Swan song for schizophrenia?

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Schizophrenia is a word that frightens people, is replete with stigma, is used pejoratively in daily speech and is etymologically absurd. There is now widespread international interest in renaming the syndrome (Essock and Rogers, 2011; George and Klijn, 2013; Levin, 2006; Tranulis et al., 2013). In this Editorial, we examine the justification for giving up the term and consider strategies for finding an alternative.

Bleuler, Kraepelin, Schneider and Meyer

In a recent article, Lasalvia and Tansella (2013) point out that when Bleuler proposed the name schizophrenia in 1911, he was aware from the outset of the considerable diversity in its clinical manifestations (Bleuler, 1911, 1950).

Bleuler gave primacy to dissociative pathology but also emphasized the importance of negative symptoms and interpersonal difficulties. This broadened the definition of schizophrenia, which was captured in the Diagnostic and Statistical Manual of Mental Disorders, First and Second Editions (DSM-I and DSM-II), and contributed the differences that emerged with respect to its diagnosis across Europe and the USA (Bleuler, 1950). Other key influences that shaped the definition of schizophrenia were the views of Kraepelin and Schneider. Kraepelin’s perspective centred on avolition and emphasized longitudinal outcome and chronicity, whereas Schneider focused on the distortion of reality, which manifests as positive symptoms (Kraepelin, 1971; Schneider, 1959). Diverse views and inconsistencies in diagnosis prompted DSM-III to construct the definition by giving prominence to Schneiderian first-rank symptoms, poor functioning and chronicity, so as to achieve greater homogeneity. However, the criteria were once again loosened in subsequent editions of DSM, with the inclusion of negative symptoms, and by no longer stipulating onset before the age of 45 years. Arguably, DSM-IV schizophrenia has been a useful term that has reasonable validity and high reliability (Tandon et al., 2009). As a diagnosis it has proven to be quite stable (Bromet et al., 2011) and hence DSM-5 has retained much of the core structure of DSM-IV schizophrenia. Interestingly, the ‘classic’ subtypes of schizophrenia appear to have fallen out of favour with clinicians and the majority of psychiatrists subtype their patients as having schizophrenia of a paranoid or undifferentiated form, if they do so at all. The remaining subtypes, namely catatonic and hebephrenic/disorganized, are rarely, if ever, diagnosed and have little prognostic value (Linscott et al., 2010). But simply refining the definition of schizophrenia, both internally with respect to subtypes so as to diminish heterogeneity, and externally so as to demarcate its boundaries with adjacent constructs, is not enough. Schizoaffective disorder (SAD) is a good example of a nebulous diagnosis that can be used to fill in the gaps as the dominant diagnosis of schizophrenia expands and contracts (Malhi et al., 2008). Indeed, in DSM-5, SAD has once again been modified so as to increase its specificity and limit its misuse (Malhi, 2013), but as long as it shares a boundary with schizophrenia it will continue to obfuscate diagnosis.

Adolf Meyer, a contemporary of Bleuler and Kraepelin, viewed schizophrenia as a ‘reaction’ to a whole range of causes. Enormously influential at the beginning of the 20th century, he contextualized mental illness within a framework of reactions as opposed to biologically based diseases; schizophrenia (dementia praecox) was thought to be a group of maladaptive reactions, which were in essence attempts at coping with the stressors that produced the illness. Interestingly, the idea that schizophrenia is a reaction may...
have a biological basis, and conceptually it is in keeping with much of our understanding of the illness and its treatment. For example, presynaptic neuronal pruning within the thalamus in combination with an increase in the release of dopamine and a change in dopamine D2 receptors and their sensitivity leads to an overactive dopamine system (Seeman, 2011). The individual experiences this as unpleasant over-stimulation and attempts to adapt to this, but in doing so generates the signs and symptoms of schizophrenia. In this schema, the original causes for dopamine system overactivity are myriad, and it is the pattern of response (symptoms, signs and behaviours) that form the illness as we see it (Howes et al., 2012). This is concordant with Meyer’s view (Meyer, 1922).

**Schizophrenia ... by any other name?**

One of the consequences of DSM is the reification of schizophrenia as a disease. The public, and indeed many doctors, consider schizophrenia to be a single entity; a myth that DSM-5 will no doubt continue to promulgate. In reality, there is now a rich corpus of evidence that it is a heterogeneous syndrome, not only in its core psychopathology but in terms of its derivation from environmental exposures, the role of comorbidity, the course of the disorder, the extent of cognitive impairment, response to treatment and, above all, the diverse needs it presents for clinical care. Van Os et al. (1999) pointed out that groups of patients identified by the common label of ‘schizophrenia’ may often have very little in common. The conclusion is that using the word schizophrenia is no longer appropriate in clinical practice because it is not a single disorder and the term has become associated by the public with negative connotations such as unpredictable behaviour and violence (van Os, 2009).

Just as mongolism became Down’s syndrome and senile dementia became Alzheimer’s disease, schizophrenia could be superseded by a term less freighted with stigma. The Department of Mental Health and Substance Abuse at the World Health Organization (WHO) in Geneva is currently working on the *International Classification of Diseases, 11th Revision* (ICD-11), due to be presented to the World Health Assembly in late 2015. For Mental and Behavioural Disorders, a number of Work Groups have been established for the task. These contain experts from a range of countries differing greatly in their economic and socio-political conditions. The Work Group engaged in revising the psychoses will give careful attention to the viability of the term schizophrenia. They are conscious that an exceptional opportunity currently exists for WHO to remove the word from the public and professional vocabulary.

