

Split minds, splitting hairs?: An interdisciplinary perspective on renaming schizophrenia

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Abstract

The long-standing debate regarding whether schizophrenia should be renamed has been gaining traction since the turn of the century. Since the term was first coined in 1918, significant developments in our conceptions of the disorder have taken place – while some East Asian countries have already rebranded ‘schizophrenia’ in light of this, there remains institutional resistance in Europe and America to a new name. In this essay, I draw on recent developments in biomedicine, alongside socio-historical, anthropological and philosophical critique to make an interdisciplinary case for renaming schizophrenia. I urge a deeper consideration of the role that psychiatric language plays in shaping attitudes towards mental illness and a broader imagination of the impact of a new name on society at large. I argue alongside many other researchers, clinicians and patients that the word ‘schizophrenia’ is outdated, failing to reflect contemporary biomedical and socio-cultural understandings of the condition. In addition, due in no small part to its etymological roots and acquired meanings over history, that the term perpetuates public and iatrogenic stigma attached to the diagnosis. I provide a brief overview the debate at hand, and discuss the potential of the name ‘psychosis spectrum disorder’ in relation to these considerations.

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I. Introduction

When I looked up 'What is schizophrenia?' on Google, the top result was an American Psychiatric Association (APA) webpage that offers information to people newly diagnosed with schizophrenia and their families, which reads:

Schizophrenia does not mean split personality or multiple-personality. Most people with schizophrenia are not dangerous or violent. They also are not homeless nor do they live in hospitals. Most people with schizophrenia live with family, in group homes or on their own. (Parekh 2017)

The next result was an overview of schizophrenia on a National Health Service (NHS) webpage that contained a similar disclaimer:

Some people think schizophrenia causes a "split personality" or violent behaviour. This is not true.

The cause of any violent behaviour is usually drug or alcohol misuse. (NHS 2016)

These statements refute a stereotype of persons with schizophrenia as dangerous individuals that are necessarily excluded from participation in society because of the risk they pose to others. Concurrently, they serve as an acknowledgement that this stereotype is pervasive and perhaps even considered a common-sense belief. Based on their wording and in particular their references to violence, one would imagine that the very mention of the word 'schizophrenia' plunges people into a state of alarm. This is reflected in a write-up on the Royal College of Psychiatrists (RCPsych) website below:

'Schizophrenia' is a word that makes many people uneasy. The media regularly uses it – inaccurately and unfairly – to describe violence and disturbance... It can feel as though society has judged you to be violent and out of control – when you clearly are not. (RCPsych 2015)

The question must be posed: in an age where information is so widely and readily accessible, why does schizophrenia continue to mystify, confound and unsettle? How have portrayals of schizophrenia as a disorder of multiple personalities or violent tendencies endured in the media, when neither of these is representative of the condition?

Over the last few decades and increasingly since the turn of the century, there have been calls to rename schizophrenia on the basis that the term is neither useful in clinical practice nor helpful to improving public perceptions of the disorder. In spite of the extensive body of literature surrounding this debate, there has not been much effort to integrate a diversity of perspectives from the fields of biomedicine, humanities and social sciences on the subject at hand.

In this essay I argue, alongside numerous professionals and patients, that the term 'schizophrenia' is outdated. Weaving together strands of biomedical, socio-historical, anthropological and philosophical critique in my discussion, I suggest 'schizophrenia' should be replaced by a new name that is more relevant to the experience of patients with the condition and to contemporary understandings of mental illness. I reiterate the fact that psychiatric language must evolve in accordance with broader trends in society in order to remain relevant and meaningful – furthermore, that this language plays a crucial role in defining clinical realities, and should be considered more seriously in efforts to de-stigmatize mental illness in both iatrogenic and public contexts. In section II, I discuss the origins of the term 'schizophrenia' and briefly trace a history of how the disorder has been conceptualized over time. In the three sections following, I outline ways in which the term 'schizophrenia' is understood and no longer useful: as a biomedical construct (III), as a socio-cultural phenomenon (IV) and in the way it perpetuates stigma attached to the disorder (V). In the latter section, I also discuss the example of East Asian countries where the name change has already taken place alongside preliminary findings regarding the potential impact of a name change in Europe and America. In section VI, I explore the relationship between language, meaning and stigma construction, and suggest how medical language plays a role in defining clinical and social realities. In section VII, I discuss the alternative names that have been put forward to replace 'schizophrenia', and expound further on the proposal

of a 'psychosis spectrum disorder'. I conclude the essay in section VIII with final comments on the significance of this debate to the mental health profession, to the patient population and to the positioning of mental illness in society.

II. What is 'schizophrenia'?

It becomes easy to understand the confusion surrounding 'schizophrenia' when we consider its etymology. The term comes from the German *Schizophrenie*, comprised of the Greek words *skhizen*, which means 'to split', and *phren*, which means 'mind' – hence, translating into 'split mind' (Hoad 2003). It was first coined in 1911 by the Swiss psychiatrist Eugen Bleuler in his essay 'Dementia praecox or the group of schizophrenias' (see *Figure 1*). He adopted the phrase 'a group of schizophrenias' to capture the heterogeneity of the disorder, which was already evident at the time. In popular usage, however, 'schizophrenia' remained in its singular form, reified in the collective consciousness as a bounded entity (cf. van Os 2009), rather than a composite of symptoms that may vary from one individual to the next.

