

# What is in a name? Renaming schizophrenia as a starting point for moving ahead with its re-conceptualization

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‘Stat rosa pristina nomine, nomina nuda tenemus’  
(trans. ‘Yesterday’s rose endures in its name, we hold empty names’)  
from *De contemptu mundi*, Bernard of Cluny,  
12th-century, cited by Umberto Eco, *The Name of the Rose*, 1983

Over the last decades ‘schizophrenia’ has been one of the most controversial and contested concepts in psychiatry (Peralta & Cuesta, 2003; Bentall, 2006; Cuesta *et al.* 2009). The term itself was originally coined by Bleuler (1911) with the intention to rename *Dementia praecox*, a nosological construct conceptualized by Kraepelin (1896) as an adolescent-onset form of dementia. The new term (from the Greek ‘*schizein*’-‘*phren*’, literally ‘a splitting of the mind’) conveyed the concept that the disorganized thoughts and loosening of associations shown by patients were central to its psychopathology [‘I call dementia praecox ‘schizophrenia’ because (as I hope to demonstrate) the ‘splitting’ of the different psychic functions is one of its most important characteristics’, p. 8] (Bleuler, 1950). The richness of the psychopathology of schizophrenia as described by Kraepelin and Bleuler, however, soon appeared to be its main weakness. Thus, though the description of symptoms and signs of schizophrenia has remained mainly unchanged over the years, authors’ articulations of the varied phenomenological manifestations have been very inconsistent.

Indeed, from its first conceptualization with the term ‘schizophrenia’ Bleuler meant to define a heterogeneous group of several diseases (*die Gruppe der Schizophrenien*), rather than a singular disease entity (*‘For the sake of convenience, I use the word in the singular although it is apparent that the group includes several diseases’, p. 8*) (Bleuler, 1950). Unfortunately, the use of

‘the word in the singular’ has eventually resulted in the common misperception that schizophrenia is a single homogeneous disease entity. Contemporary research evidence and clinical practice suggest that ‘schizophrenia’ is an umbrella term that can describe symptoms in a diverse group of patients. The significant heterogeneity in psychopathology has consequently resulted in heterogeneity in the need for clinical care, treatment response, illness course, cognitive vulnerabilities, environmental exposures and biological correlates. When all these factors are considered, it suggests that the ‘schizophrenia’ construct has limited predictive power and clinical utility. Different definitions of schizophrenia frequently define different people as suffering from schizophrenia, and groups of patients identified by the common label of ‘schizophrenia’ may often have very little in common (van Os *et al.* 1999).

Over the last two decades, the DSM-IV definition of schizophrenia has been the most influential in clinical practice and research and its clear criterion-based definition has facilitated diagnostic agreement and communication among practitioners and researchers. However, although the DSM-IV definition has shown high reliability, it has not provided any information about the fundamental nature and structure of the disorder. In-depth analyses of the DSM-IV diagnostic criteria suggest that the concept of ‘schizophrenia’ lacks an underlying paradigm (Maj, 1998). It seems, therefore, that symptomatological, chronological and functional criteria do not collectively characterise schizophrenia as a syndrome (all of them may be fulfilled by several cases of dementia, major depression, or bipolar disorder). Thus the DSM diagnosis of schizophrenia effectively becomes a diagnosis by exclusion (Maj, 1998).

Moreover, the diagnosis of schizophrenia is often stigmatizing, resulting in effects that can be as debilitating as the associated symptoms. The term confusingly and mystifyingly refers to a ‘disease’ characterized by a ‘split mind’, a pathological state that the public cannot personally relate to and

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therefore induces fear and exclusion (van Os, 2009). In addition, the term (particularly 'in the singular') seems to suggest that it refers to a well-specified disease entity due to a 'brain disease' that exists as such in nature. This is a misleading suggestion, however, as schizophrenia more accurately reflects 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 (van Os, 2009). The stigmatizing public and professional perceptions of schizophrenia as an irreversible brain disease associated with violence and unpredictability inevitably impact the patients' identity, self-esteem, self-efficacy, hope and social functioning (Livingston & Boyd, 2010).

For these and other reasons, a number of authors (Carpenter, 2007; Craddock & Owen 2007; Murray & Dutta, 2007; Tosato & Lasalvia, 2009) have commented on the weaknesses of the schizophrenia construct for both clinical and research purposes, and they have highlighted the need for developing and adopting new approaches in rethinking and, possibly, renaming it.

Renaming schizophrenia is however controversial, and has been rejected by some authors as not addressing the core problem of stigmatization. Moreover, the benefit arising from renaming schizophrenia *per se* may be temporary, as the image attached to the old concept for the disorder could be passed on to a new name (Lieberman & First, 2007). Nevertheless, renaming schizophrenia may be a welcome initial step. Such an action would draw public attention providing an unprecedented opportunity for fostering better public understanding of the disorder. Naming is an important strategy for transforming public perceptions, and should not be summarily dismissed (Kingdon *et al.* 2007), especially if conducted in coordination with other health promotion initiatives (Sugihara & Takei, 2013). On recent evidence, the introduction of a new term, has been welcomed by patients themselves (George & Klijn, 2013) as well as mental health professionals and the public (Kingdon *et al.* 2008). Moreover, it has been thought to be potentially beneficial both from both a public health perspective (Bentall, 2013; Brabban *et al.* 2013) and for research purposes (van Os, 2009; van Os *et al.* 2013). Thus, a more pertinent question is perhaps not whether to replace the term 'schizophrenia', but rather what its replacement should be. Simple relabeling is unlikely to address the many scientific and clinical limitations of the construct, or the problem of stigma, which arises out of assumptions about the nature of severe mental illness (Bentall, 2013). Therefore, an overall re-conceptualization of the *definition* of schizophrenia is also required.

This issue of *Epidemiology and Psychiatric Sciences* publishes two Editorials addressing the controversial topic of renaming and re-conceptualizing schizophrenia. For this purpose we invited two of the world's leading groups, who over recent years did both theoretical work and empirical research in the field. In the light of the recent development of cognitive behavioural therapy for psychosis and psychosocial epidemiological research, Kingdon *et al.* (2013) propose an alternative way for conceptualizing schizophrenia based on the major psycho-social factors (i.e. drug misuse and childhood trauma) identified as having a significant impact on the onset of disorder. New nosological constructs based on these 'psychosocial descriptors' would probably be more acceptable to patients and perceived as less stigmatizing by the general public. After all, it is probably easier to accept the idea that psychosis arises, in part, from adverse life experiences – while of course acknowledging that genetic factors must play some role. Moreover, a new nosology may at the same time greatly benefit research, clinical and therapeutic practice. Next, Bakker *et al.* (2013) suggest a novel system of diagnosis that relies on continuous monitoring of relevant information in daily life that complements retrospective categorical symptom criteria. This proposed approach is also likely to be more beneficial for patients and their families, as it may be linked more strongly to treatment needs and prognosis.

Overall, the alternative approaches to the schizophrenia concept proposed in the two Editorials have the potential to benefit patients, researchers and clinicians alike, and seem therapeutically relevant. These benefits are consistent with our foremost goals of providing effective and acceptable treatments to our patients.

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### Conflicts of Interest

None.

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