12.4 Classification and Diagnosis of Schizophrenia

AQA 7182 · about 55 minutes · Write-in edition

Total Marks

Name: _____ Date: ____ / ____ / _____

Answer ALL questions.

1 Outline two negative symptoms of schizophrenia with brief presentation.

(Total for Question 1 is 2 marks)

2 Outline two limitations of diagnostic criteria across cultures and explain why each matters.

(Total for Question 2 is 4 marks)

3 Explain a DSM-5 versus ICD-10 difference and a practical implication.

(Total for Question 3 is 3 marks)

4 Outline inter-rater reliability and one way to improve it.

(Total for Question 4 is 3 marks)

5 Outline symptom overlap and give an example and consequence.

(Total for Question 5 is 4 marks)

6 Outline one argument supporting and one challenging the claim that higher reliability may reduce validity.

(Total for Question 6 is 4 marks)

7 Discuss the reliability and validity of diagnosis and classification of schizophrenia.

(Total for Question 7 is 16 marks)

8 Explain, using the case study, features supporting schizophrenia diagnosis and features suggesting alternative or comorbid diagnosis.

(Total for Question 8 is 6 marks)

Mark scheme · 12.4 Classification and Diagnosis of Schizophrenia

Question 1

names one negative symptom with a brief description, e.g. speech poverty/alogia, reduced quantity or content of speech oe — **B1**

names a second negative symptom with a brief description, e.g. avolition, lack of motivation and reduced initiation of goal-directed activity oe — **B1**

Answer: Examples: Speech poverty (alogia), reduced amount or content of speech; and avolition, diminished motivation and reduced initiation of tasks or social activities.

Question 2

identifies a limitation: cultural interpretation of symptoms can differ, e.g. voice hearing may be normal in some cultures oe — **M1**

explains why it matters: risk of false positive diagnosis and inappropriate treatment or stigma oe — **A1**

identifies a second limitation: diagnostic criteria are developed largely from Western samples and may not capture culturally specific presentations oe — **M1**

explains why it matters: clinicians may under-diagnose or miss presentations common in non-Western groups, affecting access to services and research generalisability oe — **A1**

Answer: Limitations: cultural differences in interpreting experiences like hearing voices can lead to false positives if clinicians do not account for cultural meaning; this matters because it can result in unnecessary treatment and stigma. Also, DSM and ICD criteria are largely based on Western samples and may miss culturally specific presentations, leading to under-diagnosis and unequal access to care.

Question 3

states a correct difference, e.g. DSM-5 tends to emphasise presence of core positive symptoms and specific symptom criteria, whereas ICD-10 allows diagnosis from a broader combination of symptoms including negative symptoms oe — **M1**

provides a supporting detail about the difference, e.g. DSM-5 requires at least one of the core symptoms such as delusions, hallucinations or disorganised speech in many cases, whereas ICD-10 can be satisfied by characteristic symptom combinations oe — **A1**

explains a practical implication, e.g. different systems may lead to different diagnostic rates and clinicians must be aware that a patient may meet criteria on one system but not the other, affecting eligibility for services or research inclusion oe — **A1**

Answer: DSM-5 emphasises specific core positive symptoms and tighter criteria, while ICD-10 can allow diagnosis from a broader mix of symptoms including prominent negative features. Practically, this can produce different diagnostic rates so clinicians need to be aware which system is used for clinical records and service eligibility.

Question 4

explains inter-rater reliability: the extent to which different clinicians independently agree on the same diagnosis for the same patient oe — **M1**

gives a practical method to improve reliability, e.g. using structured diagnostic interviews such as SCID or using standardised training in DSM or ICD criteria oe — **A1**

explains why this helps, e.g. standardisation reduces subjective judgement and increases consistent interpretation of symptoms across raters oe — **A1**

Answer: Inter-rater reliability is how consistently different clinicians make the same diagnosis. It can be improved by using standardised diagnostic interviews and training in DSM or ICD criteria, because these reduce subjective variation in interpreting symptoms.

Question 5

defines symptom overlap: when symptoms of schizophrenia are similar to symptoms of another mental disorder, making it hard to tell which disorder is present oe — **M1**

gives an example, e.g. bipolar disorder can include psychotic features such as delusions and hallucinations during mood episodes, overlapping with schizophrenia symptoms oe — **A1**

explains how overlap complicates diagnosis, e.g. clinicians must determine whether psychotic symptoms occur only during mood episodes or persist independently, which affects the correct diagnosis and treatment path oe — **A1**

may mention the need for longitudinal assessment or collateral history to resolve overlap oe — **A1**

Answer: Symptom overlap occurs when schizophrenia symptoms resemble those of another disorder, for example bipolar disorder with psychotic episodes can produce delusions or hallucinations. Overlap complicates diagnosis because clinicians must assess whether psychotic symptoms are limited to mood episodes or persist independently, often requiring longitudinal information.

Question 6

supports claim: states that strict training and structured criteria can lead to focus on checklist symptoms and ignore contextual or cultural nuances oe — **M1**

justifies support: this may miss individual variation and lived experience, reducing construct validity of the diagnosis oe — **A1**

challenges claim: states that improved reliability can increase validity by ensuring consistent identification of core symptoms across clinicians oe — **M1**

justifies challenge: consistent assessment allows comparison across settings and better research into true markers of the disorder, potentially improving diagnostic validity over time oe — **A1**

Answer: Support: overemphasis on agreement and checklists can miss contextual, cultural or individual features, harming construct validity. Challenge: greater consistency across clinicians can enhance validity by enabling reliable identification of core features and clearer research, improving the diagnostic construct in the long term.

