

# Selecting a Diagnosis

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## Selecting a Diagnosis: The Clinical Case of Schizophrenia

**Primary Disciplinary Field(s):** Clinical Psychology; Psychiatry; Abnormal Psychology

### 1. Core Definition and Diagnostic Criteria (DSM-5)

The process of **selecting a diagnosis** involves careful clinical assessment and the systematic application of established criteria, most notably those outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). For complex conditions such as Schizophrenia, the diagnosis is made based on the presentation of specific symptomatic clusters. Schizophrenia is primarily characterized by both **positive symptoms** and **negative symptoms** (Rigby & Alexander, 2008). Positive symptoms represent an excess or distortion of normal functions, typically involving psychotic experiences, while negative symptoms reflect a deficit in typical cognitive or emotional processes, often resembling depression-like symptoms.

**Psychosis** is the most widely recognized characteristic of Schizophrenia (Owen, Sawa, & Mortensen, 2016). The positive symptoms associated with this psychotic state include **delusions**, **hallucinations**, and **disorganized thinking**. Delusions, which are fixed beliefs not amenable to change in light of conflicting evidence, encompass various subtypes, such as **grandiose delusions** (belief in exceptional abilities or identity), **referential delusions** (belief that certain gestures or environmental cues are directed at oneself), and **persecutory delusions** (belief that one is going to be harmed or harassed) (APA, 2013). Hallucinations are sensory experiences occurring without an external stimulus, with auditory hallucinations being the most common form observed in Schizophrenia.

Conversely, negative symptoms often indicate the developing stages of the disorder before a full psychotic break occurs. These symptoms include diminished emotional expression, avolition (decrease in motivation for self-initiated, purposeful activities), and alogia (diminished speech output). The accurate selection of a Schizophrenia diagnosis requires the clinician to differentiate these symptoms from those of other conditions, ensuring that the constellation of symptoms meets the duration and functional impairment criteria specified by the DSM-5.

### 2. Theoretical Models and Etiological Approaches

The selection of a diagnosis, particularly Schizophrenia, is often complemented by an understanding of underlying theoretical models that inform etiology and intervention. These models are broadly categorized into biological, psychological, and social/interpersonal frameworks, providing a comprehensive, multi-faceted perspective on the disorder.

## Biological Approaches

The **biological approach** focuses on neurodevelopmental factors and genetic predispositions in the manifestation of Schizophrenia. This model posits that the disorder arises from disrupted **brain development** (Owen, 2016) and encourages investigation into specific brain areas, neurotransmitter activity, and synaptic functioning that may be abnormal. A strong implication of this model is the endorsement of pharmacological interventions. **Antipsychotic medication** is frequently utilized to treat Schizophrenia by attempting to correct abnormal neurotransmitter imbalances, particularly involving dopamine pathways (Snyder & Murphy, 2008). Furthermore, the biological model asserts the possibility of a significant **genetic component**, suggesting that genetic risk factors, often interacting with environmental elements, contribute heavily to the onset and manifestation of the disorder (Park & KiPark, 2012).

## Psychological Approaches (CBT)

Psychological models emphasize cognitive processes and learned behavioral patterns. Cognitive-Behavioral Therapy (CBT) has gained considerable traction as a highly useful approach for managing Schizophrenia and its associated psychotic symptoms (Dopke & Batscha, 2014). CBT operates on the principle of identifying and modifying **irrational thought processes** that contribute to problematic behavior. For a client experiencing paranoid delusions, CBT techniques can be employed to challenge these beliefs and help the individual evaluate reality more accurately, even though the fear remains subjectively real to them. Key CBT interventions, such as the **ABC Model** (Activating event, Belief, Consequence), **role-play**, and **goal-setting**, are utilized to ascertain triggers and develop healthier cognitions and coping mechanisms. Pioneering work, such as that by Aaron Beck in applying CBT to patients suffering from delusions, demonstrates its utility in lessening the severity of symptoms and improving self-esteem (Morrison, 2009; Dopke, 2014; Nowak et al., 2016).

