# Diagnostic criteria for schizophrenia

Lesson 3.1.1 | Clinical psychology

## Core ideas

Schizophrenia is diagnosed using patterns of symptoms, duration and impact on daily functioning.

Positive symptoms are added experiences or behaviours, such as hallucinations, delusions or disorganised speech.

Negative symptoms involve a reduction or loss of typical functioning, such as reduced emotional expression or motivation.

Diagnosis is not based on one symptom alone; clinicians consider combinations of symptoms and rule out other explanations.

Evaluation should consider reliability, validity, cultural interpretation, symptom overlap and the effect of labels.

ICD-11 schizophrenia requires at least two characteristic symptoms present most of the time for a month or longer; at least one must be delusions, hallucinations, disorganised thinking, or experiences of influence/passivity/control. Consider exclusions such as substances and medical conditions.

## Key terms

**Schizophrenia:** A psychotic disorder involving symptoms that can affect perception, thought, emotion and functioning.

**Diagnostic criteria:** Rules or features used to decide whether a diagnosis applies.

**Positive symptom:** An added experience or behaviour, such as hallucinations or delusions.

**Negative symptom:** A reduction or loss of typical functioning.

**Hallucination:** A perception, such as hearing a voice, without an external stimulus.

**Delusion:** A strongly held belief that is not supported by reality.

**ICD:** An international classification system used for health conditions, including mental disorders.

**Persecutory ideation:** Thoughts that others intend harm; the severity and context matter.

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**ICD-11:** WHO International Classification of Diseases, eleventh revision; the terminology used by Cambridge 9990 where applicable.

**Passivity experience:** An experience that one's thoughts, actions or feelings are being controlled externally.

## Further detail and evidence

Delusions can concern persecution, reference, grandeur or control: for example, interpreting an ordinary conversation as a planned attack illustrates persecutory content. Negative symptoms include reduced motivation and emotional expression; they are not simply unusual experiences added to normal functioning.

Illustrative published case - O'Reardon et al. (2024) described a man with prolonged untreated psychosis, paranoid delusions, auditory hallucinations and disorganised speech, together with flat affect, apathy and reduced speech. Use this to distinguish positive from negative symptoms and discuss differential diagnosis and functioning; it is an example case, not a designated Cambridge key study.

Key study - Freeman et al. (2003): building on cognitive explanations of persecutory beliefs, the pilot tested whether neutral virtual people elicited persecution thoughts, and whether paranoia/emotional distress predicted these interpretations.

**Freeman:** 24 nonclinical volunteers, equally divided by sex, were recruited through University College London advertisements; 21 were students and three administrative staff. They explored a neutral virtual library containing five avatars for five minutes. Half completed questionnaires before and after VR; half only afterwards, checking possible priming.

**Freeman:** symptom/paranoia/anxiety questionnaires and a semi-structured interview assessed reactions. For the claim that avatars talked behind their back, 13/24 agreed at least a little. Interpersonal sensitivity and anxiety correlated with VR persecution; sensitivity was the strongest predictor. Many other interpretations were friendly.

**Delusion types:** persecution means being targeted or harmed; reference means neutral events have a special personal message; grandeur means exceptional power or importance; control concerns an external force governing thoughts or actions. A culturally shared belief is not automatically a delusion.

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Disorganised thinking may be inferred from speech that is difficult to follow. Negative symptoms include avolition (reduced motivation), alogia (reduced speech) and blunted affect (reduced emotional expression). Positive/negative labels describe additions or losses, not good or bad behaviour.

Other characteristic features can include markedly disorganised behaviour and psychomotor disturbances, including catatonic features. Diagnosis uses a symptom pattern over time and exclusions, rather than treating each listed feature as sufficient on its own.

## Applying the ideas

**Apply the distinction:** hearing an absent voice is a hallucination; believing that a television presenter sends personal threats concerns a delusion of reference/persecution. Reduced spontaneous speech is a negative symptom. A clinician checks persistence and exclusions rather than diagnosing from this short description alone.

## Evaluation and connections

**Freeman evaluation:** identical avatar behaviour improves control, while questionnaire/interview agreement supports convergent evidence. Correlations do not establish causation. A small university volunteer sample limits generalisations to clinical schizophrenia. Withholding the precise purpose reduced priming but raises consent/deception issues; distress monitoring supported participant welfare.

Diagnostic reliability means agreement when the same evidence is assessed; validity asks whether the classification captures the intended disorder. Standard criteria improve shared communication, but symptom overlap and cultural interpretation can still affect judgement. A laboratory measure of suspicious interpretation can inform a cognitive explanation without being a diagnostic test.

Hint: distinguish persecutory ideation in a nonclinical sample from a diagnosed delusion. The study supports a method of investigating interpretation; it did not show that all participants had schizophrenia.