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The schizophrenia myth

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In their editorial defending the 'schizophrenia' concept, apparently sparked by a press conference at which one of us participated, Professors Lieberman and First recycle some enduring myths about psychiatric diagnoses.

Here are some of the myths. Lieberman and First assert that, "Many studies have shown that these diagnostic criteria [for 'schizophrenia'] can be applied reliably and accurately". However, the accuracy of a diagnosis can only be determined if there is an absolute benchmark to compare it against. Moreover, agreement between different operational definitions of schizophrenia is poor (in the UK 700 study the number of 'schizophrenia' patients varied between 268 and 387 according to whether RDC, DSM-III-R or ICD-10 definitions were used [1]); and clinicians using the same criteria show poor agreement if they use different methods of interviewing patients [2]. Lieberman and First say, "Schizophrenia is not caused by disturbed psychological development or bad parenting" but there is compelling evidence that being unwanted at birth [3], early separation from parents [4], sexual abuse [5-7] and other kinds of adverse family relationships [8] all increase the risk of psychosis in adult life. Nor is it true that, "abnormalities in brain structure and function seen on neuroimaging and electrophysiological tests" establish the reality of 'schizophrenia' as a biological disorder, as diverse neurobiological findings have been reported in 'schizophrenia' patients, as many brain abnormalities are not specific to the diagnosis [9], and as animal and human studies have shown that adverse early experience can lead to profound changes in brain structure and function of the kind seen in patients

[10, 11].

The claim that “the evidence that vulnerability to schizophrenia is at least partly genetic is indisputable” is undermined when it is noted that methodological biases in the behavioural genetics literature have led to over-estimation of the heritability of the diagnosis [12], that no genes of major effect for ‘schizophrenia’ have ever been discovered, and that those genes of minor effect that have been identified also confer vulnerability to other diagnoses [13].

Finally, Lieberman and First’s implication that a diagnosis of ‘schizophrenia’ is useful in guiding treatment makes no sense when it is realised that relapse is better predicted by psychosocial than psychopathological variables [14] and that responses to psychiatric medications are not predicted by diagnosis [15]. Indeed, it is often forgotten that the therapeutic effect of the antipsychotics was first demonstrated on manic patients [16].

In the seventeenth century, the Roman Catholic Church asserted that the Earth was the centre of the Universe but this did not make it so. The assertion by members of the medical-pharmaceutical establishment that ‘schizophrenia’ is a useful concept does not make it so either. The results of continuing with the old assumptions about mental illness are plain for all to see. After 100 years of research on ‘schizophrenia’, researchers have not provided us with a single biological marker of diagnostic value. The promotion of biological models of psychosis, far from reducing the stigma experienced by patients, has increased it [17]. The outcomes for psychotic patients have not improved [18, 19] and the number of people suffering from enduring psychiatric disability has increased [20]. Patients in third-world countries do better than those in the industrialised world who avail themselves of modern psychiatric services [21]. Meanwhile, new and expensive antipsychotic drugs are marketed as better than the old ones although they are no better in reality [22, 23]; their main beneficiaries seem to be drug company share- holders.

Psychosis should be seen on a continuum with normal experience, and biological findings should be integrated

with observations from psychology and the social sciences [24]. Care should be offered on the basis of patients' needs and strengths rather than diagnosis. What is needed is no less than a revolution in our scientific approach to understanding severe mental illness, paralleled by a humane revolution in the way we try and help some of the most vulnerable and disadvantaged members of our society.

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EDITORIAL DE LIEBERMAN & FIRST (2007)

Renaming schizophrenia

Diagnosis and treatment are more important than semantics

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Recent reports in the media have called for schizophrenia to be “abolished as a concept” because it is scientifically meaningless.¹ This is not the first time that the validity of this diagnostic entity has been challenged, and it will not be the last until the cause of the disorder and its precise pathophysiology are known.

The current system of psychiatric diagnosis cannot describe definitive disease entities because of our inability to demonstrate “natural” boundaries between disorders. However, as Kendell and Jablensky point out, “thoughtful clinicians have long been aware that diagnostic categories are simply concepts, justified only by whether they provide a useful framework for organising and explaining the complexity of clinical experience in order to derive inferences about outcome and to guide decisions about treatment.”² In this context, the charge that schizophrenia does not define a specific illness is clearly unwarranted. Although the validity of the diagnosis remains to be established, its diagnostic reliability and usefulness are indisputable.

For more than 100 years schizophrenia has been an integral part of our nosology and has facilitated research and treatment of people affected by this disease.^{3,4} People qualify for the diagnosis if their clinical signs and symptoms conform to the operational diagnostic criteria that define schizophrenia. Many studies have shown that these diagnostic criteria can be applied reliably and accurately by trained mental health professionals.^{5,6} Although a diagnosis of schizophrenia depends on the presence of a pattern of symptoms (such as delusions, hallucinations, disorganised speech, disorganised or catatonic behaviour, and negative symptoms such as lack of motivation), evidence shows that these are manifestations of brain pathology.⁷ Schizophrenia is not caused by disturbed psychological development or bad parenting. Compared with normal controls, people with schizophrenia have abnormalities in brain structure and function seen on neuroimaging and electrophysiological tests. In addition, the evidence that vulnerability to schizophrenia is at least partly genetic is indisputable.⁸

Once a diagnosis of schizophrenia is made, the treating clinician has a wide array of treatment options available, which have been tested empirically on similar groups of people. Furthermore, the doctor will also have access to the huge body of empirical data that characterises this condition including its course, treatment response, outcome, and family history. This is important because evidence shows that early intervention may improve outcome.⁹ The diagnosis also helps when explaining to the patient and their family the nature of the problem, the range of treatments and outcomes, and the assistance available from support groups.

Of course, diagnostic labels have potential disadvantages. If a diagnosis of schizophrenia is mistakenly

applied, the patient will receive the wrong treatment and potentially have the stigma of having a mental illness. For example, if a patient with a toxic (such as phencyclidine induced) psychosis is misdiagnosed with schizophrenia, he or she may be given a long and unnecessary course of antipsychotic drugs. To avoid this situation, psychiatric diagnoses have built-in safeguards in the form of exclusion criteria that prevent a diagnosis from being made if certain conditions are present (for example, a diagnosis of schizophrenia is not permitted unless psychotic symptoms persist for a substantial period of time after the person has stopped using the drug in question).

Concerns about potential stigma associated with having a serious mental illness have resulted in proposals to change the name of schizophrenia. “Integration disorder” and “dopamine dysregulation disorder” have been suggested as possible alternatives.¹⁰ 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. Renaming may even have the unintended effect that the person, rather than the illness, is blamed for the symptoms.¹¹

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. In the meantime, we can be confident and grateful that the benefits conferred by the concept of schizophrenia far outweigh any perceived disadvantages.

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