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**Knowledge Rich Curriculum Plan**

A Level Psychology – Unit 7 Schizophrenia



| **Topic 1 – Issues in Diagnosis and Classification of Schizophrenia** | | | | |
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|  | **Intended Knowledge:**  *Students will know that…* | **Tiered Vocabulary** | **Prior Knowledge:**  *To know this, students, need to already know that…* | **Assessment** |
| **LO1: Describe the positive and negative symptoms of schizophrenia** | Schizophrenia is a serious psychological disorder characterised by severe disruptions in psychological functioning and a loss of contact with reality.  It typically involves periods of psychosis, where the individual is unable to distinguish their own thoughts from reality.  **Positive symptoms are those which appear to reflect an excess or distortion of normal functions.**   * Hallucinations: False sensory perceptions of the environment that are usually auditory * Delusions: Bizarre beliefs that seem real to the person but are not.   **Negative symptoms are those that appear to reflect a diminution or loss of normal functions.**   * Alogia: Poverty of speech, characterised by the lessening of speech fluency and productivity. * Avolition: The reduction of, or inability to initiate and persist in goal – directed behaviour | **Volition**  The act of choosing a decision based on your own free will.  **Excess**  An amount of something that is more than necessary.  **Distortion**  The act of twisting or altering something out of its natural or original state  **Diminution**  A reduction in the size, extent, or importance of something.  **Diagnosis**  The identification of an illness or other problem by examination of the symptoms.  **Psychosis**  Severe psychological disorder in which thought and emotions are so impaired that contact is lost with external reality. | **Validity**: The extent to which a diagnosis is accurate.  **Predictive Validity:** The extent to which a person diagnosed with schizophrenia responds to the drug treatment,  **Descriptive Validity**: The extent to which patients ` with schizophrenia display symptoms that describe Schizophrenia.  **Reliability**: The extent to which a diagnosis is consistent.  **Inter-Rater Reliability:** The extent to which psychiatrists can agree on the same diagnosis when independently assessing patients  Test-Retest Reliability: The extent to which the same diagnosis is produced over time |  |
| **LO2: Discuss how co-morbidity affects the diagnosis of schizophrenia.** | Comorbidity is he **simultaneous** presence of one or more disorders that exist alongside a **primary diagnosis**.  The **occurrence** of two disorders or conditions together.  ***A. person has both schizophrenia and depression.***  ***There are the following evaluation points:***   * Sim et al (2006) 32% of 142 hospitalised schizophrenics had an additional disorder. * 50% of schizophrenics had a co-morbid medical condition such as substance abuse. * Half of patients with a diagnosis of schizophrenia also have a diagnosis of depression. | **Reliability**  Refers to the consistency of a research study or measuring test**.**  **Validity**  Refers to the accuracy of a result from a study or test. | **David Rosenhan: Being Sane in Insane Places (see knowledge organiser)**  **Key AO3:**   * Supporting Evidence |  |
| **LO3: Discuss how symptom overlap affects the diagnosis of schizophrenia** | Symptom overlap occurs when two or more disorders share some of the symptoms needed for **classification**.  When there is a lack of ‘**First Rank Symptoms**’ which clearly identify the illness.  **Schizophrenia and bipolar disorder both share positive symptoms like delusions** **and negative symptoms like avolition**.  ***There are the following evaluation points:***   * Ellason and Ross (1995) point out that people with dissociative identity disorder (DID) have more schizophrenic symptoms than people diagnosed as being schizophrenic. * Serper et al. (1999) assessed patients with co-morbid schizophrenia and cocaine abuse, and found despite considerable symptom overlap it was possible to make accurate diagnosis. * Ketter (2005) misdiagnosis due to symptom overlap can lead to years of delay in receiving relevant treatment, suffering and further degeneration can occur, as well as high levels of suicide. | **First Rank Symptoms**  These are symptoms which are specific to schizophrenia. FRS were first described by Schneider in 1959. | **David Rosenhan: Being Sane in Insane Places (see knowledge organiser)**  **Key AO3:**   * Supporting Evidence * Challenging Evidence. * Negative implications |  |
