

Down With Schizophrenia

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New Scientist, October 17 2007

IN 2011, schizophrenia will be 100 years old. This also happens to be the year in which the main classification systems for psychiatric disorders are due to be revised. The question is: does the term "schizophrenia" deserve to survive into its second century?

Most patients would say no. In my work I find the diagnosis very difficult to use because it depresses patients and their carers and stigmatises them at home and at work. Patients constantly tell me how unhelpful they find it, and many simply reject the term.

Indeed, the classification has little if any scientific basis. Previously known as "dementia praecox" - early-onset dementia - schizophrenia has been used to cover a collection of diverse states ever since Swiss psychiatrist Eugen Bleuler coined the name in 1911. Conditions continued to be added until the 1970s, when it was decided that the classification had become impossibly wide. The "solution" was to focus on the nature of the symptoms (whether a patient has certain types of delusions, for example, or hears voices) but to ignore the content of those symptoms (what the patient is afraid of, or what the voices say). There is now a checklist of symptoms that helps doctors decide whether someone has schizophrenia.

["The classification of schizophrenia has little if any scientific basis"](#)

This reduced the number of patients, but it still left a very diverse group. And it devalued patients' experiences: their individual stresses, strengths and vulnerabilities were increasingly ignored, and coping strategies they had developed were not reinforced.

The majority view within psychiatry is that we should wait until we understand the biological basis of schizophrenia - what goes wrong in the brain - before changing the way we describe it. This view is supported by the [American Psychiatric Association \(APA\)](#), which publishes the [Diagnostic and Statistical Manual of Mental Disorders](#), the profession's main handbook for diagnosing disorders. Simply changing the name (as happened in Japan, where it was recently renamed "integration disorder") will not change the root cause of the stigma - general ignorance of mental illness.

The problem with this argument is that a century of trying to unpick the biological basis of schizophrenia has made very little progress, and has been utterly unhelpful to patients. The assumption that there is a biological cause, rooted in the brain and stripped of environmental influence, leaves patients thinking they have no hope of recovery. It also causes others to distance themselves from the patient in a way that disorders such as anxiety and depression do not.

In contrast, there have been major advances in understanding the social and psychological context of psychosis in general, and this has led to the development of successful interventions. Cognitive behavioural therapy, for example, can help treat symptoms. And work with people who hear voices has challenged the assumption that the phenomenon is inevitably pathological. This realisation has transformed the way that voices are considered, and helped many individuals to cope with stigmatisation and unhelpful labels, and to deal with their hallucinations more positively.

Psychosocial research into schizophrenia is also beginning to reveal the impact of environmental factors such as stimulant and hallucinogenic drugs, stress and childhood trauma. This has led to the idea of subgroups of the condition, such as stress-sensitivity psychosis, traumatic psychosis, anxiety psychosis and drug-related psychosis. Although more research is needed to better delineate these groups, this terminology is proving to be much more acceptable to patients. It is also more accurate, and may be less stigmatising. Our studies recently found that where 63 per cent of diagnosed patients have negative attitudes towards the term schizophrenia, only 16 per cent were negative about such new terms. Medical students asked to contrast these terms with schizophrenia were twice as likely to hold positive views about a patient's chance of recovery ([BMJ, vol 334, p 221](#)).

Renaming schizophrenia is highly controversial. It is difficult for psychiatrists and researchers to acknowledge that the concept they have been using for almost 100 years makes no sense. The drug industry is also likely to be resistant. Dividing patients into smaller groups means that not every drug will work in every group, reducing the potential market.

Yet there is momentum for change. [The patient-led Campaign for Abolition of the Schizophrenia Label](#) held its inaugural conference in Birkenhead in the UK last month. The APA is starting to shift its position, too. It now acknowledges that the evidence supports a spectrum of psychosis, rather than a simple divide between bipolar disorder and schizophrenia.

My worry is that the concept of schizophrenia will persist. The APA is considering how psychosis should fit within its new classification system. I hope it decides on an approach that is based on evidence and is right for patients.

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