Before Bleuler, the name for schizophrenia was continually revised throughout the 19th century, as the condition became increasingly well understood from patient accounts (Kyziridis 2005). Falvet's original 'Folie Circulaire' (cyclical madness) in 1851 was followed by Hecker's 'Hebephrenia' (after Hebe, goddess of youth and frivolity) in 1871, and again by Kahlbaum's account of disorders of catatonia and paranoia in 1874. The condition of schizophrenia as we know it today was first delineated in 1878 by Kraepelin, who grouped of all these descriptions under the label 'dementia praecox' (dementia of early onset), which Bleuler (1911[1950]) finally renamed 'schizophrenia' in his seminal 1911 essay.

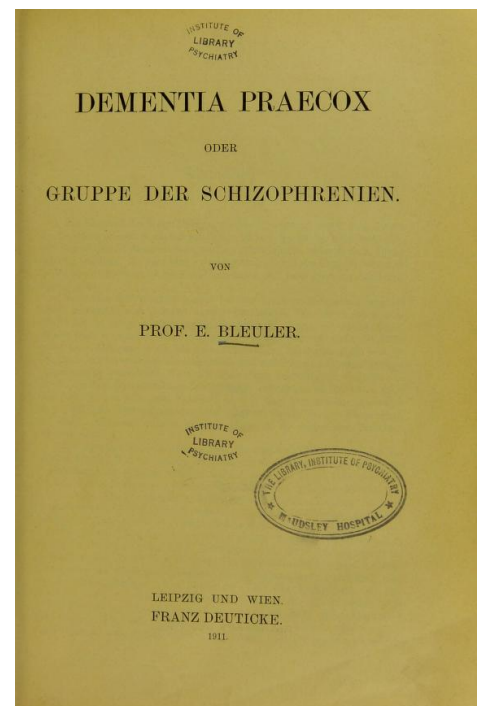


Figure 1: The original 1911 cover of Bleuler's essay (Internet Archive 2015)

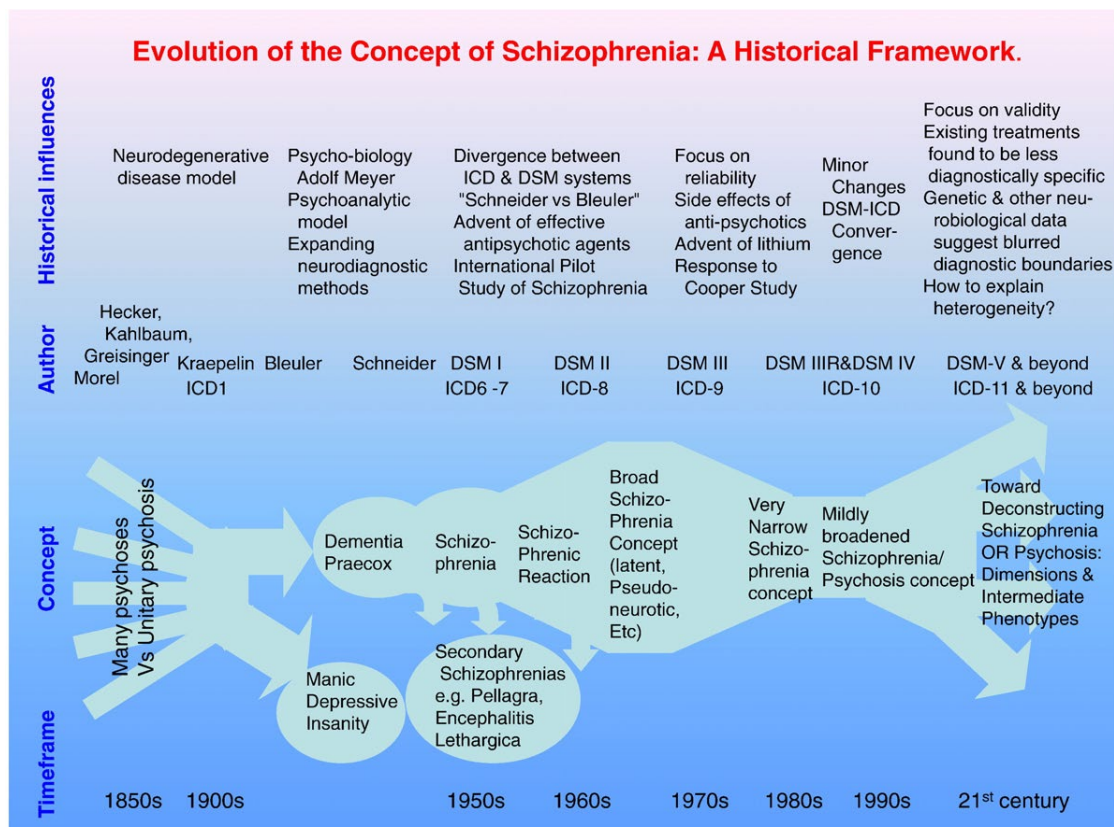


Figure 2: A timeline representing the evolution of the concept of schizophrenia over history (Tandon et. al 2009:3)

In the last century, however, there have been no serious contenders to Bleuler's term. A timeline (*see Figure 2*) featured in a paper by Tandon and colleagues (2009) reflects how conception of the disorder has evolved over the past 150 years, while the word 'schizophrenia' has remained unchanged over five revisions and repeated sub-revisions of APA's Diagnostic and Statistical Manual of Mental Disorders (DSM), and five versions of World Health Organization's (WHO) International Classification of Diseases (ICD). Previous diagnostic classifications up to the DSM-IV attempted to organize the varieties of schizophrenia into discrete subtypes: disorganized (hebephrenic), paranoid, catatonic and undifferentiated (Tandon et. al 2013:6). While retained for the sake of tradition, these categories failed to capture the complexity of the disorder and account for the considerable overlap between them in clinical presentation. Rebranding efforts, such the introduction of 'schizophrenia spectrum' in the 2013 publication of DSM-5 (Tandon et. al 2013, Heckers et. al 2013), have sought to provide a less simplistic way of thinking about the disorder. It remains however that the word