| **LO4 Discuss how gender bias affects the diagnosis of schizophrenia** | Gender Bias is the tendency for diagnostic criteria to be applied differently to males and female (**androcentric**)  Tendency to **pathologize** essentially ‘normal ’female behaviour.  The gender of the psychiatrist may affect the likelihood of a diagnosis.  **Men are far more likely to diagnosed with schizophrenia than women.**  ***There are the following evaluation points:***   * US clinicians equated psychologically healthy ‘adult’ behaviour with mentally healthy ‘male’ and women were perceived as abnormal. * 290 psychiatrists to diagnose a case and if was described ‘male’ 56% only 20% if described as ‘female’. * The gender bias was not evident amongst the female psychiatrists. * Reported that male patients suffer from more negative symptoms than female patients. females have better recovery rates and lower relapse rates, suggesting schizophrenia may present differently in men and women. | **Androcentrism:**  The view that male thinking and behaviour is normal, and female thinking is deviant, inferior or abnormal.  **Pathologize/Pathologizing:**  Labelling a normal behaviour as a problem, a behaviour that requires intervention, treatment, or drugs. | **David Rosenhan: Being Sane in Insane Places (see knowledge organiser)**  **Key AO3:**   * Supporting Evidence * Challenging Evidence. * Gender Bias |  |
| **LO45Discuss how culture bias affects the diagnosis of schizophrenia** | Culture Bias The tendency for diagnostic criteria to be applied differently to patients of different cultures.  There is also evidence that the ethnic origin of the psychiatrist may affect the likelihood of a diagnosis.  **Individuals of a Non Western origin are more likely to diagnosed with schizophrenia**  ***There are the following evaluation points:***   * When individuals of African Caribbean origin live in Britain they are 7 times more likely to be diagnosed with schizophrenia. * Description of a patient to 134 US and 194 British psychiatrists. 69% of the US psychiatrists diagnosed schizophrenia Harrison et al.'s (1984) * Those of West Indian origin were over-diagnosed with schizophrenia, by white doctors in Bristol (almost a third of patients were non white). but only 2% of the British did. |  | **David Rosenhan: Being Sane in Insane Places (see knowledge organiser)**  **Key AO3:**   * Supporting Evidence * Culture Bias |  |

| **Topic 2 – Explanations of Schizophrenia** | | | | |
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|  | **Intended Knowledge:**  *Students will know that…* | **Tiered Vocabulary** | **Prior Knowledge:**  *To know this, students, need to already know that…* | **Assessment** |
| **LO6: Describe and evaluate the Genetic explanation of Schizophrenia** | * Schizophrenia runs in families. * There is a strong correlation between the degree of genetic similarity shared between family members and the risk of developing schizophrenia. Gottesman (1991) * Different studies have identified that different candidate genes which means that schizophrenia is aetiologically heterogeneous – i.e. a number of different combinations of genes can lead to the illness. * Schizophrenia is polygenic – but all the genes that have been identified included those that code for the transmission of different neurotransmitters including dopamine.   ***There are the following evaluation points:***   * Gottesman (1991) found that the concordance rate for MZ twins was 48% compared to 17% for DZ twins. * MZ twins may share 100% the same genes but they are also more similar in terms of shared environments * Gottesman and Shields (1982) who used the Maudsely twin register and found 58% of MZ twins reared apart were concordant for schizophrenia. * Even in twin studies were twins have been reared apart they still share the same environment in the womb before birth. * Concordance rates for twin studies are never 100% for MZ twins, which Suggests that genetics are only half of the picture (Diathesis-Stress) * About 89% of people diagnosed with schizophrenia have no known relative who has the disorder. | **Predisposed**  To make something more likely to happen.  **Aetiology**  The study or science of the causes of disease.  **Candidate Gene**  A gene that could be the determinant (cause) of a disease.  **Concordance Rate**  The percentage of pairs of twins (or other blood relatives) who exhibit (show) a particular trait or disorder.  **Monozygotic & Dizygotic**  MZ twins come from a single ovum and are identical whereas DZ twins come from two ova and are not identical. | How psychologists study the genetic basis of behaviour (Approaches – The Biological Approach)  Fertilisation of the ovum (GCSE Biology)  Role of Dopamine as an excitatory NT (Biopsychology – Synaptic Transmission)   * Supporting Evidence * Challenging Evidence * Issues with twin studies * Nature Nurture Debate and an Interactionist approach. |  |
