Discuss the reliability and validity of the diagnosis of Schizophrenia (16)

One issue related to the classification and diagnosis of schizophrenia is reliability. This refers to the consistency of a measuring instrument, such as the DSM or ICD that is used when classifying and diagnosing schizophrenia. Reliability can either be measured in terms of inter-rater reliability, which is the extent to which two or more independent assessors give a similar diagnosis, or in terms of test-retest reliability which is the extent to which the tests used to deliver these diagnoses are consistent over time. Although it has been claimed that the DSM and ICD 10 are reliable, evidence shows that the reliability is low when assessed by inter-rater reliability. For example Elie Cheniaux (2009) found in the same 100 patients psychiatrist one diagnoses 26 using the DSM compared to 13 patients diagnosed by psychiatrist two. It was similar for the OCD with 44 (psychiatrist one) and 24 (psychiatrist 2). This is evidence for poor reliability of both systems and is a weakness of the diagnosis of Schizophrenia. However evidence suggests that the DSM is actually a more reliable system with Soderberg (2005) finding an 80% concordance compared to 60% for the ICD which shows a difference in the reliability of the systems. It is suggested that as the DSM has much more specific outline for their symptoms and that this accounts for the increased reliability. This is supported by evidence that shows that the reliability of both systems has improved as the systems are updated and made more specific and focused.

Another issue concerning both classification and diagnosis of schizophrenia is validity. Validity is the extent to which we are measuring what we are intending to measure; in the case of schizophrenia it concerns how accurate the diagnosis is. One standard way to assess validity of diagnosis is **criterion validity**; do different assessment systems arrive at the same diagnosis for the same patient? Looking at the results from the Cheniaux et al. study previously mentioned we can see that schizophrenia is much more likely to be diagnosed using ICD than DSM. This suggests that schizophrenia is either over-diagnosed in ICD or under diagnosed in DSM. Either way, this is poor validity- a weakness of diagnosis.

Validity can also be assessed using predictive validity- if diagnosis leads to successful treatment, then diagnosis is seen as valid. Mason et al. (1997) tested the ability of 4 different classification systems of diagnosis to predict the outcome of the disorder (over a 13 year period) in 99 schizophrenic patients. They found more modern classification systems had high predictive validity, especially if only symptoms that lasted at least 6 months were considered. This suggests that predictive diagnosis has improved over time, as classification systems have been updated.

However, the predictive validity of diagnosis can be argued to be low because there is too much variety in the outcomes of schizophrenia. For example, Birchwood & Jackson (2001) argue that 20% of schizophrenics recover and never have another episode, but 10% are so affected they commit suicide. These differences in symptoms and outcome make it very difficult to establish the validity of the diagnosis systems.

Another issue with the reliability and validity of the diagnosis of Schizophrenia is co morbidity, which is the extent to which two or more conditions, such as schizophrenia and depression, occur in the same patient at the same time. This makes it difficult to diagnose schizophrenia as a valid, real and distinct mental illness, and thus decide on appropriate treatment. Therefore, the poor levels of functioning found in many schizophrenics may be less the result of their psychiatric disorder and more to do with their untreated co morbid physical disorders. A study by Buckley concluded that half of the patients with a diagnosis of schizophrenia also have a diagnosis of depression. In terms of classification it maybe that severe depression looks a lot like Schizophrenia and vice versa which raises the issues of descriptive validity, as having simultaneous disorders suggests that schizophrenia may not actually be a separate disorder. Also the fact that 47% are also substance abusers makes reliable and valid diagnosis difficult to achieve and therefore leads to increased hospitalisation, lower compliance with medication and effective treatment also difficult to achieve.

Culture bias is another issue and concerns the tendency to over-diagnose members of other cultures as suffering from schizophrenia. In Britain, for example people of Afro-Caribbean descent are much more likely than white people to be diagnosed as schizophrenia. They are also more likely to be confined in secure hospitals than white schizophrenics, with the accusation being that most British psychiatrists are white and thus more likely to perceive black schizophrenics as more ‘dangerous’ than white schizophrenics.

Research by Cochrane (1977) reported the incidence of schizophrenia in the West Indies and Britain to be similar, at around 1%, but that people of Afro-Caribbean origin are 7 times more likely to be diagnosed with schizophrenia when living in Britain. Considering the incidence in both cultures is very similar this suggests that higher diagnosis rates are not due to a genetic vulnerability, but instead may be due to a cultural bias. This suggests a lack of validity in diagnosing schizophrenia cross-culturally and one suggestion why this may be is ethnic differences in symptom expression are overlooked or misinterpreted by practitioners.

All of the issues discussed suggest that even though classification systems have improved in terms of their reliability and validity that they still aren’t perfect and that issues such a culture and co-morbidity mean that some sufferers will continue to be misdiagnosed and so the systems need to continue to change and become more specific and exact to improve validity and that clinicians need to continue to be trained and tested to improve reliability.