PSY.OPT9 Classification and Diagnosis of Schizophrenia

Total Marks

AQA 7182 · Calculators not allowed · about 80 minutes

Name: _____ Date: ____ / ____ / _____

Answer ALL questions. Show all your working.

1 Outline two positive symptoms of schizophrenia used in clinical classification and diagnosis, naming and briefly describing each symptom in the context of a clinical interview.

Outline two positive symptoms of schizophrenia with brief descriptions.

(Total for Question 1 is 2 marks)

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2 Outline two negative symptoms of schizophrenia relevant to diagnosis and briefly describe how each might present during a clinical assessment.

Outline two negative symptoms of schizophrenia with brief presentation.

(Total for Question 2 is 2 marks)

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3 Explain one main difference between the DSM-5 and the ICD-10 classification systems in how they approach diagnosing schizophrenia, and give one practical implication of that difference for clinicians.

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

(Total for Question 3 is 3 marks)

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4 Outline what is meant by inter-rater reliability in the diagnosis of schizophrenia and give one practical method clinicians use to improve inter-rater reliability in routine assessments.

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

(Total for Question 4 is 3 marks)

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5 Explain what is meant by co-morbidity in the context of diagnosing schizophrenia and give one example of a disorder commonly co-morbid with schizophrenia, with a brief reason why co-morbidity complicates diagnosis.

Explain co-morbidity, give an example and a brief consequence for diagnosis.

(Total for Question 5 is 2 marks)

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6 Outline what is meant by culture bias in the diagnosis of schizophrenia and give one example of how cultural differences might lead to misdiagnosis in a clinical setting.

Outline culture bias in diagnosis and give an example.

(Total for Question 6 is 2 marks)

7 Explain briefly what is meant by gender bias in schizophrenia diagnosis and give one piece of evidence or an observation that supports the idea there may be gender differences in how schizophrenia is identified or recorded.

Explain gender bias in diagnosis and provide supporting observation.

(Total for Question 7 is 3 marks)

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8 Outline what is meant by symptom overlap and give one example of another mental disorder whose symptoms overlap with schizophrenia, explaining briefly how overlap complicates differential diagnosis in routine clinical practice.

Outline symptom overlap and give an example and consequence.

(Total for Question 8 is 4 marks)

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9 Case vignette: A 28-year-old woman, Erin, attends an outpatient psychiatric assessment. Her partner reports that for six months Erin has been talking less, stopped attending her art class and often not getting out of bed. When asked about hearing voices Erin says she sometimes hears a voice commenting on what she is doing, but she insists the voice is not telling her to harm herself. Erin reports low mood for part of the time but also describes brief periods over the past year when she felt unusually energetic and slept less, during which she had very optimistic plans that did not last. Explain, using the case study, which features support a diagnosis of schizophrenia and which features suggest an alternative or comorbid diagnosis. Refer to classification and diagnostic issues in your answer.

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

(Total for Question 9 is 6 marks)

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10 Outline two limitations of using DSM-5 or ICD-10 diagnostic criteria for schizophrenia when applied across different cultures, and for each limitation give a brief reason why it matters for clinical practice.

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

(Total for Question 10 is 4 marks)

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11 Identify and briefly explain two methods researchers or services use to try to improve the validity of schizophrenia diagnosis in clinical practice.

Identify and explain two methods to improve validity of diagnosis.

(Total for Question 11 is 4 marks)

12 A clinician argues that high inter-rater reliability in diagnosing schizophrenia is achieved at the cost of validity, because training clinicians to agree can encourage rote application of criteria without capturing the lived experience. Outline one argument that supports this claim and one argument that challenges it, each with a brief justification.

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

(Total for Question 12 is 4 marks)

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13 Discuss the reliability and validity of diagnosis and classification of schizophrenia. In your answer, define reliability and validity in this context, evaluate evidence and practical issues such as inter-rater reliability, symptom overlap, co-morbidity, culture and gender bias, and implications for clinical practice. You should include reasoned judgements and, where appropriate, suggest ways classification and diagnosis might be improved.