| **LO7: Describe and evaluate the Dopamine Hypothesis n of Schizophrenia** | **Hyperderminergia in the Subcortex**   * Hyperderminergia in the Subcortex. * Originally the Dopamine Hypothesis states that there was excess levels and/or elevated activity of dopamine in the brains of patients with schizophrenia. * For example – too much dopamine in Broca’s Area (speech production) could be linked with poverty of speech and/or auditory hallucinations.   **2. Hypodopaminergia in the Cortex**   * The updated dopamine hypothesis focusses on abnormal dopamine activity in the cortex. * Goldman-Rakic (2004) unedified a role for low levels of dopamine in the Prefrontal Cortex (responsible for thinking and decision making) which could possibly explain the negative symptoms of schizophrenia.   ***There are the following evaluation points:***   * Wong et al (1986) used PET scans and found increased dopamine receptor density in the brain of people with Schizophrenia. * Drugs that inhibit dopamine (neuroleptic) are successful in treating the positive symptoms of schizophrenia, but the treatment aetiology fallacy. * Post mortem evidence from patients with schizophrenia has revealed a specific increase in dopamine and an increased number of dopamine receptors. * Clozapine is the one of the most effective drugs in treating schizophrenia. Clozapine works on the serotonin system not the dopamine system which is an inhibitory neurotransmitter. * The diathesis stress model suggests that biological factors predispose someone to schizophrenia, but this has to be ‘triggered’ by some sort of event or environmental stressor. | **Predisposed**  To make something more likely to happen.  **Dopamine**  Dopamine is a neurotransmitter made in the brain. It acts as a chemical messenger in the synapse between neurons. Dopamine is released when your brain is expecting a reward.  **Hypothesis**  A testable statement or prediction.  **Cortex**  The outer layer of the brain (cerebrum)  **Sub Cortex**  The area of the brain which lie directly beneath the cortex. | Role of Serotonin as an inhibitory NT (Biopsychology – Synaptic Transmission)   * Supporting Evidence * Challenging Evidence * Use of scan studies * Nature Nurture Debate an interactionist approach. |  |
| **LO8 Describe and evaluate the neural correlates explanation of Schizophrenia** | **1. Enlarged Ventricles**  Fluid filled cavities in the brain.  **2. Reduced Activity in the Superior Temporal Gyrus**  Allen et al (2007) scanned the brains of patients experiencing auditory hallucinations and compared them to a control group – their task was to identify a pre-recorded voice as belonging to them or someone else.  They found lower activity in the superior temporal gyrus.  **3. Reduced Activity in the Ventral Striatum**  The Ventral Striatum is an area of the brain which is involved in the anticipation of a reward.  Juckel (2006) measured activity in the VS and lower levels in patients with Schizophrenia com[pared to controls.  They also found a negative correlation between activity in this area and the severity of negative symptoms such as avolition.  ***There are the following evaluation points:***   * Brown et al (1986) who found decreased brain weight and enlarged ventricles in schizophrenic brains compared to non-schizophrenic brains. * Suddath et al. (1990). used MRI scans to compare pictures of MZ twins. The schizophrenic twin had enlarged ventricles and the differences were so large the schizophrenic twins could be easily identified from the brain images in 12 out of 15 pairs. * MRI studies have continuously shown quite definite structural abnormalities in the brains of many patients with schizophrenia. * Whilst these studies appear to provide strong evidence of neural abnormalities they do not always agree on the regions of the brain which are affected. The diathesis stress model suggests that biological factors predispose someone to schizophrenia, but this must be ‘triggered’ by some sort of event or environmental stressor. * Much of the evidence to support this explanation of schizophrenia is correlational in nature. * The diathesis stress model suggests that biological factors predispose someone to schizophrenia, but this has to be ‘triggered’ by some sort of event or environmental stressor. | **Predisposed**  To make something more likely to happen.  **Aetiology**  The study or science of the causes of disease.  **Candidate Gene**  A gene that could be the determinant (cause) of a disease.  **Concordance Rate**  The percentage of pairs of twins (or other blood relatives) who exhibit (show) a trait or disorder.  **Monozygotic & Dizygotic**  MZ twins come from a single ovum and are identical whereas DZ twins come from two ova and are not identical. | **Positive symptoms are those which appear to reflect an excess or distortion of normal functions.** Hallucinations: False sensory perceptions of the environment that are usually auditory Delusions: Bizarre beliefs that seem real to the person but are not.  **Negative symptoms are those that appear to reflect a diminution or loss of normal functions.**  Alogia: Poverty of speech, characterised by the lessening of speech fluency and productivity.  Avolition: The reduction of, or inability to initiate and persist in goal – directed behaviour  **Key AO3:**   * Supporting Evidence * Challenging Evidence * Use of correlational evidence. * Use of scan studies * Nature Nurture Debate an interactionist approach. |  |
| **LO9: Describe and evaluate the family dysfunction explanation of Schizophrenia** | **Expressed Emotion – Brown & Rutter (1966)**  The level of negative emotion expressed towards a patient by its family members/carers, includes the following 3 behaviours:   * Verbal criticism (sometimes accompanied by violence) * Hostility towards the patient (anger and rejection) * Emotional over involvement   This is a source of stress for the patient, and can cause relapse in patients who return to families with high levels of EE. Can be a stress which triggers the onset inn patients who are already genetically vulnerable (diathesis stress)  **2. Double Bind Theory – Bateson (1972)**   * Emphasised the role of the communication style as being the important factor. * Receive mixed messages from parents, told they are loved, but behaviour is different. * When they do wrong, they are punished by withdrawal of love. * This leads to disorganised thinking and paranoid delusions. * Bateson was very clear that this was only a risk factor in the development of schizophrenia.   **3. The Schizophrenogenic Mother – Fromm Reichman (1948)**   * Based on patients accounts of childhood. * Schizophrenogenic – ‘Schizophrenia Causing’ * Cold, rejecting, controlling, tends to create a tense and secretive family environment. * This leads to distrust and paranoid hallucinations/delusions**.**   ***There are the following evaluation points:***   * Linszen (1997) who found that a patient returning to a family with high levels of EE is about 4 times more likely to elapse than a patient returning to a family with low EE. * Read at al (2005) reviewed 46 case studies schizophrenia and found that 69% of women and 59% of men with schizophrenia had suffered physical abuse, sexual abuse or both as children. * There is almost no empirical evidence or research base to support the concept of the shcizophrenogenic mother or double biind theory. * Family dysfunction theories place blame on parents who will then bear lifelong responsibility for their child’s illness. * Some may say these theories therefore have ethical implications and are socially sensitive. * Information about childhood experiences is often gathered after the development of symptoms. This data is unreliable as patients may forget details and give inaccurate data due to social desirability bias. * The diathesis stress model suggests that biological factors predispose someone to schizophrenia, but this has to be ‘triggered’ by some sort of event or environmental stressor. | **Dysfunction**  Abnormal or unhealthy interpersonal behaviour or interaction within a group (family).  **Hostility**  Unfriendliness or opposition (against)  **Maladaptive**  Behaviours that stop prevent an individual from adapting to new or difficult circumstances (situations).  **Relapse**  A deterioration (worsening) of someone’s mental health after a period of improvement. | **Positive symptoms are those which appear to reflect an excess or distortion of normal functions.** Hallucinations: False sensory perceptions of the environment that are usually auditory Delusions: Bizarre beliefs that seem real to the person but are not.  **Negative symptoms are those that appear to reflect a diminution or loss of normal functions.**  Alogia: Poverty of speech, characterised by the lessening of speech fluency and productivity.  Avolition: The reduction of, or inability to initiate and persist in goal – directed behaviour  **Key AO3:**   * Supporting Evidence * Challenging Evidence * Socially Sensitive Research * Nature Nurture Debate an interactionist approach. |  |
