DIAGNOSIS

POSITIVE SYMPTOMS

→ Additional to normal experiences, distort behaviour or thoughts and respond to medication.

- Hallucinations (all senses)
- Delusions

NEGATIVE SYMPTOMS

→ disrupt normal functioning, respond poorly to medication.

- Avolition
- Speech poverty
- Affective flattening
- Anhedonia

BIOLOGICAL EXPLANATIONS

GENETICS

- polygenic / diathesis-stress model plays a big role.
- 16% of children with Sz mother developed Sz compared to 2% of children with a non-Sz mother.
- **Gottesman** → MZ twins (48%) both parents (46%) DZ twins (17%)
- **Joseph** → meta-analysis. MZ twins (40%) DZ twin (7%)
- **Tienari** → adoption study. 7% of children with biological Sz mothers developed Sz compared to 2%.
- ☹ Concordance s never 100%

DOPAMINE HYPOTHESIS

- **Snyder** → Too much = positive symptoms → Sz drugs REDUCES dopamine / L-Dopa INCREASES dopamine and gives symptoms / drugs INCREASE dopamine and gives symptoms.
- **Davis** → Not everyone has high levels → atypical drugs affect dopamine and serotonin. He suggests that positive symptoms are caused by TOO MUCH (Mesolimbic) and negative symptoms are caused by a DEFICIT (Mesocortical) – supported by rat study.

NEURAL CORRELATES

- MRI scans show enlarged ventricles which are associated with negative symptoms.

ALTERNATE EXPLANATIONS

- **Smoking during pregnancy** → heavy nicotine increases risk of Sz by 38%
- **Evolution** → there must have been an advantage to Sz symptoms for it to still be common.
- **Socio-cultural** → deprivation, city life, population density, unemployment and increased inequality increases risk.

DRUG THERAPY

DRUG THERAPY → blocks dopamine receptors on the post-synaptic neuron.

TYPICAL → 1st gen. Only treats positive symptoms and only acts on dopamine. Symptoms reduce in a few days. Severe side effects.

ATYPICAL → modern drugs with side effects. Treats positive, negative and cognitive symptoms. Acts on serotonin and dopamine.

- ☹ only treats symptoms / biologically reductionist / reinforces diagnosis and removes accountability.
- ☺ Medication is more effective than placebo / cost effective / economy / atypical advantageous.

RELIABILITY & VALIDITY

RELIABILITY → Consistency of the diagnosis tool / **VALIDITY** → Accuracy of the tool and clinician.

DIAGNOSIS & CLINICIANS

DSM & ICD used in different countries and have different criteria.

- ☹ Lack of inter-rater reliability (0.11 / 0.46 / 0.4) between clinicians using DSM, which means low criterion validity – the tools are inaccurate, and clinicians misinterpret.
- ☺ ROSENHAN study – all PPs were admitted. Hospital couldn't identify real/fake patients → socially sensitive research.

GENDER BIAS

- Healthy adult behaviours is based around male norms (androcentric) / clinicians ignore male symptoms / male clinicians are likely to over diagnose female patients.

CULTURE BIAS

- Hearing voices is acceptable in some cultures / Clinicians are ethnocentric towards voices and abnormal behaviour / white clinicians distrust and misinterpret black patients / negative voices common in western cultures where its not accepted / diagnosis more likely in western cultures.

SYMPTOM OVERLAP

- DID patients have more Sz symptoms / Sz and Bipolar often misdiagnosed / SZ and Bipolar share genetic overlap.

COMORBIDITY → 2+ conditions developing at the same time.

- OCD and Sz common (Dopamine?) / co-morbid Sz are often excluded from research which impacts treatment and validity / diagnosis of patients rarely share same symptoms, so outcome will be different for all / lacks predictive validity → too many outcomes to predict treatment/recovery.

PSYCHOLOGICAL TREATMENT

CBTP → NICE recommend 16 sessions to treat residual symptoms drugs can't treat / Aims to identify and challenge delusions and hallucinations and establish links between thoughts, feelings and actions.

- **Reality-testing –** examining evidence, challenging and assessing delusions & hallucinations (NIGEL)
- **Normalising** – reduces stigma and anxiety.
- ☺ Reduces rehospitalisation / no side effects or addiction.
- ☹ Limited availability / only beneficial at certain stages of illness / often used alongside drugs.

FAMILY THERAPY → aims to treat family dysfunction for 10 sessions over a year.

- Psychoeducation – understanding the illness.
- Support network / Improving communication / decrease guilt and responsibility.
- ☺ meta-analysis show smallest readmission rates and highest medical compliance, reduction in relapse for up to 2y / positive impact on whole family / cost-saving for NHS.

TOKEN ECONOMY (MANAGEMENT) → operant conditioning within institutions. Clinicians set targets and are rewards when desirable behaviour is displayed.

- ☺ Works best in institutions when paid hourly.
- ☹ Make patients socially acceptable / targets can breech human rights.

PSYCHOLOGICAL EXPLANATIONS - FAMILY DYSFUNCTION

SZ MOTHER (1948)

- Psychodynamic / focus on childhood / cold, rejecting, controlling, tension and secrecy leads to paranoid delusions.
- Can be supported by EE / Double-bind and Insecure Avoidance attachment.

DOUBLE-BIND THEORY

- Contradictory messages from parents leads to failure to develop internal construction of reality → affective flattening, paranoid delusions and disorganised thinking.

EXPRESSED EMOTION

- The communication style of the family is critical, hostile, over-involving, intense, conflicting and negative.
- Can lead to relapse if vulnerable to stress.
- **Vaughn** → High EE and no drugs = 92% relapse / High EE on drugs = 53% relapse / Low EE and no drugs = 15% relapse.

COGNITIVE DYSFUNCTION

Metarepresentation → inability to reflect on own thoughts which impacts insight into intentions and goals – explains auditory hallucinations.

Central control → inability to supress automatic responses, this can explain derailment (disorganised speech)

- Impaired insight leads to an inability to recognise cognitive distortions and failure to substitute realistic explanations for events.
- Sz with hallucinations are hypervigilant so expect to experience them more and less likely to reality-test noises or sounds.

INTERACTIONIST APPROACH → we need to look at biological, behavioural and cognitive explanations to understand Sz (biopsychosocial).

Diathesis → biological vulnerability. Eg early trauma which can encourage the HPA to become overactive and make a person more vulnerable to stress.

Stress → stressful life event. Eg, children who experience trauma before 16 are Sz likely to develop Sz / High EE 4x more likely to relapse / Cannabis increases risk of Sz 7x.

☹ Too many treatments at once can be time-consuming