'schizophrenia' still persists in public discourse, still poorly understood. Of this, Lasalvia (2018) makes the following observation:

Over the past century, psychiatry has made Humpty Dumpty's fundamental error, believing it possible to remain the master of its own words and to control their usage by, and connotations for, others. However, words tend to take on a life of their own, often becoming ambiguous and misleading in the process... A similar process seems to have specifically occurred for schizophrenia. (Lasalvia 2018:33)

There is no denying that 'schizophrenia' exists, whether as a concept or group of concepts. The criteria listed in the DSM-5 and even the DSM-IV has proven the diagnostic reliability and validity (Tandon et. al 2013:3) of the construct, even though the latter has been called into question (Guloksuz & van Os 2018:234). As a diagnosis, it has stood the test of time – since the condition was first defined in the mid-19th century, accounts of schizophrenia have largely remained unchanged. The question in discussion is whether a new label will promote more accurate perceptions of the disorder in society, as well as mediate the social distance that currently exists between the patient population and the public.

III. A biomedical construct

Firstly, it is widely understood that the term 'schizophrenia' fails to encapsulate current biomedical conceptualizations of the disorder. While accounts of its symptoms have largely remained unchanged since Bleuler's time, decades of advancement in the fields of neuroscience, psychology and medicine have given rise to a diverse array of explanatory models for schizophrenia (Peralta & Cuesta 2003:142, Tandon et. al 2009:3). The dual connotations of the word 'schizophrenia' – (1) that the disorder stems from a 'split' mind (Kim & Berrios 2001:182) and (2) that it is a singular entity (Maric et.al 2004:600) – have long failed to correspond to these models. Amidst these variations, and even in the absence of a consensus, it has long been apparent that there is little

scientific evidence for Bleuler's original concept of schizophrenia, or at least how his concept is expressed today.

Critics of the term often suggest that 'schizophrenia' is a misnomer because of its embedded reference to disassociative 'splitting', which reflects an outdated concept of the condition.

Both Bleuler and Kraepelin defined two essential components of the disorder: (1) dissociative experiences *i.e. disorganized thought and behavior* and (2) a lack of volition *i.e. negative symptoms that have prevailed in contemporary thought*. In particular, the link between dissociation and schizophrenia was formative to Bleuler's belief that schizophrenia arose from a 'splitting' in the psyche (1911[1950]:2) leading to a lack of coordination between mental functions. Bleuler was reported to have understood that the individual with schizophrenia 'thinks, feels, and acts in many respects as if there were different souls in him, as if he consisted of different personalities... he becomes 'split' to a psychotic degree' (Moskowitz & Heim 2011:474). Bleuler's perspective was very much inspired by the intellectual context of his time – his writings were heavily influenced by early 20th century interest in psychological mechanisms of association and dissociation pioneered by Pierre Janet (Van der Hart et. al 1989), which likely encouraged his choice of language in his descriptions of 'schizophrenia', and the term itself. However, since Bleuler, diagnostic criterion for the disorder has broadened considerably. Rather than a fundamental component of schizophrenia, dissociation – which presents as disorganized thought and behavior – is only reflected in one out of six criterion in the DSM-V (Tandon et. al 2013:5). Furthermore, the concept of 'splitting' as Bleuler understood it is now considered outmoded and obsolete. Kim and Berrios (2001) conclude:

Thought derailment" and "loose associations," once considered the "clinical" manifestations of splitting, are now explained otherwise and no longer considered as "pathognomonic" of schizophrenia... The same can be said of Bleuler's fundamental symptoms (now called "negative"), which are no longer believed to result from splitting. All

this suggests that there is no longer a reason for "splitting" to be part of the name of the disease (2001:184)

Besides the attribution of schizophrenia to mechanisms of 'splitting', the notion that disorder is a unitary entity (i.e. a *schizophrenia*) – an isolated disorder with a singular set of symptoms – has been thoroughly disputed in psychiatric circles and even by Bleuler himself (Maric, et.al 2004:600).

In the early 1960s, Paul E. Meehl proposed the existence of a genetic variant that predisposed an individual to schizophrenia, which he termed 'schizotaxia' (Meehl 2017[1962]:830). Schizotaxic individuals would go on to develop 'schizotypic' personality traits, and only a proportion of these individuals would undergo 'decompensation' into clinical schizophrenia – a process largely influenced by socio-environmental factors. More recently, a large systematic review conducted by van Os and colleagues (2009) showed a correlation between environmental factors and individual susceptibility to psychotic experiences. Furthermore, the latest evidence in research suggests that schizophrenia is in fact influenced by a vast array of single nucleotide and chromosomal copy variants across multiple genomic regions, a finding that has led to the development of polygenic risk scores for the condition (Purcell et. al 2009, Wray et. al 2014). These scores enable patients to be stratified according to their genetic predisposition to schizophrenia based on their genotype, relative to a normal distribution of genetic variance in the general population. Such data provides scientific basis for Meehl's 1962 model of schizotaxia and support for his hypothesis that 'schizotypy' is phenotypically variable. All of this suggests that within a given population, schizophrenia represents one end of a 'psychosis continuum' (Derks et. al 2012) – a concept that will be returned to in later sections – and should not be understood as an isolated disorder. Additionally, it has been widely acknowledged that there are in fact no symptoms that are uniquely 'schizophrenic' (Gaines 1992:4) and that the construct displays considerable overlap with other psychiatric conditions, such as autism and bipolar disorder (APA 2013:100). In response to this, van Os (2009) makes the following comment:

[S]chizophrenia refers to a syndrome of symptom dimensions that for unknown reasons cluster together in different combinations in different people with different contributions of known risk factors and dramatically different outcomes and response to treatment; no knowledge exists that may help decide to what degree schizophrenia, for example, reflects a single or 20 different underlying diseases – or none at all. (2009:368)

Here, van Os argues that 'schizophrenia' perpetuates an all too narrow concept of the disorder that does not account for the variability in symptomatic presentation that clinicians encounter in practice – a 'complicated, albeit meaningless greek term' (2009:368) that has outlived its usefulness.