| **LO10 Describe and evaluate the cognitive distortion explanation of Schizophrenia** | **Schizophrenia is associated with several types of abnormal cognitive processing (disorganised thoughts, auditory hallucinations).**  **1. Metarepresentation:**   * The cognitive ability to reflect on thoughts and feelings. * Gives us insight into our own intentions and goals and allows us to predict and interpret the actions of others. * Dysfunction in metarepresentaion would disrupt our ability to recognise our own thoughts and actions and may interpret them as somebody else. * This would explain auditory hallucinations and abnormality of thoughts like thought insertion.   **2. Central Control**   * The cognitive ability to suppress automatic responses while we preform deliberate actions. * Disorganised speech and thoughts could reflect the inability to suppress automatic responses. * E.g. problems with speech (word salad/loose associations) could reflect this inability to control automatic responses.   **3. Cognitive Neuroscience:**   * Reduced processing in the Ventral Striatum is associated with negative symptoms (avolition) * Whilst lower activity in the superior temporal gyrus and the anterior cingulate gyrus leads to positive symptoms (hallucinations) * This leads us to suggest that neuropsychological impairment can lead to disruption of normal cognitive processing.   ***There are the following evaluation points:***   * O’Carroll (2000) found cognitive impairment in 75% of patients in areas like memory and attention. Patients with Schizophrenia consistently perform worse on cognitive tests like the Stroop test showing cognitive dysfunction. * It is difficult to establish if the cognitive impairment/dysfunction is a cause of schizophrenia or a symptom of due to correlational evidence. * Bowie and Harvey (2006) found evidence that cognitive impairments pre-dated the onset of the disorder and were evident throughout the course of the illness. This suggests that cognitive impairment is a cause not an effect of schizophrenia. * Studies of brain damaged patients have shown they have similar cognitive deficits to people with schizophrenia yet they do not develop symptoms of schizophrenia. * Cognitive theories can explain symptoms of schizophrenia but not necessarily the cause. Suggests that these theories are more descriptive and lack explanatory power which reduces the practical applications of these theories. * The diathesis stress model suggests that biological factors predispose someone to schizophrenia, but this has to be ‘triggered’ by some sort of event or environmental stressor. | **1. Cognitive Neuroscience**  The study of how brain activity underlies cognitive processes (using brain imaging technology).  **2. Metarepresentation**  The cognitive ability to reflect on, and have insight into, our own intentions and use this to predict the actions of others.  **3. Central Control**  The ability to suppress automatic responses due to external stimuli. | **Positive symptoms are those which appear to reflect an excess or distortion of normal functions.** Hallucinations: False sensory perceptions of the environment that are usually auditory Delusions: Bizarre beliefs that seem real to the person but are not.  **Negative symptoms are those that appear to reflect a diminution or loss of normal functions.**  Alogia: Poverty of speech, characterised by the lessening of speech fluency and productivity.  Avolition: The reduction of, or inability to initiate and persist in goal – directed behaviour  **Key AO3:**   * Supporting Evidence * Challenging Evidence * Correlational research. * Explanatory power. * Nature Nurture Debate an interactionist approach. |  |

| **Topic 3 – Therapies for Schizophrenia** | | | | |
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|  | **Intended Knowledge:**  *Students will know that…* | **Tiered Vocabulary** | **Prior Knowledge:**  *To know this, students, need to already know that…* | **Assessment** |
| **LO11: Discuss the use of typical and atypical anti-psychotics in the treatment of schizophrenia.** | Drug therapy (chemotherapy), the most common treatment for schizophrenia uses antipsychotic drugs.  **Typical Anti-Psychotics:**   * Act as dopamine antagonists, attempting to reduce dopamine activity. * They bind to dopamine receptors on post-synaptic neurons, meaning that less dopamine is transmitted across the synapse. * Reduces positive symptoms such as hallucinations. Tend to have (sometime severe) side-effects. * They do this by binding to dopamine receptors but do not stimulate them, which blocks their action. * These drugs block dopamine activity within 48 hours but can take several weeks before there is any significant reduction in symptoms.   **Atypical Anti-Psychotics:**   * An example is clozapine. These drugs also combat positive symptoms, but there are claims they have some beneficial effects on negative symptoms as well. * Atypical anti-psychotics also work on the dopamine system, but are thought to block serotonin receptors in the brain too. * The introduction of atypical anti-psychotics raised expectations for the outcomes possible with medication. * Developed in the 1970s, as an attempt to find drugs with fewer severe side-effects than typical antipsychotics.   ***There are the following evaluation points:***   * Some psychologists suggest that the drugs are merely placebos. The user feels like they should have reduced symptoms and this positive thinking leads to the reduction in symptoms. * Meltzer et al. (2014) 481 patients into 3 conditions: (1) a new trial drug; (2) typical antipsychotic; (3) placebo. After 6 weeks, patients in condition (1) and (2) had reduced symptoms whereas patients in condition (3) were the same. * Approximately 30% of people taking typical anti-psychotic medication develop tardive dyskinesia. This is uncontrollable movements of the lips, tongue, face, hands and feet this and it is irreversible in 75% of cases (chemical straightjacket). * Drug therapy does not cure schizophrenia, it temporarily reduces the symptoms; when the patient stops taking them, the symptoms usually return in 3-6 weeks. * Drug therapy doesn't work for everyone. Although more patients respond to the atypical drugs than to the typical antipsychotics, this is still not all patients.t is estimated that half of patients do not benefit from drug therapy * The interactionist approach believes that both biological and psychological therapies should be used to combat schizophrenia. The most common method to use both anti-psychotic medication and CBT. | . | Role of Dopamine as an excitatory NT and serotonin as an inhibitory NT.  (Biopsychology – Synaptic Transmission)  **Key AO3:**   * Supporting Evidence * Placebo effect. * Ethical Issues * Implications for the economy * Symptom Substitution * Nature Nurture Debate and an Interactionist approach. |  |
| **LO12 Discuss the use of CBT in the treatment of schizophrenia.** | CBT is now a common therapy used to treat Schizophrenia. Lasts between 5-20 sessions, either in groups or on a one to one basis. There are 2 parts to CBT:  **1. Cognitive:**   * The aim of CBT is to help the patient identify paranoid beliefs and/or irrational thoughts and try to change them. * This may involve a discussion about how likely the patients beliefs are to be true. * This will not get rid of the paranoid belief or irrational thought – but will help the patient manage them. * Helping patients make sense of their symptoms can have positive impact on their behaviour and feelings. * *For example, if they understand that the voices in their heads are not demons, or someone plotting to kill them this will help to reduce their anxiety.*   **2. Behavioural**:   * Patients may be set behavioural assignments with the aim of improving their general level of functioning. * The client & therapist work together to develop and coping strategies. * Potential strategies include cognitive techniques such as distractions from intrusive thoughts or breathing & relaxation techniques.   ***There are the following evaluation points:***   * Bradshaw & Roseborough (2004) meta-analysis of 22 case studies and found that 86% improved their psychosocial functioning and 82% had reduced severity of symptoms. 100% of cases achieved more than was expected * Kuipers (1997) noted that there were lower patient drop out rates and greater patient satisfaction when CBT was used in addition to anti-psychotic medication. * Psychological treatments such as CBT do not have the serious side effects or medical risks of drug treatments * Benefits could be due to the warm/supportive relationship with the therapist. The tendency of participants in any therapy to show improvement when they think "somebody cares“ – this is known as the Hawthorne Effect. * Kingdon and Kirschena 142 schizophrenic patients in Hampshire and found that many patients were not deemed suitable for CBT because they could not fully engage (older patients) * The interactionist approach believes that both biological and psychological therapies should be used to combat schizophrenia. The most common method to use both anti-psychotic medication and CBT. | **Irrational**  Not logical or reasonable.  **Unconditional Positive Regard**  Accepting a person exactly as they are, without judgement | Basic principles of CBT  (Psychopathology cognitive therapy for Depression)  **Key AO3:**   * Supporting Evidence * Attrition/Refusal * Implications for the economy * Symptom Substitution * Nature Nurture Debate and an Interactionist approach. |  |
