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Forum

Would a rose, by any other name, smell sweeter?

Methods of psychiatric classification have numerous uses, ranging from the clinical (communication

between clinicians, the facilitation of decisions about treatment), to the scientific (selecting participants for research into the aetiology and treatment of mental illness), through to the social and political (keeping statistics about mental health, developing mental health policy). Diagnoses also have unintended consequences, as emphasized by George & Klijn (2013), who argue that the term 'schizophrenia' increases the stigma experienced by psychiatric patients, and that it should therefore be replaced by something else. They cite the experience of Japan, where replacing the term with *Togo-Shitcho Sho* (integration dysregulation syndrome) is claimed to have ameliorated the stigma experienced by patients. While I applaud the overall goal of reducing stigma, and sympathize with authors' suggestion, I think that simple rebranding is unlikely to be enough to achieve what they desire.

The problems of schizophrenia

Schizophrenia has been a contested label for many years (Sarbin & Mancuso, 1980; Bentall *et al.* 1988) not only because it is associated with stigma, but also because it fails to achieve any of the purposes for which it was originally designed. Even in the world of operationalized diagnostic criteria, different definitions of schizophrenia sometimes define different people as schizophrenic (van Os *et al.* 1999). In carefully conducted studies in which patients are followed up over time, patients sometimes move from one diagnosis to another within the psychosis spectrum (Bromet *et al.* 2011) and diagnostic shifts, for example between schizophrenia and bipolar disorder, are probably much more common in the rough and tumble of routine psychiatric care. Statistical analyses of symptoms fail to provide any support for the kind of categorical diagnoses contained within the DSM or ICD systems (Kotov *et al.* 2011). Instead, the psychotic disorders seem best described in terms of five relatively independent dimensions of positive symptoms, negative symptoms, cognitive disorganization, depression and mania (Demjaha *et al.* 2009), although there may also be a superordinate general psychosis dimension (Reininghaus *et al.* 2012), which is also suggested by genetic research (Craddock & Owen, 2005). Importantly, there is considerable evidence that at least some of these dimensions lie on continua with normal functioning (Linscott & van Os, 2010). Not surprisingly, given these findings, there is very little evidence that categorical diagnoses, at least in the psychotic domain, predict treatment response. Patients diagnosed as suffering from bipolar disorder, like those diagnosed with schizophrenia, are now commonly treated with antipsychotic drugs, leading to suspicions that patients with the two diagnoses suffer

from a common dopaminergic disorder (Tamminga & Davis, 2007). The only study which, to this author's knowledge, has randomly assigned patients in the psychosis spectrum to an antipsychotic (pimozide) and/or a mood stabilizer (lithium) found almost no evidence that diagnosis was a useful predictor of treatment response (Johnstone *et al.* 1988).

Rebranding schizophrenia solves none of these problems. By replacing one ill-fitting label with another, we do nothing to advance psychiatric research or to develop better treatment plans for our patients. Moreover, some of the proposed rebrandings are potentially misleading – for example 'salience syndrome' (van Os, 2009) implies the acceptance of one particular biological model of positive symptoms (Kapur *et al.* 2005), ignores other kinds of models (what about 'self-monitoring deficiency syndrome?') and cannot apply to dimensions other than the positive. Nor is it obvious how, in the long-term, this kind of rebranding will ameliorate the unintended consequence of the schizophrenia label that concerns George & Klijn (2013).

Of course, it is possible that the label is now so toxic that changing the name may well have a temporary effect, but unless the real causes of stigma are addressed, in a matter of only a few years the new term is likely to acquire its own toxic qualities, every bit as troublesome as those of its predecessor.

It is not hard to locate some of these causes. Without a doubt, one is the media's treatment of schizophrenia, which consistently over-emphasizes the risk of dangerous behaviour by patients (Philo *et al.* 1994; Coverdale *et al.* 2002; Owen, 2012), conveying the impression that people with psychosis are responsible for an epidemic of interpersonal violence. The reality is, of course, quite different. Whereas there is an increased risk of violence associated with psychosis, most of this is attributable to co-morbid substance abuse (Fazel *et al.* 2009) and most psychiatric patients pose absolutely no risk to their neighbours.

A second, less obvious source of the toxicity of the schizophrenia label is the hopelessness that surrounds it. For example, consistent with Kraepelin's original conception of dementia praecox, for many clinicians, patients and the general public, the term implies a life doomed to be limited by mental illness until death. Again, the reality is different, with many patients making a full recovery, and others being able to pursue a fulfilling life despite persisting symptoms and disability (Ciompi, 1984; Harding, *et al.* 1987). It is findings such as these that have led to a radical reappraisal of the concept of recovery from severe mental illness (Anthony, 1993).

Finally, the background scientific assumptions that surround the label schizophrenia make a major

contribution to the stigma associated with it. Many of those who defend the term support a narrow biomedical conception of psychosis as a largely genetically determined neurological condition, while objecting to any possibility that there may be important social and environmental determinants. For example, in an editorial in the *British Medical Journal* supporting the retention of the schizophrenia label, Lieberman & First (2007) asserted that,

Although a diagnosis of schizophrenia depends on the presence of a pattern of symptoms... evidence shows that these are manifestations of brain pathology. Schizophrenia is not caused by disturbed psychological development or bad parenting.

Consistent with this viewpoint, mental health literacy campaigns have typically promoted the idea that schizophrenia is 'an illness like any other illness' (Read *et al.* 2006).

The irony is not only that a narrow biomedical conception of schizophrenia (whatever the term refers to) is no longer scientifically defensible (contrary to Lieberman & First, there is compelling evidence that adverse early childhood experiences play an important causal role in psychosis; Varese *et al.* 2012) but also that genetic-neurological accounts of psychosis actually increase the stigma experienced by psychiatric patients (Read *et al.* 2006; Angermeyer, *et al.* 2011). The general public, it seems, finds accounts of mental illness that emphasize environmental stressors, not only more believable, but more sympathy-evoking than accounts that emphasize genetic and neurological factors. From a common sense perspective this should not be surprising. (Who would the reader prefer to live next-door to – someone who is behaving erratically because of some kind of life trauma, or someone whose unpredictable behaviour is the consequence of some kind of endogenous genetic defect in the central nervous system?)

Conclusion

When, at the beginning of my career, I first argued that the concept of schizophrenia should be abandoned (Bentall *et al.* 1988) it was widely regarded as a marginal, perhaps preposterous position. From a purely personal perspective, it is satisfying that what was once marginal is now in danger of becoming mainstream. The problem has become not whether to replace schizophrenia, but what to replace it with. Simple relabelling will do nothing to address the many scientific and clinical limitations of the categorical approach to diagnosis that I have briefly summarized. Nor is it likely to address the problem of stigma, which arises out of background assumptions

about the nature of severe mental illness. To persuade the general public to be more accepting of people with mental illness, we must persuade them that psychosis arises, in part, understandably from adverse life experiences (while of course acknowledging that genetic factors must play some role), that it does not necessarily lead to violence, and that recovery is possible. Fortunately, there is a now a considerable volume of research that supports this position.

Declaration of Interest

None.

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