## Social/Interpersonal Approaches (Family Systems)

The **social and interpersonal approaches** mandate viewing Schizophrenia not merely as an individual pathology but as a systemic issue embedded within a broader environmental context. The **Family Systems approach**, for instance, looks at various factors within the family dynamic that contribute to the disorder, thereby lessening the tendency to place blame solely on the diagnosed individual. This model places high value on **psychoeducation** for the entire family unit, which has been shown to be helpful in the treatment process (Smerud & Rosenfarb, 2008). By addressing family dysfunction and maintaining a robust **therapeutic alliance** with every member, the clinician works to reduce stigma and improve the family's ability to support the client. This systemic view is also crucial given the high rate of **co-occurring disorders** or dual diagnoses observed in this population (Gottlieb, Mueser, & Glynn, 2012).

### 3. Clinical Observation of Key Symptoms

When **selecting a diagnosis**, the clinician must rely heavily on direct observation of the client's current presentation. If a client is actively experiencing an episode, the therapist may observe overt **psychotic symptoms**, including florid delusions, active hallucinations, or marked disorganization (Owen, 2016). The observed symptoms typically fall into the categories of positive or negative indicators of Schizophrenia.

In the realm of delusions, the clinician must be vigilant for common presentations, such as **persecutory delusions**, which are the most frequently reported (APA, 2013). Other observed delusional content might include **grandiose delusions** (e.g., believing one is married to a famous, unattainable figure) or **erotomanic delusions** (e.g., believing a celebrity is secretly in love with them). Regarding hallucinations, the most typical presentation in Schizophrenia is **auditory hallucinations**, often described by clients as "hearing voices."

In severe cases, the clinician may observe states of extreme behavioral disorganization, such as **catatonia**, where the client might exhibit inappropriate reactions, total unresponsiveness, or profound motor abnormalities. A thorough diagnostic selection process requires careful documentation of these specific symptoms to meet the defined criteria and ensure the accuracy of the final diagnosis.

### 4. Historical Context and Development of the Label

The history of Schizophrenia as a formal mental illness dates back to 1887, when Dr. Emil Kraepelin first identified and cataloged the disorder (N.A., 2010). Over the decades, the understanding and conceptualization of the condition have evolved, but so too has the accompanying social baggage. The historical trajectory of the disorder has resulted in a significant and persistent **stigma**.

This historical stigma often leads to a societal perception that individuals with this disorder are permanently impaired and incapable of leading functional lives. The family system plays a critical role in mitigating or exacerbating the client's experience of this diagnosis. The way the family views the diagnosis can deeply influence the individual's own acceptance and coping mechanisms. Effective treatment therefore requires addressing the dysfunction within the family dynamic and developing a strong clinical relationship to deliver psychoeducation effectively (Smerud, 2008).

### 5. Ethical and Societal Impact of Diagnostic Labels

The selection and subsequent assignment of a diagnostic label carry profound ethical and societal implications for the client and their family. The label of Schizophrenia can be devastating, contributing to the experience of **discrimination** and exclusion in various social settings

(Dickerson et al., 2002). This stigma can severely impede the client's ability to find or retain stable employment and may foster feelings of shame, particularly if there is an existing history of mental illness within the family.

Clinicians must constantly balance the necessity of diagnosis with the client's well-being. A diagnosis is often a practical requirement for securing **insurance compensation** for services rendered, necessitating written documentation and a specified time frame for sessions. However, the ethical imperative dictates that the clinician must always act in the client's best interest. It may be therapeutically necessary to delay or cautiously introduce the diagnosis if the client is emotionally unprepared to cope with the information, as revealing it prematurely could potentially damage the essential **therapeutic alliance**. The focus should be on processing the client's lived experience and helping them cope with the reality of the diagnosis, rather than allowing the label to define their entire identity or lead to permanent impairment assumptions. The emphasis must remain on the therapeutic process over the mere diagnostic content.

## 6. Further Reading

Schizophrenia

Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Cognitive-Behavioral Therapy (CBT)

Emil Kraepelin

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. (5th ed.)