While there is a tacit understanding among psychiatrists that schizophrenia is a much more heterogeneous disorder than its label implies, this knowledge has not yet been transmitted to the general public. This gap in knowledge presents in studies such as that by Kingdon and colleagues (2004) among UK practitioners, which demonstrated that psychiatrists surveyed had more favorable attitudes towards people with schizophrenia relative to the general population, presumably due to misinformation that exists in the public sphere regarding the condition along with a lack of contact with these individuals. Indeed, the role that health terminology plays in public health education cannot be underestimated, especially when terminology obfuscates or detracts from the meaning of a medical diagnosis. A brief look at the history of how the biomedical concept of 'schizophrenia' has been developed by clinicians and researchers over the past hundred years, it appears that a change of name is long overdue.

IV. A socio-cultural phenomenon

Secondly, I draw attention to the failure of the term 'schizophrenia' to articulate socio-cultural representations of psychosis in present-day Euro-American society, which are undergirded by postmodern conceptions of mental illness and psychosis. The

etymological characterization of schizophrenia as a 'split-mind disorder' has been criticized for its bizarre and enigmatic quality, which bears no relation to ordinary human experience or similarity to other illness terms within the vernacular. In contrast, the word 'depression' implies a negative feeling that people can relate to and even empathize with, while the name 'bipolar disorder' reflects the nature of its clinical presentation and relates it to other types of medical disorders (including physical ones). As discussed above, the word 'schizophrenia' suggests that the condition is an isolated phenomenon – a thing, rather than a concept (van Os 2009:268) – that occupies a unique position outside the realm of normal or 'normalised' pathology.

Over the past few decades, schizophrenia and other psychoses have been written about extensively not only through a biomedical lens, but also through that of sociology (Doubt 1996), anthropology (Jenkins & Barrett 2004), art and literature (Sass 1992, 2001). Amidst a post-modern era marked by plurality and reflexivity, a conceptual reframing of the condition in Euro-American thought has occurred: once considered extraneous to ordinary human experience, schizophrenia is now viewed by many as a phenomenon grounded in universal psychological processes (Jenkins 2004) and deeply embedded in socio-cultural context, and thereby susceptible to its influence (Lin & Kleinman 1988). Rather than an otherworldly entity, the condition is steadily becoming situated at one end of a spectrum of normative human behavior.

Nearly three decades ago, in his influential work *Madness and Modernism* the psychiatrist Louis Sass (1992) examined the expression of psychotic symptoms in modernist and postmodernist works of art, and the parallels between psychosis and art movements such as avant-gardism and perspectivism, to propose a correlation between schizophrenic traits and creative genius. While Sass was and remains a controversial figure in psychiatry, his work mirrored a less radical shift in medical thinking that took place in the second half of the 20th century – one towards broader and more holistic concepts of mental illness. This was marked by the advent of the biopsychosocial model in clinical practice in 1980, alongside increasing advocacy for eclecticism over dogmatism in the understanding and treatment of psychiatric illness (Ghaemi 2009:3). Another factor that contributed to the case for eclecticism (ibid.3) was the advent of transcultural psychiatry in the mid to late 20th century (Lin & Kleinman 1988), in which

schizophrenia and other psychoses came to be examined through an ethnographic lens focusing on the socio-cultural factors that determined the onset, presentation and course of an individual's illness. These considerations have led to increased research into the associations between ethnicity, culture and psychopathology, particularly in culturally diverse populations such as the AESOP and AESOP-10 studies conducted in Southeast London and Nottingham (Fearon et. al 2006, Morgan et. al 2014).

Overall, trends towards the socialisation and depathologisation of mental illness have persisted into the 21st century, as evidenced by further research supporting an association between creativity and psychosis (Power et.al 2015, Acar et. al 2018, Crabtree & Newton-John 2019), an increased recognition of culture-bound syndromes (Simons & Hughes 2012) and the emergence of concepts such as neurodiversity (Silberman 2015) that challenge old paradigms of normativity. In a commentary on the history of the DSM, Gaines (1992) argues that because psychiatric classification is culturally derived, it must be informed by cultural developments in order to remain relevant to its audience:

What is 'said' by inclusion or exclusion? By who is it said? In what voice is it said? To what end does this classificatory process move? I suggest that the realities expressed are experience-near to the human condition...they express a culture's existential philosophy and its psychology (1992:11)

In the above excerpt, Gaines proposes that medical categories should convey meaning that is 'experience-near' to the wider population. It should be noted that a vast number of voices calling for the renaming of schizophrenia belong to patients themselves, reflected in the various patient-organized campaigns and petitions that have emerged in countries such as the United Kingdom, North America and the Netherlands over the years (George & Klijn 2013, Lasalvia 2018:33-34). One notable example was the Campaign for the Abolition of Schizophrenia Label launched in 2006 in the UK, by volunteer-run groups represented by 'Hearing Voices Network' and *Asylum* magazine. In 2013, the Dutch association *Anoiksis*, described as 'of and for people with a susceptibility to psychosis', called for 'schizophrenia' to be replaced by 'psychosis

susceptibility syndrome (Groege & Klijn 2013). The construct of schizophrenia has traditionally been defined through a top-down approach, at the level of powerful organizations such as the WHO and the APA (Jenkins & Barrett 2004:4). I believe that a ground-up approach that takes into account subjective experiences of ill health, temporally-situated and culturally informed, is necessary to the development of a more nuanced expression of the disorder that is meaningful to both patients and clinicians.