In Japan, until 2002, schizophrenia was known as ‘mind-split disease’ or *seishin-bunretsu-byo*, a direct translation of the word schizophrenia. At the direct request of the Japanese National Federation of Families with Mental Illness, and being themselves aware of the high level of public stigma associated with the word, in 2002 the Japanese Society of Psychiatry and Neurology took the bold step of changing the term to *tōgō-shitchō-shō* or ‘integration disorder’ (Sato, 2009). There is some evidence about the benefit this has brought, with no apparent adverse consequences (Takahashi et al., 2009). Other countries, such as Canada, China, Hong Kong, The Netherlands and South Korea, have also started to consider a new name. In the latter, for example, the term *johyeounbuung* (attunement disorder) has been proffered and, in each instance, the initiative seems to have come from consumer groups as well as from mental health professionals. There is some evidence that patients themselves would welcome a new term. In the former, for example, the term *johyeounbuung* (attunement disorder) has been proffered and, in each instance, the initiative seems to have come from consumer groups as well as from mental health professionals. There is some evidence that patients themselves would welcome a new term. Kingdon et al. (2013) found that “psychosocially descriptive terms have been found to be more acceptable to patients and perceived as less stigmatising by others”.

Lasalvia and Tansella (2013) have dissected the issues to be confronted. They point out that renaming schizophrenia may bring only temporary benefit in reducing stigma because a new name might soon attract the same negative properties (Lieberman and First, 2007). Indeed, Tranulis et al. (2013) found some evidence that a name change might bring only temporary relief from stigma. But the possible benefit to public understanding and to research investment could be considerable, as happened so successfully for Alzheimer’s disease. Levin (2006) argues that a name reflecting the neurobiological nature of schizophrenia would be useful to assist communication, educate the public and reduce stigma.

The gradual acquisition of stigma by psychiatric terms is a recurring problem and, alongside renaming schizophrenia, it is important to consider what else needs to be in place to avoid any new term suffering the same fate in years to come. Research has shown that an advanced understanding of an illness imbues positive attitudes towards it (Brockington et al., 1993), and with schizophrenia this can perhaps be achieved by making people aware of the facts regarding its known pathophysiology and successful management. This is best achieved in adolescence, when individuals are at their most receptive and are themselves dealing with similar issues regarding their identity and psychological well-being. In addition, actual ‘contact’ with patients has been found to be a powerful transformer, and therefore the management of mental illnesses such as schizophrenia needs to occur alongside medical illnesses in hospital, primary care and community settings. But having examined the information currently available, Lasalvia and Tansella conclude that “a more pertinent question is perhaps not whether to replace the term ‘schizophrenia’, but rather what its replacement should be”. Here we consider how this might be tackled. To guide the process, a
A number of desiderata can be identified, as follows:

1. In determining a new name, there should be input from patients, families, carers and non-government organizations, in addition to clinicians.
2. It should clearly reflect that the condition is not a single entity.
3. If possible, it should be related to the clinical features or the subjective experience associated with the condition.
4. It should be understandable by the general public.
5. Consideration should be given to an eponym, as in Down’s syndrome and Alzheimer’s disease.

Several new names have already been proposed. The Dutch association Anokis ‘of and for people with a susceptibility to psychosis’, is now campaigning internationally for the term Psychosis Susceptibility Syndrome (PSS). As patients themselves, this group argue cogently for the term ‘psychosis’ because it covers the unreality of both hallucinations and delusions; ‘susceptibility’ because a person with schizophrenia is in many cases not psychotic all the time; and ‘syndrome’ because it involves multiple domains (George and Klijn, 2013). However, within the domains defined by DSM-5, signs and symptoms exist on a continuum from normalcy to psychosis along putative gradients that reflect severity, and duration of psychopathology is used to capture forms of illness that are less severe, such as schizophreniform disorder (Heckers et al., 2013). This highlights another source of potential heterogeneity in schizophrenia and the complexity of the illness that needs to be disentangled in order to achieve clarity and specificity.

The name Psychotic Spectrum Disorder (Peralta, 1999) has the merit of being rationally derived, with both the adjectives being independently valid. Van Os (2009) has proposed Salience Syndrome and we now await how well this term will be received. Another candidate is the simple expression Psychotic Syndrome, preceded by the adjectives ‘acute’, ‘recurrent’ or ‘continuing’ according to the course taken in the individual case. An alternative would be an eponym, an obvious candidate being Bleuler’s Syndrome because it was he who recognized the distinction from dementia praecox, as Kraepelin (1896) had encountered it in a largely hospital-based series.

Conclusion
It is clear that schizophrenia as a term has probably come to the end of its useful life. From the standpoint of clinicians and research workers, it has to be accepted that the word no longer accommodates the scientific advances made in understanding this complex and heterogeneous group of disorders. Our own view is that simple terms such as either Psychotic Spectrum Disorder or Bleuler’s Syndrome are attractive alternatives, but will only be of benefit if our understanding of the illness advances significantly and we are able to communicate this new knowledge effectively.

Keywords
Psychosis, schizophrenia, stigma, classification, ICD-11, DSM-5

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