| **LO13: Discuss the use of Family Therapy in the treatment of schizophrenia.** | Family Therapy with families rather than the actual patient. And aims to improve the quality of communication within the family (Reduce Levels of EE)  There are a range of different approaches to family therapy –the most common is trying to reduce the risk of relapse by reducing levels of Expressed Emotion.  Pharoah et al (2010) suggest that the following techniques, in which all of the family are involved, are used:   * Form a therapeutic alliance between family members. * Reduce the stress of caring for a relative with schizophrenia * Improve the ability of the family to anticipate and solves problems. * Reduce anger and/or guilt in family members. * Help family members achieve a balance between caring for the relative and having their own life. * Improve families understanding about schizophrenia * Improve family members behaviour towards the relative with schizophrenia.   ***There are the following evaluation points:***   * Anderson et al (1991) found a relapse rate of 40% when patients had drugs only, compared to 20% when Family Therapy was used and only 5% when both were used together. * Lobban et al analysed the results of 50 family studies and 60% reported a positive impact on at least one outcome for relatives, ( e.g. coping, family functioning or relationship quality) * Family therapy is cost effective as it reduces relapse rates which means patients are less likely to be re-hospitalised and treated as in patients. * Family therapy requires both the patient and all family members to be motivated and willing to engage with the sessions. * Many patients with schizophrenia do not belong to a functioning family, so this therapy would be inappropriate. * The interactionist approach believes that both biological and psychological therapies should be used to combat schizophrenia. The most common method to use both anti-psychotic medication and CBT. | **1. Alliance**  A relationship in which people or groups agree to work together  **2. Respite**  A short period of rest or relief from something difficult or unpleasant.  **3. Anticipate**  Regard as probable (likely); expect or predict. | Basic principles of CBT  (Psychopathology cognitive therapy for Depression)  **Key AO3:**   * Supporting Evidence * Attrition/Refusal * Implications for the economy * Symptom Substitution * Nature Nurture Debate and an Interactionist approach. |  |
| **LO14: Discuss the use of Token Economy in the management of schizophrenia.** | Token economies are a form of behaviour modification based on the principle of operant conditioning. Token Economies are reward systems that are used to manage the behaviour of patients with schizophrenia.   * They are specifically targeted at patients who have spent a significant amount of time in psychiatric hospitals (institutionalised). * Patients like this can often have developed bad habits such as poor hygiene. * Token Economy aims to change (or modify) these bad habits. * This does not cure schizophrenia but it does improve the patient’s quality of life. * This is carried out within the hospital so once released from hospital the patient has a better quality of life. * Tokens are given to the patient in exchange for ‘correct’ or ‘desirable’ behaviours, such as getting dressed, or having a shower. * The reward has to be given in a timely way or it may lead the ‘delay discounting’ (reduced effect of a delayed reward). * Tokens have no value alone. * They can be accumulated and then exchanged for a reward such as cigarettes, magazines, or privileges such as a walk outside the hospital.   ***There are the following evaluation points:***   * Ayllon and Fzrin (1968) investigated the use of Token Economy with female patients who had been hospitalised for an average of 16 years. They found that it was successful in helping the patients. * Token economies can lead to a reduction in behaviours such as aggression within an institution due to a lack of reinforcement. This will support the recruitment and retention of staff such as mental health nurses. * Token Economies do not cure schizophrenia or address the positive symptoms such as hallucinations or delusions, they simply manage the negative behaviours such as avolition. * Token economy only manages a small number of specific symptoms (i.e. those which are targeted by the tokens). Which behaviours are targeted is decided by the person managing the token economy (unethical). * There is the chance that the behaviours may stop being repeated once the tokens are no longer available, so many critics argue that this is not a long term solution. * It is widely accepted that Family Therapy is not an effective treatment for schizophrenia on its own and should be used in conjunction with other treatments. | **Depreciates**  Diminish in value over a period.  **Positive Reinforcement**  Introducing a desirable stimulus (i.e. a reward) to encourage the behaviour that is desired.  **Delay Discounting**  When the value of a reward depreciates due to the amount of time spent waiting to receive that reward. | Basic principles of Operant Conditioning and Positive Reinforcement.  (Psychopathology/Approaches)  **Key AO3:**   * Supporting Evidence * Implications for the economy * Nature Nurture Debate and an Interactionist approach. |  |

