



Schizophrenia: a critical psychiatry perspective

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Purpose of review

The term 'schizophrenia' has been hotly contested over recent years. The current review explores the meanings of the term, whether it is valid and helpful and how alternative conceptions of severe mental disturbance would shape clinical practice.

Recent findings

Schizophrenia is a label that implies the presence of a biological disease, but no specific bodily disorder has been demonstrated, and the language of 'illness' and 'disease' is ill-suited to the complexities of mental health problems. Neither does the concept of schizophrenia delineate a group of people with similar patterns of behaviour and outcome trajectories. This is not to deny that some people show disordered speech and behaviour and associated mental suffering, but more generic terms, such as 'psychosis' or just 'madness', would be preferable because they are less strongly associated with the disease model, and enable the uniqueness of each individual's situation to be recognized.

Summary

The disease model implicit in current conceptions of schizophrenia obscures the underlying functions of the mental health system: the care and containment of people who behave in distressing and disturbing ways. A new social framework is required that makes mental health services transparent, fair and open to democratic scrutiny.

Keywords

disease model, disease model of mental disorders, schizophrenia, schizophrenia diagnosis

INTRODUCTION

Over the last few decades, several commentators have challenged the concept of schizophrenia, and argued for different ways of framing the variety of problems the term currently designates. A critical psychiatry perspective attempts to shed light on these views and to explore their implications for the practical, clinical management of these problems.

SCHIZOPHRENIA AS A DISEASE

Szasz [1] referred to schizophrenia as the 'sacred symbol' of modern psychiatry. Like all other psychiatric diagnoses that lack a confirmed histopathological basis, schizophrenia, for Szasz, is an invented term applied to a variety of behaviours that society has deemed abnormal and undesirable.

Szasz is well known for his criticism of the idea that what we refer to as 'mental illness' is a 'disease, just like any other', and for his views that the medicalization of the 'problems of living' acts as a mechanism for the social control of unwanted behaviour [2]. Many people might agree that psychiatry has shown a tendency, exaggerated in recent

years, for the inappropriate medicalization of normal behaviours and emotions, such as grief, sadness, shyness and childhood behaviour problems, but common discourse and academic consensus continue to refer to schizophrenia as a bona-fide 'disease' in the sense that Szasz uses the term 'disease' (a condition that arises from a confirmed abnormality of bodily function) [2]. Indeed, Kraepelin formulated the concept of dementia praecox with the goal of delineating something whose biological origins could then be uncovered [1]. Similarly, modern versions of the Diagnostic and Statistical Manual, from the third edition of 1980, aimed to produce a reliable diagnosis that would help research identify the underlying pathology. In this sense therefore,

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KEY POINTS

- The disease model of schizophrenia is not supported by evidence, and obscures the real function of psychiatric care.
- The label 'schizophrenia' is not associated with a consistent pattern of deviant behaviour or outcomes.
- Historically, the care and containment of people with mental and behavioural problems were addressed without recourse to the disease framework.
- We need to abandon the disease model in order to develop more transparent and democratic mental health services.

the idea that schizophrenia is a disease is inherent in the concept.

As other critics have pointed out, however, 100 years of research has failed to produce evidence of any defect in the structure or function of the brain, or any other part of the body, that is specific to schizophrenia [3]. The most consistent evidence presented as discriminating people diagnosed with schizophrenia comes from studies showing reduced brain size and larger brain cavities compared with 'normal controls'. These differences started to be identified in brain scans when computerized tomography was developed in the 1980s, and were replicated using MRI technology in the 1990s. However, as with other areas of biochemical and physiological research, important differences between people with schizophrenia and control subjects were not adequately accounted for. In particular, most studies made no allowance for the fact that overall people with schizophrenia have a lower intelligence quotient, which is known to be associated with smaller brain size [4]. Moreover, effects of treatment with antipsychotics and other drugs were ignored, until recently, when it was confirmed in animal and human studies that exposure to antipsychotic drugs can reduce brain size [5,6].

Despite repeated assertions that schizophrenia is a neurological disease, there is no evidence of any particular biological characteristic that distinguishes people diagnosed with schizophrenia. Schizophrenia thus remains a condition that is defined by unusual talk and behaviour. Although Szasz was widely criticized during his lifetime because his position was understood to be a denial of the realities of the suffering, distress and aggravation that can accompany the occurrence of phenomena we generally identify as 'schizophrenia', he did, in fact, acknowledge that 'these differences in behaviour and speech may moreover be gravely disturbing to the so-called

schizophrenic person, or to those around him, or to all concerned' ([1], p. 191).