It follows then, that anthropological and socio-historical perspectives may help in understanding the role that rhetoric surrounding health and illness plays in shaping the field of medicine and a community at large. Judy Segal (2001), who has written extensively on the semantics surrounding health and medicine, observes that biomedicine is 'subject to the vagaries —and the rhetoric — of situation', clearly evidenced in what she refers to as 'the instability of the nosology, the catalogue of illnesses' (2001:28). Segal also cites the emergence of diagnoses such as chronic fatigue syndrome and Gulf War syndrome as examples of the continually shifting frame of medical discourse across time and space, describing these shifts as marks of progress in the medical narrative. A notable case study is the abolition of the word 'hysteria' in psychiatric classification, following 4000 years of history dating back to ancient Egypt and Greece (Tasca et. al 2012). Hysteria had been understood as a 'female' disorder caused by uterine movements, an aetiology from which its name is derived. By the 18th century it was becoming apparent to physicians that the brain, not the uterus, was the primary locus of the condition (2012:114), yet medical usage of the words 'hysteria' and 'hysterical' continued for over 200 years. The World Wars of the first half of the 20th century signaled a turning point for the disorder, during which hysteria presented commonly among male soldiers as a response to stress and after which the frequency of the diagnosis began to decline, replaced by depressive and anxiety-related diagnoses (2012:115-116). The official abolishment of the term in the late 20th century, signified by its absence in the 1980 publication of DSM-III, finally occurred following the Second Wave of feminism that emerged in the 1960s in Europe and America (Devereux 2014:20), along with the rise of feminist-historical critique in the 1970s (Micale 2019:71). While 'hysteria' as a group of symptoms still existed in society, the diagnosis had become recognized as a tool of oppression used against women over

centuries. It had also become viewed as a natural response to – or an act of rebellion against – repressive societal structures and social roles (Devereux 2014:32-33). A convergence of historical event, cultural development and social change eventually culminated in the relegation of ‘hysteria’ to the backwaters of medical history. As Segal (2001) suggests:

The most salient narrative of medical history is the narrative of progress, the narrative that says, “We used to have things wrong, and now we have them right, or on the road to having them right.”
(2001:22)

Ultimately, clinical vocabulary should be updated in correspondence not only with scientific discovery but also with historico-cultural moment – as in the case of ‘hysteria’ – and not conserved for the sake of tradition. The perpetuation of the word ‘schizophrenia’ in clinical usage neglects not only the neurobiological basis of the disorder, but also a century’s worth of ideological shifts and intellectual developments that warrant greater consideration towards a change.

V. A stigmatised label

The final point of contention I take up against the name ‘schizophrenia’ is that the word itself is heavily stigmatised. Evidence from national surveys conducted in the United States (NAMI 2008:7), the United Kingdom (PHE 2015:15) and France (Durand-Zaleski,et.al 2012:6) demonstrate that while most mental illnesses are gaining increasing acceptance in Euro-American society as a result of socio-cultural factors discussed in the previous section, the notion of schizophrenia remains disproportionately plagued by stigma. Prejudice against schizophrenia was shown to be markedly higher than depression in the UK, and other chronic mental conditions in France. Patients with the diagnosis report being discriminated against or receiving worse treatment by the police, employers and even medical practitioners after disclosing their diagnosis (Schulze & Angermeyer 2003, Pandya et. al 2011).

The pronounced bias against schizophrenia may be attributed, certainly not exclusively but in part, to semantics. Kingdon and colleagues (2008a) criticize the term as one that is 'semantically inexact – essentially meaningless' (2008a:242). True enough, devoid of reference to other disorders or understood psychological functions, the meaning of the word 'schizophrenia' is foreign to most – this renders individuals with the diagnosis prone to caricaturization. In *Illness as Metaphor*, Sontag (1978) describes how medical language has a symbolic function, conveying metaphors by which society understands a particular illness. She notes that diseases of unknown aetiology such as cancer (in this case, schizophrenia) that are 'multi-determined' and 'mysterious' to the population are most susceptible to being expressed through 'metaphors for what is felt to be socially or morally wrong' (1978:61), and thus most likely to provoke fear. In an excerpt from his aforementioned book, Sass (1992) writes:

Schizophrenia's elusiveness makes itself felt not only at the theoretical or scientific level but also in the more immediate sphere of the human encounter, in the intense yet indescribable feelings of alienness such individuals can evoke (1992:14).

Consequently, the person with schizophrenia becomes perceived as foreign and alien by society. To borrow Goffman's (1963) terminology, the term 'schizophrenia' evokes in people a fear of the unknown that forms the basis for their exclusion of the 'schizophrenic' Other from a society of 'normals'. Yang and colleagues (2007) describe this fear of the unknown as a natural defense mechanism towards danger, whether real or perceived (2007:1528). The role of semantics in stigma construction highlights the importance of elucidating terms used in descriptions of mental illness, for the sake of promoting clearer understanding and acceptance within society at large.