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

(Total for Question 13 is 16 marks)

Mark scheme · PSY.OPT9 Classification and Diagnosis of Schizophrenia

Question 1

- **B1** names one positive symptom and gives a brief description, e.g. hallucinations, perceptual experiences without external stimulus, often auditory voices oe
- **B1** names a second positive symptom and gives a brief description, e.g. delusions, firmly held false beliefs not shared by culture, such as paranoid delusions oe
- **Answer: Examples: Hallucinations, perceiving sights or sounds that are not present, often hearing voices. Delusions, strongly held false beliefs such as paranoid beliefs that others intend harm.**

Question 2

- **B1** 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
- **Answer: Examples: Speech poverty (alogia), reduced amount or content of speech; and avolition, diminished motivation and reduced initiation of tasks or social activities.**

Question 3

- **M1** 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
- **A1** 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
- **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

- **M1** explains inter-rater reliability: the extent to which different clinicians independently agree on the same diagnosis for the same patient oe
- **A1** 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
- **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

- **M1** defines co-morbidity: the presence of one or more additional disorders occurring alongside the diagnosis of schizophrenia in the same individual oe
- **A1** gives an example and consequence, e.g. substance misuse or depression commonly co-occur and this can mask or mimic schizophrenia symptoms, making diagnostic decisions harder oe
- **Answer: Co-morbidity is when another mental disorder occurs alongside schizophrenia, for example substance misuse or major depression. Co-morbidity complicates diagnosis because symptoms may overlap or one disorder may mask the other.**

Question 6

- **M1** defines culture bias: diagnostic criteria and clinicians' interpretations may reflect the norms of one culture, disadvantaging patients from other cultural backgrounds oe
- **A1** gives an example, e.g. hearing voices or spiritual experiences may be interpreted as psychosis in one culture but regarded as culturally normal in another, leading to misdiagnosis oe
- **Answer: Culture bias is when diagnostic norms reflect one culture and lead clinicians to misinterpret culturally normal beliefs or experiences as symptoms. For example, spirit possession or culturally sanctioned voices may be treated as psychotic symptoms by clinicians unfamiliar with that culture.**

Question 7

- **M1** explains gender bias: clinicians may over- or under-diagnose schizophrenia in one gender due to stereotypes or gendered presentation of symptoms oe
- **A1** gives an observation or evidence, e.g. men are more often diagnosed at younger ages and show higher recorded rates of schizophrenia in some datasets, which may reflect bias or true epidemiological differences oe
- **A1** briefly explains why this matters, e.g. different diagnostic thresholds by gender could affect treatment access and stigma oe
- **Answer: Gender bias is when diagnostic practice treats men and women differently, for example men are often diagnosed younger and have higher recorded rates in some studies. This could reflect bias in recognition or real differences in onset, and it matters because it affects access to care and the understanding of the disorder.**

Question 8

- **M1** 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
- **A1** 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
- **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 9

- **M1** identifies features supporting schizophrenia, e.g. auditory hallucinations (voice commenting) and negative symptoms such as speech reduction and avolition, persisting for six months oe
- **A1** 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
- **M1** 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
- **A1** 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
- **M1** 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
- **A1** 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
- **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.**

Question 10

- **M1** identifies a limitation: cultural interpretation of symptoms can differ, e.g. voice hearing may be normal in some cultures oe
- **A1** explains why it matters: risk of false positive diagnosis and inappropriate treatment or stigma oe
- **M1** identifies a second limitation: diagnostic criteria are developed largely from Western samples and may not capture culturally specific presentations oe
- **A1** explains why it matters: clinicians may under-diagnose or miss presentations common in non-Western groups, affecting access to services and research generalisability oe
- **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 11

- **M1** identifies one method, e.g. using structured clinical interviews and standardised assessment tools (SCID, PANSS) oe
- **A1** explains how this improves validity, e.g. provides systematic symptom assessment and reduces reliance on unstructured judgement oe
- **M1** identifies a second method, e.g. obtaining longitudinal information and collateral history from family or services oe
- **A1** explains how this improves validity, e.g. establishing symptom duration and relation to mood episodes helps distinguish schizophrenia from mood disorders with psychosis oe
- **Answer: Examples: use of structured interviews and standardised rating scales to ensure systematic assessment of symptoms, and gathering longitudinal and collateral history to confirm symptom timing and duration. Both reduce misclassification and improve diagnostic validity.**

Question 12

- **M1** supports claim: states that strict training and structured criteria can lead to focus on checklist symptoms and ignore contextual or cultural nuances oe
- **A1** justifies support: this may miss individual variation and lived experience, reducing construct validity of the diagnosis oe
- **M1** challenges claim: states that improved reliability can increase validity by ensuring consistent identification of core symptoms across clinicians oe
- **A1** justifies challenge: consistent assessment allows comparison across settings and better research into true markers of the disorder, potentially improving diagnostic validity over time oe
- **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 13

- **Level 4** (13-16): 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.
- **Level 3** (9-12): 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.
- **Level 2** (5-8): 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.
- **Level 1** (1-4): 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.
- **Level 0** (0): No creditable content.
- **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.