Question 7

Level 4 Knowledge of issues about reliability and validity is accurate and detailed. Discussion is thorough, well balanced and evaluative, showing a range of evidence and implications used interactively. Addresses inter-rater reliability, symptom overlap, co-morbidity, culture and gender bias and practical consequences for diagnosis. Offers justified suggestions for improvement and reaches a reasoned conclusion. Specialist vocabulary used appropriately and answer is coherent.	**13-16**
Level 3 Knowledge of reliability and validity is clear with reasonable detail. Discussion includes evaluation of several relevant issues and some use of evidence. Practical implications are considered and some suggestions for improvement offered. The answer is mostly well organised and focused with appropriate terminology.	**9-12**
Level 2 Knowledge of reliability and validity is present but limited. Discussion is descriptive or unbalanced with few evaluative points. Issues such as culture or co-morbidity may be mentioned but not fully developed. Little or no consideration of improvements. Organisation may be uneven.	**5-8**
Level 1 Very limited knowledge or relevance. Answer may consist of brief, unsupported points or a list. Little or no attempt at evaluation or synthesis. Specialist terms used incorrectly or not at all.	**1-4**
Level 0 No creditable content.	**0**

Indicative content:

- AO1 definitions: Reliability in diagnosis means the consistency of diagnostic decisions, for example inter-rater reliability, and test-retest reliability. Validity means that the diagnosis accurately identifies a distinct disorder with predictive, concurrent and construct validity.
- AO1 evidence: Early field trials showed improved inter-rater reliability when DSM-III style operational criteria were introduced, but later work still finds only moderate agreement for schizophrenia in routine clinical practice.
- AO3 evaluation: High inter-rater reliability can be improved by structured interviews and training, but may risk checklist application that misses contextual detail, creating a potential tension between reliability and validity.
- AO3 symptom overlap: Psychotic symptoms occur in bipolar disorder, schizoaffective disorder and severe depression, creating difficulties for differential diagnosis and reducing diagnostic validity unless longitudinal information is obtained.
- AO3 co-morbidity: High rates of co-morbid substance misuse and depression complicate attribution of symptoms and may inflate or obscure a schizophrenia diagnosis; this has practical consequences for treatment planning.
- AO3 culture bias: Diagnostic criteria developed in Western contexts may misinterpret culturally sanctioned experiences as psychosis, producing false positives in minority groups. Cross-cultural research shows variation in presentation and outcomes.
- AO3 gender bias: Differences in age of onset and recorded prevalence may reflect real epidemiology or diagnostic bias; potential bias affects access to services and our understanding of the disorder.
- AO3 practical implications: Misdiagnosis can lead to inappropriate treatment, stigma and resource allocation errors. Reliable diagnosis matters for research, prognosis and service planning.
- AO3 improvements: Use of standardised interviews, training, multi-source collateral history, longitudinal assessment, cultural competence training and flexible criteria that explicitly consider cultural context are ways to improve validity while retaining acceptable reliability.
- AO3 conclusion: Weighing the evidence, current classification improves reliability compared with earlier eras but significant validity concerns remain, especially around overlap, co-morbidity and cultural factors. Balanced approaches that combine standardisation with contextual assessment offer the best route forward.

Question 8

identifies features supporting schizophrenia, e.g. auditory hallucinations (voice commenting) and negative symptoms such as speech reduction and avolition, persisting for six months oe	**M1**
explains why these support schizophrenia under diagnostic systems, e.g. presence of hallucinations and negative symptoms meet core symptom criteria and duration raises concern for chronic psychosis oe	**A1**
identifies features suggesting alternative or comorbid diagnosis, e.g. mood symptoms with episodes of high energy and low sleep suggest possible bipolar disorder with psychotic features or schizoaffective disorder, and current low mood might indicate comorbid depression oe	**M1**
explains diagnostic implication, e.g. psychotic symptoms limited to mood episodes would point to bipolar disorder rather than schizophrenia, so clinicians must establish timing of psychosis relative to mood episodes oe	**A1**
identifies diagnostic complication such as co-morbidity or symptom overlap, e.g. overlapping mood and psychotic symptoms and the need for longitudinal history or collateral information oe	**M1**
explains a practical step, e.g. need for detailed timeline, informant history and perhaps repeated assessments to distinguish schizophrenia from bipolar disorder or schizoaffective disorder and to address culture or gender bias if relevant oe	**A1**

Answer: Support for schizophrenia: Erin reports auditory hallucinations and negative symptoms (reduced speech and motivation) persisting six months, which align with core criteria. However, periods of high energy and reduced need for sleep suggest possible bipolar disorder with psychotic features or schizoaffective disorder, and current low mood could indicate comorbid depression. Because psychotic symptoms can occur during mood episodes, clinicians must determine the timing of hallucinations relative to mood states, use collateral history and possibly longitudinal assessment to make a differential diagnosis or identify co-morbidity.