This line of criticism has already prompted change in some East Asian nations (Sartorius et.al 2014). In 2002, Japan famously abolished the term 'Seishin-Bunretsu-Byo' (mind-split-disease) in favour of 'Togo-Shitcho-Sho' (integration disorder) in a bid to mitigate the stigma associated with the disorder. Neighbouring countries began to follow suit: in Hong Kong and Taiwan, 'Jing Shen Fen Lie' (精神分裂, mind-split) was replaced with 'Si Jue Shi Tiao' (思覺失調, perception dysfunction). In Korea, 'Jeongshin-

bunyeol-byung' (mind-split-disorder) was changed to 'Johyun-byung' (attunement disorder), which compares the state of the mind in schizophrenia as a musical instrument that requires tuning – a metaphor inspired by a 16th century Buddhist text (Sato 2006).

But the question remains: would renaming schizophrenia truly lead to the destigmatization of the disorder, within the clinic and at the level of wider society? As will be discussed in the following section, skeptics disregard calls for change as 'just' a matter of semantics – that quibbling over psychological jargon has no bearing on the actual experience and treatment of schizophrenia, which should be the priority of mental health professionals. Incontrovertibly, there are many other factors that contribute to this stigma, not least of all negative portrayals of psychosis and schizophrenia in the media (Angermeyer et. al 2005, Klin & Lemish 2008, Owen 2012). As stigma is facilitated by attitudes that are deeply entrenched in a community, efforts to combat it do not produce results overnight or within the time frame in which most studies are conducted. Hence, the true effectiveness of anti-stigma measures can be difficult to ascertain. In spite of the development of tools to measure stigma for research purposes (Link et. al 2004), there remains an absence of 'sound scientific models of stigma' (Tranulis et. al 2013) that could be used to predict the impact of renaming schizophrenia in Europe and America.

In Japan, however, multiple studies conducted to research this question have found that the new name has shown promise in changing perceptions towards schizophrenia among university students (Takahashi et.al 2009, Koike et.al 2015). However, it has not made much difference to the level of stigma in media portrayals thus far (Koike et.al 2016). It has been suggested that this is partly due to the reluctance of the media to adopt the new name, because of the lack of understanding among the public of what 'integration disorder' entails and the need for further explanation of the term. There is hope that continued usage of the new term in the public sphere will reduce this vocabulary gap over time and encourage the population to rethink their impressions of the disorder. Overall, while various studies have produced promising outcomes (e.g. Umehara et. al 2011; Lasalvia et. al 2015:282), the results are so far

inconclusive regarding its long-term impact on Japanese society – it is simply too early to tell.

Therefore, to imagine the possible consequences of such a name change in Euro-American countries, we can only rely on preliminary data. A study conducted by Kingdon and colleagues (2008b) on a sample of UK medical students employed a questionnaire to ascertain whether changes in terminology surrounding schizophrenia would influence their perceptions of the disorder. They found that referring to subgroups contained within Bleuler's (1950[1911]) 'group of schizophrenias' such as 'sensitivity psychosis', 'drug psychosis', 'anxiety psychosis' and 'traumatic psychosis' incurred more positive responses than the word 'schizophrenia' (Kingdon et. al 2008b:421). A large study by Ellison and colleagues (2015) investigating whether renaming schizophrenia have destigmatising effects on the diagnosis employed the case of bipolar disorder a point of comparison. They suggested that the replacement of the name 'manic depression' with 'bipolar disorder' in 1980 had a significant and lasting impact in reducing the stigma around the condition. When comparing the term 'schizophrenia' with 'integration disorder', however, the results were mixed: while 'integration disorder' reduced associations with dangerousness, it increased desire for social distance. Ellison and colleagues conclude that this emphasizes the complex relationship between a diagnostic label and stigma, and that while the potential benefits of renaming schizophrenia are evident, serious consideration should be undertaken in deciding on what the new name should be (2015:342).

VI. What is in a name?

The subject of this essay is a controversial one, and each proposal to rename 'schizophrenia' has been met with significant opposition. Central to the debate is the question of whether a new term would become just as stigmatised as the old, and thereby ineffectual in bringing about any real change. As this debate first came to the fore in the late 20th century, Cromwell (1991) purported that because language is arbitrary and the meaning it conveys determined by its receivers, the concept of 'schizophrenia' is ultimately defined by those who use it and not by the term itself.

'Schizophrenia is a word', he writes, 'no more, no less' (Cromwell 1991:45). Adopting a similar stance, others have suggested that a name change serves as a distraction from more urgent reforms needed in the diagnosis and treatment of the condition (e.g. Lieberman & First 2007, Gaebel & Kerst 2019). Ultimately, those who oppose the change suggest it is a superficial move that would do little to transform negative perceptions of the schizophrenia:

Unfortunately, changing the name of the condition (or even abolishing the concept) will not affect the root cause of the stigma—the public's ignorance and fear of people with mental illness. (Lieberman & First 2007:108)

It is right to suggest that a new name will not be a panacea to the negative stigma associated with mental illness. However, it would be an act of ignorance to discount the intimate relationship between language and stigma in the same swoop. If there is any truth in what Wittgenstein (1958[1953]) supposes, that every word conjures an image of that which it represents and thus one's perception of the world is determined by language, further thought to the term 'schizophrenia' must be given. The abstract meaning of a diagnostic term, composed of one, two, three words, shapes attitudes towards the diagnosis itself that are eventually concretized in clinical practice and in public life. Referring to this process, Kleinman (1988) describes how a word in itself represents 'meaningful phenomenon' (1988:9-11) and diagnostic labels eventually become incorporated into the clinical subconscious as part of Nature, and by extension, of medical reality.

