Cognitive explanation for Schizophrenia

Root of difficulties traced back to childhood, Primary caregiver-helps overcome anxieties, develops handling emotions and enables to distinguish the internal/external world. If inadequate won’t develop a sense of self. During transitional/turbulent period of adolescence, threats to fragile sense of self occur, symptoms start to emerge. Little evidence. Behavioural approach-failed to provide explanation- children learn to behave in odd ways, repeat these behaviours-rewarded, highly unlikely.

Family Models:
Early-Clinical observations, not supported by empirical research. Double blind theory, child has repeated experiences with one or more family members, he/she receives contradictory messages. Repeated exposure causes child to resort to self-deception, develop false sense of reality, inability to communicate effectively. Research before 1970’s supported the view that it developed from dysfunctional families, studied after diagnosed, rarely involved proper control groups.
Recent research focused on expressed emotion (EE) based on Brown’s work-patients with Schizophrenia likely to relapse if they returned to homes, characterised by high EE than to homes with low EE. EE assessed-taping interview with relative and rate; number of critical comments, statements of dislike/resentment towards patient, rating of statements reflecting emotional over-involvement with, or over-protectiveness of, patient. Family have impact, prospective studies found high-risk patients more likely to come from dysfunctional families. Israeli high-risk study, high risk group – none of those with good parenting developed Schizophrenia. These alone don’t cause Schizophrenia also vulnerability of individuals and environmental stressors.
A02: Studies of EE are correlational and may reflect the consequences of living with severely disturbed individuals rather than having any causal significance. High EE patterns have been found in the families of patients with other disorders such as depression and eating disorders. So, it isn’t a defining characteristic of families with a schizophrenic member. Also, some concerns about the way in which EE is measured- assessment requires only one observation or interview and this might not be sufficient to give an accurate picture of family dynamics.
Cross cultural EE – Individuals with schizophrenia in developing countries are much less likely than those in developed countries to suffer relapse. This is counterintuitive, patients generally have better access to treatment and medication in developing countries. Explanation is that levels of EE within the families of individuals with schizophrenia is lower in developing country than in developed ones. Supporting evidence by Leff et al shows high levels of EE in 74% of families of individuals with schizophrenia in Chandigarh, India compared with 47% in families in London. Kavangh, study, schizophrenics living in families with high EE were nearly 4x as likely to relapse as those living in families with low EE.
Double blind hypothesis:
Bateson et al suggests children who frequently receive contradictory messages from their parents are more likely to develop schizophrenia. The child’s ability to respond to the mother is incapacitated by such contradictions because one message once deception, develop false sense of reality, inability to communicate ineffective. Research before 1970’s supported the view that it developed from dysfunctional families, studied after diagnosed, rarely involved proper control groups.
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