| **Topic 4 – The Interactionist Approach in Explaining and Treating Schizophrenia** | | | | |
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|  | **Intended Knowledge:**  *Students will know that…* | **Tiered Vocabulary** | **Prior Knowledge:**  *To know this, students, need to already know that…* | **Assessment** |
| **LO15 Discuss the interactist approach in explaining and treating schizophrenia.** | **The Original Diathesis-Stress Model:**   * Both a biological vulnerability and a stress trigger are needed in order for the person to develop schizophrenia. * Meehl; (1962) stated that the diathesis was entirely genetic – the result of a single ‘schizogene’, which would cause the development of schizotypal personality. * But if the person did have the gene, then chronic stress in childhood and adolescence and in particularly a schizophrenogenic mother – could result in schizophrenia. * The Schziophrenogenic Mother (Fromm-Reihcman (1972):   **The Modern Diathesis-Stress Model:**   * We now understand that many genes can cause the disorder (polygenic). Ripke (2014) there is no single schizogene. * It is now thought that a range of factors could make the individual vulnerable (such as psychological trauma). * Read (2001) suggested that if psychological trauma was severe and early enough in childhood it could alter the development of the brain, making them less resistant to stress. * It is now thought that the stress can be a range of factors beyond the family. For example, use of cannabis has been found to increase the chance of develop schizophrenia.   **Turkington (2006) suggests that we can still believe in a biological cause of schizophrenia and use CBT to relieve the psychological symptoms.**  **Typical Anti-Psychotics:**  Act as dopamine antagonists, attempting to reduce dopamine activity.  They bind to dopamine receptors on post-synaptic neurons, meaning that less dopamine is transmitted across the synapse.  Reduces positive symptoms such as hallucinations. Tend to have (sometime severe) side-effects.  **Atypical Anti-Psychotics:**  An example is clozapine. These drugs also combat positive symptoms, but there are claims they have some beneficial effects on negative symptoms as well.  Atypical anti-psychotics also work on the dopamine system, but are thought to block serotonin receptors in the brain too.  The introduction of atypical anti-psychotics raised expectations for the outcomes possible with medication.  PLUS: **CBT** is now a common therapy used to treat Schizophrenia. Lasts between 5-20 sessions, either in groups or on a one to one basis.  ***There are the following evaluation points:***   * Houston (2008) found that childhood sexual abuse and use of cannabis by the Mother during the prenatal stage of foetal development are both Considered risk factors in those genetically vulnerable * There is not enough known about the mechanisms which cause the vulnerability and stress factors to interact in order to produce the schizophrenic symptoms. * The original model of a single schizogene and schizophrenic parenting style is widely considered to be over simple. A specific candidate gene has never Been located and there is no evidence to support the concept of the schizophrenogenic mother. * Drury (1996) found a 25-30% reduction in recovery time and a reduction in positive symptoms for patients given a combination of CBT and medication, supporting the interactionist approach to treating the illness. * Kuipers (1997) noted that there were lower patient drop out rates and greater patient satisfaction when CBT was used in addition to anti-psychotic Medication It is widely accepted that the most effective way to treat schizophrenia is to use a range of different psychological and biological therapies. | . | Role of Dopamine as an excitatory NT and serotonin as an inhibitory NT.  (Biopsychology – Synaptic Transmission)  **Key AO3:**   * Supporting Evidence * Placebo effect. * Ethical Issues * Implications for the economy * Symptom Substitution * Nature Nurture Debate and an Interactionist approach. |  |