So what are we really saying when we say 'schizophrenia'? Notwithstanding its etymology, the word 'schizophrenia' is laden with connotations accumulated over the course of a century although many of these, such as the link between schizophrenia and violence (Angermeyer 2000), have been proven false and misguided. In his inquiry into the of unique phenomenon of 'heart distress' in Maragheh, a city in northwest Iran, the anthropologist Byron Good (1977) explores the process by which medical terminology becomes invested with socio-cultural meanings, leading to the formation of a 'semantic network' (1977:40) around a single term (see *Figure 3*). Through his

fieldwork, Good discovered that factors people associated with the term 'heart discomfort' – the primary symptom in 'heart distress' – included: *worry about poverty, interpersonal problems, pregnancy, infertility and old age*. He argues that through these

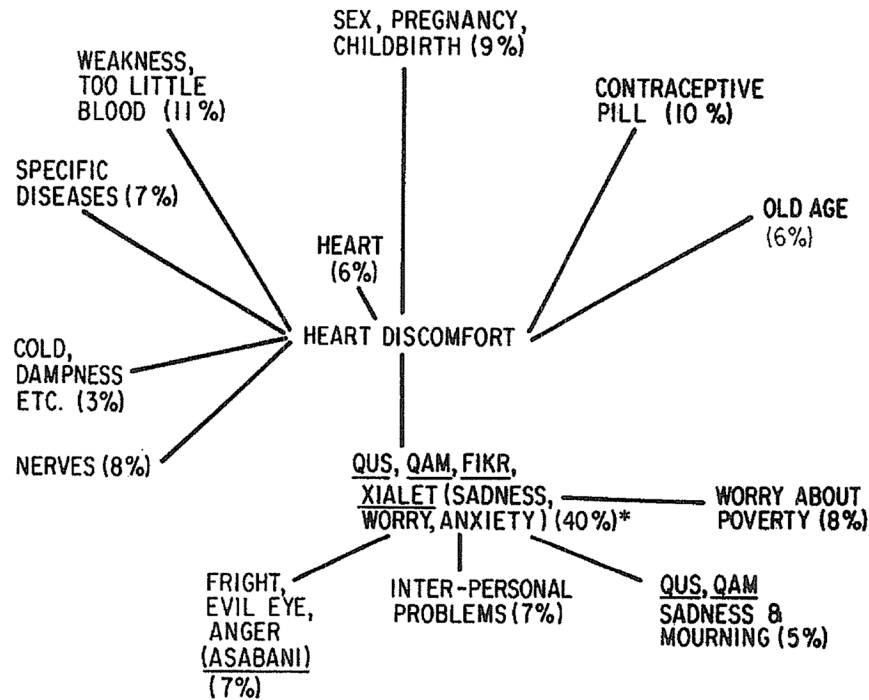


Figure 3: A map of the semantic network surrounding 'heart discomfort' (Good 1977:40)

associations, medical terms must function in society 'to articulate the experience of distress and to bring about action which will relieve that distress' (1977:48-49), whether this distress is physical, psychosocial or a mixture of both.

It can be argued that the term 'schizophrenia', with a semantic network comprised of terms like 'dangerous' and 'violent behavior', does not serve to relieve the distress experienced by its sufferers – rather, it exacerbates it. Surely the first step in shedding these damaging associations is to consider shedding the label to which they have been attached for so long, and allow the disorder to acquire new semantic meanings moving forward. In support of this change, Kingdon and colleagues (2008a) cite some examples from recent history:

Changing terminology appears to have been successful at making it more acceptable for people with long-term disorders in other areas of medicine, e.g. “spastic” has been replaced by “cerebral palsy”; “mongolism” by Downs Syndrome; “idiot”, “imbecile”, “defect” and “retard” with mental handicap and, latterly, learning disability; “manic depression” with bipolar disorder. (Kingdon et. al 2008a:242)

Stigma surrounding medical terminology exists not only in lay society, but also within the walls of healthcare institutions and among mental health professionals (Sartorius 2002, Schulze 2007) – this iatrogenic stigma is often overlooked. A new name for the disorder might just be a small stepping-stone in the movement towards reducing stigma surrounding mental illness – but it is a crucial and definitive one. It would serve as an expression of commitment by the medical community towards the destigmatisation project and pave the way for bolder advancements in psychiatric classification. In a review of the literature on the subject over the past two decades, Lasalvia and colleagues (2015) conclude:

From the available literature it seems that, on balance, the advantages of renaming schizophrenia outweigh the disadvantages... A new term for schizophrenia that avoids any stigmatizing connotation would be more acceptable for both users and professionals. (2015:282)

The Japanese psychiatrist Iwao Akita (2017) writes, ‘A concept or a word is much more powerful than is generally understood. If you define or say something, it comes to be.’ (2017:7). It is in this spirit that Japan became the first country to officially abolish the 20th century description of the disorder, and that Euro-American countries should begin to consider a new set of semantics for schizophrenia.

VI. The question of alternatives

An additional source of inertia to this reform is the gaps in clinical understanding of the aetiology of schizophrenia that remain, even as old hypotheses have been

disproved. In spite of improved understanding of the genetic and epigenetic factors involved in the onset and progression of schizophrenia (Derks et. al 2012, Millan et. al 2016), the DSM-V itself states that ‘the predictors of course and outcome [of schizophrenia] are largely unexplained’ (APA 2013:102). Lieberman and First (2007) argue this point, stating:

Ultimately, we must gain a more complete understanding of the causes and pathophysiological mechanisms underlying schizophrenia. Only then can we replace the way we characterise schizophrenia with a diagnosis that more closely conforms to a specific brain disease. (2007:108)

This claim is founded on the assumption that the primary objective of renaming schizophrenia is scientific precision, which cannot be properly achieved until our present repository of knowledge regarding the disorder becomes ‘more complete’. In addition to the vagueness of what ‘more complete’ might entail, the implications of the term ‘schizophrenia’ extends beyond the boundaries of biomedical meaning (as discussed in the course of this essay) and the insurmountable evidence in favour of renaming outweighs any risk of inaccuracy. Nevertheless, it rightly supposes that the selection of a new name should not be made lightly and must be subject to serious evaluation.