The fact that some people sometimes develop unwarranted interpretations of their own experiences and show associated bizarre and concerning behaviours is undeniable. The position held by many who would identify themselves with 'critical psychiatry' is not a denial of the 'reality' of adverse and troubling states of mind, but the suitability of identifying them, when they do occur, with medical terminology. The terms 'illness' and 'disease' have well developed meanings and implications, which might not usefully apply to troubled states of mind [7]. When used in its native habitat, that is physical medicine, 'illness', for example, refers to a state of disablement and discomfort generally attributed to natural world causes beyond the control of the victim; 'disease' refers to an explanation of the illness employing knowledge derived from natural sciences, which enables the illness to be understood as the result of disturbed anatomy or physiology [8,9].

The assumption that mental disorders represent disease entities draws down the specific arrangements of the sick role onto sufferer and helper alike. The suffering person is excused responsibility for their actions, but obliged to forego agency and submit to paternalism [10]. Although this can be a helpful response to a bodily illness, especially if acute and life threatening, the obligations and consequences of the sick role are less suited for mental health difficulties [11].

SCHIZOPHRENIA AS BEHAVIOURAL DEVIANCE

Alternatively, the term 'schizophrenia' could derive its legitimacy, not by reference to its presumed disease status, but by encapsulating a recognizable pattern of deviant behaviour. Several scholars have, however, pointed out that there is no unifying pattern of abnormalities among people labelled as having schizophrenia that distinguishes them from people with other mental health problems, or from people without. Notably Bentall [3] describes schizophrenia as a condition with 'no particular symptoms, no particular course, no particular outcome and which responds to no particular treatment' ([3], p. 33).

Kraepelin's original concept of 'dementia praecox' consisted, by definition, of a condition that had a progressively deteriorating course. A situation that resolved, or resolved and then recurred, was a different condition, even if it was characterized by the same features [12]. In contrast, Bleuler's concept of 'schizophrenia' was defined not by its trajectory, but

by its phenomenology, and it was associated, as Bleuler pointed out, with widely different outcomes [13]. The phenomenology Bleuler considered as characteristic of schizophrenia was vague and subjective and, focusing as it does on what we would now call 'negative symptoms', it would exclude most people who currently develop psychotic symptoms. Subsequent attempts to refine the phenomenology of schizophrenia to delineate a distinct set of people either resulted in criteria so narrow that they exclude all but a small minority of those with severe mental disturbance (Schneider's first rank symptoms), or so broad that they include every situation that confronts mental health services that cannot be categorically defined as something else. Despite decades of effort to produce strict and replicable criteria for its application, the diagnosis of schizophrenia is as much of a ragbag today as it was in the 1970s when variations in rates of diagnosis across the world caused concern.

Diagnostic criteria for schizophrenia explicitly rule out the pattern of symptoms separately identified as classical bipolar disorder or manic depression, with periods of severely heightened arousal (mania) or severe depression followed by complete remission, and situations in which psychosis is a direct and predictable response to taking psychoactive substances like cannabis or amphetamines. The diagnosis of 'schizoaffective disorder', however, incorporates people with symptoms associated with both manic depression and schizophrenia. It was necessary to invent this diagnosis because of the nonspecificity of these symptoms. The diagnoses of schizophrenia and schizoaffective disorder combined therefore designate more or less everyone who shows a psychotic disturbance, apart from a small minority who can be labelled categorically as having bipolar disorder or a discrete drug-induced episode.

Despite the heterogeneity of problems embraced by the diagnosis of schizophrenia, it continues to convey a message that the condition is life-long, and entails an ongoing need for treatment and supervision. A 'psychotic episode' may or may not recur, but once it has been decided that someone has 'schizophrenia', the expectation is for some degree of ongoing or recurrent impairment. This has been a source of grievance for the service user movement, among others, who feel that the diagnosis thereby consigns people to a lifetime of deficit and dependency [14].

It is not clear therefore that the term 'schizophrenia' adds anything to the use of more general terms that describe nonintelligible behaviour such as 'psychosis', and earlier terms including madness and insanity. Such concepts can incorporate a

variety of symptoms, and do not preclude a diversity of outcomes. In medieval law, for example, the concept of 'insanity' distinguished situations that were thought to involve the possibility of recovery, from 'imbecility', which was recognized as a lifelong condition [15].

IMPLICATIONS AND ALTERNATIVES

Accepting the criticisms of the concept of 'schizophrenia', but recognizing that some people sometimes act in ways that are bizarre, irrational and occasionally dangerous and disturbing, critical psychiatry proponents are trying to explore the significance of calling these situations a disease, and to consider less damaging ways in which a civilized society might respond to them.

