**Changes to DSM-5 Schizophrenia Diagnosis**

*By Aaron A. Gubi, Cassandra Mcdonnell & Joel O. Bocanegra*

**S**chizophrenia is a severe and persistent mental illness that is typically associated with distress and severe functional impairment. Individuals presenting with schizophrenia have symptoms that markedly impair their ability to perceive, think, engage, or express themselves clearly. Key features of schizophrenia include what mental health professionals frequently term “positive” symptoms, and include delusions (fixed beliefs that do not alter with conflicting evidence), hallucinations (perceiving things that are not there), disorganized speech that impairs communication, and abnormal motor behavior (which may include agitation, catatonia, stereotyped movements; American Psychiatric Association [APA], 2013). Schizophrenia is also marked by “negative” symptoms including diminished emotional expression (reduced facial expressions, eye contact, intonation, and gestures) and avolition (decreased self-initiated activity; APA, 2013).

Schizophrenia typically first presents during the late teens and early twenties; much more rarely, it may also present in childhood (McClellan & Stock, 2013). Early onset schizophrenia in children and adolescents is diagnosed according to the same criteria as adults. It is important to note that childhood onset schizophrenia is rare, and that the majority of children who report hallucinations or delusions do not have a psychotic illness or meet criteria for schizophrenia (McClellan & Stock, 2013). The worldwide prevalence of schizophrenia is approximately 1% (McGrath, 2006). Schizophrenia frequently co-occurs with substance-related disorders; rates of anxiety disorders and obsessive–compulsive disorder are also elevated in individuals with schizophrenia. Suicidality is prevalent among this group, with 20% attempting suicide one or more times and 5% to 6% completing suicide (APA, 2013).

**Changes From DSM-IV-TR And Rationale For DSM-5 Changes**

Because the diagnostic criteria for schizophrenia articulated in the DSM-IV have been shown to have clinical utility, validity, and reliability, the core of these criteria are retained in the DSM-5 (Tandon et al., 2013). The modest changes include three changes to the “Characteristic Symptoms” criteria (Criterion A). The DSM-IV-TR required that two characteristic symptoms be present for diagnosis; the DSM-5 further specifies that at least one of these symptoms must be delusions, hallucinations, or disorganized speech. Research has demonstrated these symptoms to be highly reliable among individuals with schizophrenia (Tandon et al., 2013). The previous qualification that only one characteristic symptom is required if a Schneiderian first-rank symptom is present (these symptoms include bizarre delusions, thought broadcasting, auditory hallucinations that comment on one’s behavior, a voice keeping up a running commentary, or two plus voices conversing) has been removed. The removal of the Schneiderian first-rank criteria was made due to poor diagnostic reliability; research indicates that 2% or fewer of diagnoses were made using the Schneiderian first-rank criteria and that dropping this from the diagnostic criteria will improve clinical utility of the diagnosis (Tandon et al., 2013). Thus, DSM-5 now requires two Criterion A symptoms for a diagnosis of schizophrenia, and that at least one positive symptom must be present. Adding cognitive impairment as a diagnostic criterion was considered but not implemented due to the concern that comparative data has yet to clearly establish that cognitive deficits distinguish schizophrenia from other related disorders (Barch et al., 2013).

DSM-5 has also made changes to some of the descriptors involving negative symptoms associated with the diagnosis of schizophrenia. This was done for the sake of clarity (Ritsner, Mar, Arbitman, & Grinshpoon, 2013). Negative symptoms, previously defined as affective flattening, alogia, or avolition, are now defined as diminished emotional expression or avolition. Criteria B–E remain unchanged. Criterion F previously stated that a schizophrenia diagnosis required that prominent delusions or hallucinations be present for at least a month (or less if untreated) in cases with a history of autistic disorder or pervasive developmental disorder. In DSM-5, this caveat is also applied to cases with a history of other communication disorders of childhood onset, as these (like autism spectrum disorders) may be associated with disorganized speech and diminished emotional expression (Dyck, Piek, & Patrick, 2011).