It would be easy to infer that the name ‘schizophrenia’ has remained unchanged for want and lack of a better alternative. This is not the case, however – over the past two decades various alternative names have been proffered. In their timely review, Lasalvia and colleagues (2015) provide a summary of these names, weighing evidence for and against each of these – the list includes: Kraepelin-Bleuler Disease (Kim and Berrios 2001), neuro-emotional integration disorder (Levin 2006), salience dysregulation syndrome (van Os 2009), dysfunctional perception syndrome (George 2012) and psychosis susceptibility syndrome (George & Klijn 2013). Amidst a stalemate arising from a lack of consensus in psychiatric circles over whether to proceed with a renaming, Guloksuz and van Os (2018; 2019) volunteer a less radical shift towards the name ‘psychosis spectrum disorder’, in the hope of extricating the word ‘schizophrenia’ from medical discourse.

In their 2018 paper, Guloksuz and van Os discuss the limited scope of the schizophrenia construct and its failure to encompass the immense variation of its symptomatic presentation, leading to problems encountered in both research and clinical practice (2018:231-232). While their argument, which they expound on further in a later editorial (Guloksuz & van Os 2019), is much more elaborate than I can capture here, I will focus on two crucial points discussed in their paper.

Firstly, they argue that research into schizophrenia becomes susceptible to Berkson's bias, a selection bias arising from the restriction of a sample population to help-seeking individuals and exclusion of individuals with less severe cases of the disorder such as schizophreniform disorder and brief psychotic disorder (Guloksuz & van Os 2018:230). The resulting research sample becomes representative of a limited section of the 'broader phenotype' of psychosis associated with a poorer prognosis, and does not account for less severe presentations. Secondly, they suggest that since psychotic disorders that are currently differentiated share a similar pathogenesis and aetiology (ibid.233), they should be grouped under a single heading. In their proposed model of psychosis, individual disorders (brief psychotic episode, bipolar disorder, schizoaffective disorder, schizophrenia) represent discrete patterns or expressions of the same illness. As an example of how similar models are employed in medicine, they cite the understanding multiple sclerosis as a spectrum, consisting of four distinct illness patterns with a common underlying pathophysiology (clinically isolated syndrome, relapsing-remitting, secondary progressive and primary progressive). They summarise both points as such:

From a researcher's standpoint, an artificial categorization leads to a considerable loss of power and precision (Kraemer, 2007); from a clinician's standpoint, categories based on illness course – regardless if they are different types of the same illness or not – are pragmatically necessary to determine treatment strategy (Guloksuz & van Os 2008:233)

Alluding to the spectrum model of psychosis that is already recognized in present diagnostic classification (ibid. 232) and taking inspiration from the renaming of autism as

'autism spectrum disorder', they suggest rebranding schizophrenia as a psychosis spectrum disorder (PSD) – a modest, but feasible step towards change.

In this framework, PSD represents a 'unitary model of psychosis' (ibid.233) comprising of schizophrenia alongside other demarcated psychotic disorders such as bipolar disorder, schizoaffective disorder and brief psychotic disorder. The concept of PSD is not too far off from Bleuler's initial 'group of schizophrenias' or DSM-V's 'schizophrenia spectrum', but it marks both a departure from the usage of the word 'schizophrenia' as a catchall for psychotic disorders as well as recognition of the inadequacy of our present understanding of the disorder. If more serious consideration is given to taking this step forward, perhaps what Guloksuz and van Os posit in the concluding line of their paper could be true: 'There is hope for schizophrenia' (ibid.238).

VII. Conclusion

In her introductory message to the World Health Report 2001 entitled 'Mental Health: New Understanding, New Hope', then Director-General of the WHO Gro Harlem Brundtland established that the key objective of public mental health in the 21st century must be 'to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason' (WHO 2001:x). For decades, the label of 'schizophrenia' has been viewed as a source of shame and a purveyor of stigma in societies around the world. Advancements in diverse fields of 'science and reason' – in biomedicine, psychology, philosophy, sociology and anthropology – have provided the hope of a new way forward; the option to tell an alternative narrative about the condition that reflects this progress. It requires no stretch of the imagination to consider how the subject of this narrative should acquire a new name in order to symbolize its entry into a new era of mental health care.

In this essay, I hope that I conveyed how this debate is not only relevant to healthcare professionals and patients, but to a much broader population that encompasses fields, disciplines and sectors beyond medicine. I believe that the continued participation of psychiatry in interdisciplinary collaboration would enable a richer conversation to be had about the responsibility of the profession to society at

large, and engage a much broader audience in the critical dialogue surrounding mental health and illness.

There remain significant gaps in our knowledge regarding the relationship between psychiatry, semantics and stigma. However, these gaps should not lead us to disregard the knowledge we have gained from research and the lessons we have learnt over the history of mental illness. Foucault (1973[1963]) suggests that medical classification 'reaches the truth of the disease only by allowing it to win the struggle and to fulfill, in all its phenomena, its true nature' (1973[1963]:9). Although we are far from comprehending the whole 'truth' of the psychopathologic phenomenon currently known as schizophrenia, we can strive to refine our representations of the experience of individuals with the condition, through conscientious evaluation of the words we choose to describe it. And this evaluation calls for fresh psychiatric language – a new paradigm consisting of 21st century terms – to give the diagnosis shape, form, meaning and ultimately, a valid place in the realm of human experience.

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