On the one hand, the medical orientation has entailed some humanitarian advances in the care of the mad. Thus, it is generally understood as humane and charitable to excuse a confused or profoundly distressed person responsibility for their actions, in the same way that a serious medical condition excuses people affected from their normal responsibilities. Yet, as Szasz frequently protested, the medical model that underpins the modern mental health system also disguises the real degree to which it continues to function as an institution of social control, providing 'socially acceptable methods for coping with certain economic, political and personal problems which would otherwise have to be dealt with in untried and unfamiliar ways' ([1], p. 141).

The authority of medicine, which derives from privileged access to scientific knowledge, produces an inevitable power imbalance between doctor and patient. In psychiatry, however, the usual justification for this imbalance is lacking, since natural scientific knowledge does not extend the understanding of the difficulties a person presents, but merely provides an alternative description of those difficulties couched in seemingly technical language.

In this way, the medical framing of mental disturbance and its management acts as a smoke-screen behind which the control and manipulation of some people by others can go unscrutinized. Interventions aimed at controlling unwanted behaviour, including the numerous sedating and tranquillizing drugs that are prescribed in mental healthcare, can be rebranded as expert-endorsed medical treatments, which can then be enforced on unwilling recipients with impunity. Even those people who are not overtly coerced into accepting 'treatment' often perceive themselves to have no choice because of the ever-present possibility of compulsory measures being applied [16]. Moreover,

the pseudo-medical approach can foster frustrated expectations of therapeutic success, dependency and other features of impaired personal agency, stigmatization and questionable claims for mitigated responsibility.

Social arrangements for the care and containment of mental derangement long pre-date the medical paradigm. Plato proposed that 'if any be a madman, he shall not appear openly in the city; the relatives of such persons shall keep them indoors, employing whatever means they know of...' ([17], p. 443, cited in [18]). In 17th Century England, local officials were empowered to ensure that an individual who was mentally disturbed and felt to be dangerous was locked up until he or she recovered. They could require the family to do this, they could make arrangements for another local person to do it, or they could order the person to be incarcerated in the local gaol or House of Correction [18].

The same officials that oversaw the safety and security of the community also administered local taxes (collected under the Poor Law) and distributed food, clothing and money to those in dire need of assistance, including those affected by a mental disorder and their families. Again, neighbours were occasionally enlisted to provide care where the family was unable to do so [19]. Wealthier families made their own private arrangements for the care of their relatives, increasingly turning to private madhouses from the 18th Century.

Clearly many of these arrangements were harsh and we are not recommending that policy makers embrace a return to pre-19th-Century conditions. They do indicate, however, that there are other ways of providing support through difficult times than applying the sick role.

As well as financial assistance, personal care and locked institutions, today we have drugs that can suppress and reduce the most dramatic manifestations of mental disturbance for most people, although at some cost in terms of personal comfort, physical health, quality of life and possibly social functioning [20]. None of these measures requires that mental disturbance be regarded as a biological disease. Indeed, many contemporary charities working in this field attempt to provide support in ways that avoid the oppressive paternalism of statutory, medically oriented services.

CONCLUSION

The current concept of schizophrenia is neither valid nor useful, since it does not map onto an identified bodily condition (disease) and it does not describe a predictable pattern of behaviour. We suggest a return to a more generic term, such

as 'madness' or 'psychosis', that does not have the implication that the condition it labels is a disease, and which allows the unique nature of each individual's difficulties to be recognized. Although certain patterns might be recognized within this group, such as a paranoid psychotic picture in older, isolated women (that which used to be referred to as paraphrenia), and a small minority of cases where people show prominent negative symptoms and cognitive impairment in line with Kraepelin's picture of dementia praecox, these would be acknowledged merely as patterns, with no definitive predictive power, and no aetiological implications.

Divorcing the concept of madness from the idea that it is a disease would necessitate legislation that is transparent about its motives. The social control of unwanted behaviour would have to be openly and democratically debated, rather than hidden away behind the language of medicine and 'treatment'. Greater scrutiny of the use of drugs and other interventions would be required, as these would not be automatically justified as treatments for diseases. The extent to which drugs are used to modify unwanted behaviour in the interests of people other than the patient would have to be acknowledged, and carefully circumscribed.

Modern societies have become dependent on using a medical framework to manage the problems arising from irrational and disturbing behaviour, but other arrangements are possible. Abandoning the concept of schizophrenia, and the disease theory embedded within it, would enable society to develop an approach that was more honest, fairer and more transparent.

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