The most notable change is the discontinuation of distinguishing between four distinct subtypes of schizophrenia (disorganized, catatonic, paranoid, and undifferentiated). The validity of these subtypes has not been supported by research (Linscott, Allardyce, & van Os, 2010). Research findings suggest that these subtype classifications tend to be unstable over time (Helmes & Landmark, 2003) and do not provide meaningful information about an individual’s prognosis or treatment response (Korver-Nieberg, Quee, Boos, & Simons, 2011). In lieu of subtypes, DSM-5 utilizes a dimensional psychopathological description that allows for specification of the course of the disorder. This change reflects research indicating that a focus identifying characteristic symptoms and explicating the course of the disorder is more useful to the clinician (Galderisi et al., 2013). There is significant variability in how schizophrenic and other psychotic disorders proceed over the course of time. Some individuals may meet diagnostic criteria for the disorder continuously for long periods of time, while others may experience an intermittent course with partial or full symptom remission between episodes (APA, 2013). To address this, DSM-5 includes course specifiers that identify both an individual’s current symptom status (acute, partial, or full remission) and the course of their illness prior to the current period (first episode, multiple episodes, or continuous; Tandon et al., 2013).

**Possible Consequences Of The DSM-5 Changes**

The prominent symptoms associated with a diagnosis of schizophrenia make it among the more reliably diagnosed psychiatric disorders (Ritsner et al., 2013). The changes made to the DSM criteria are nonetheless intended to improve the diagnostic reliability and clinical utility of the diagnosis. In particular, the subtype specifiers (e.g., paranoid schizophrenia) were dropped and the prominence given to bizarre delusions and Schneiderian first-rank symptoms in the diagnostic criteria was changed to improve reliability in the diagnosis. Although school psychologists are not diagnosticians and would typically refer a student they suspect of being impacted by schizophrenia or a related psychotic disorder, as first line mental health providers, it will benefit all school psychologists to be familiar with the basic symptoms of this disorder. Although rare, early onset schizophrenia will significantly impact an afflicted student’s ability to function in behavioral, academic, and social domains within school. In such cases, school psychologists may be in a position to provide crucial support to students and families impacted by schizophrenia and related psychotic disorders.

**Implications For School Psychologists**

School psychologists must keep abreast of the most recent changes in the diagnostic criteria for schizophrenia. It is important that school psychologists be familiar with both positive and negative symptoms, as such symptoms can indicate schizophrenia or other psychotic disorders. Positive symptoms are exaggerations and distortions of normal ways of perceiving and thinking about ones environment, the self, and others. Positive symptoms are often clearly identifiable. Clinical experience suggests that children and adolescents often respond to such symptoms with a high degree of distress and fear that does not characterize the typical imaginative experiences of childhood or the dramatically expressive reports of adolescents. Even in cases where the child or adolescent is more secretive about their experience, bizarre behavior and responses to internal stimuli are often noticeable and distinguishable from typical “make-believe” play. Negative symptoms include inexpressive faces or facial expressions, monotonic speech, an inability to feel or express pleasure, and what can appear to be a lack of interest in the world or in others. Negative symptoms can overlap with or be confused with symptoms of depression, other mood disorders, and with other psychiatric disorders. It is important that school psychologists communicate with the family of a student immediately if he or she suspects prominent behavioral or mental health changes. They should be prepared to consult with colleagues, school officials, outside mental health experts (e.g., clinical psychologists or psychiatrists), and other community mental health organizations or stakeholders and make appropriate referrals as indicated to best meet the needs of the individual student.

Although most school psychologists will not be the primary service providers for students suffering with schizophrenia, our understanding of this disorder can allow for the timely identification of relevant symptoms and subsequent referral to appropriate care providers. Furthermore, our understanding of this disorder and its associated symptoms prepares us for our role as primary contact, advocate, and support professional for the child within the school. Due to our training and expertise, school psychologists will play a critical role in coordinating supports within the school for the child and will also be in the forefront in maintaining communication between the school, child, family, outside service providers, and other community stakeholders. In addition, our knowledge of mental health issues, child development, and behavioral and educational theory puts us in a unique position to educate our staff on the educational, social–emotional, and behavioral health needs of students impacted by schizophrenia and other psychiatric disorders.

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