.

**A02= 13** Line of argument is a little unclear, and some ideas are not as developed as they could be.