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Schizophrenia as a symptom of psychiatry's reluctance to enter the moral era of medicine

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1. The schizophrenia debate as a debate about psychiatry itself

There has been a longstanding debate about the concept of schizophrenia and what psychiatry should do with it. The discussion typically revolves around scientific issues like validity and reliability and involves psychiatrists talking to other psychiatrists (Guloksuz and van Os, 2018). However, more recently it is becoming apparent that the schizophrenia debate is also a broader debate between psychiatry and the rest of the world. This latter debate revolves around the "psychiatric gaze", or the way psychiatrists chose to perceive the world around them, particularly when it comes to the issue of mental variation (Braslow et al., 2021; Gardner and Kleinman, 2019).

It is important to extend the narrow "schizophrenia" debate to the more fundamental debate about the scientific foundation of psychiatry itself, as arguably this is the only way through which the discussion stands a chance of ever being resolved. Currently, it remains stuck with 50% in favour of changing the concept and 50% against such change (personal estimate based on asking audiences at conferences). Only some Asian countries, more sensitized to the deleterious effects of internalized stigma, have been able to successfully modernize language. This partly semantic and partly conceptual modernization started in Japan in 1993, when the National Federation of Families with Mental Illness asked the Japanese Society of Psychiatry and Neurology for a name change, and has since spreaded to other Asian countries (Sato, 2017). Elsewhere in the world, however, psychiatry has remained unresponsive. Although service users provided a scientifically plausible and acceptable alternative in the process of the DSM-5 (George and Klijn, 2013; George and Klijn, 2014), DSM-5 was unable to reinvent itself as a platform for change, including its own plans for change to provide dimensional representations of mental suffering in addition to categories.

We argue that the reason for the eternal stalemate in the internal psychiatric schizophrenia debate has to do with the inability to extend the discussion to a broader reflection on the scientific foundation of psychiatry itself. This is never addressed but looms large in the background, as evidenced by increasingly open and exasperated discussions of the topic in influential medical journals (Braslow et al., 2021; Dumas-Mallet and Gonon, 2020; Gardner and Kleinman, 2019; Scull, 2021). The fact that our medical peers are now also increasingly concerned about "psychiatry's identity crisis" (Gardner and Kleinman, 2019) makes it difficult for traditionalists to apply the old psychiatric defence of relegating the schizophrenia debate to the discredited realm of "*anti-psychiatry*" (Sommer et al., 2015). The time has therefore come to talk about schizophrenia as a symptom of psychiatry itself.

Here, we will review the schizophrenia debate as a function of the broader but largely hidden debate about the scientific foundation of psychiatry itself. We will argue that the schizophrenia debate is a symptom of the failure to address broader epistemological issues to do with concealed assumptions about the nature of mental suffering that underly the psychiatric gaze. Failure to address these has resulted in

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psychiatry becoming defensive around a flawed concept of mental suffering, resulting in the perpetuation of low-value constructs like "schizophrenia". We will argue that change is required to enter the novel moral era of medicine, in which professionals primarily want to add value to the lives of patients, rather than remain preoccupied with the importance of their own constructs (Berwick, 2016). The moral era of medicine thus requires psychiatry to become more sensitive to the values of its stakeholders, and seek ways to cocreate a novel language and novel concepts for mental suffering, particularly in the stigmatised area of psychosis.

2. The core hypothesis underlying the psychiatric gaze

The foundation under psychiatry, particularly the dominant Northern American version of it, (Scull, 2021) can be summarized as "finding the right medication for the right brain disease" (Braslow et al., 2021; Gardner and Kleinman, 2019). This is the prism through which academic psychiatry – and thus society – has chosen to perceive the world of mental variation. It is the hypothesis, or belief system, underlying mainstream research and driving our system of messaging to the world (Dumas-Mallet and Gonon, 2020). Anthropological research suggests that the psychiatric gaze perceives two core types of mental suffering. One type is severe and of biological origin, requiring biological treatment, and the other type is mild, of psychosocial origin, and requiring psychological treatment (Ahn et al., 2009). Schizophrenia, of course, represents the "flagship" example of such a severe genetic brain disease.

The problem is that the foundational belief system of "finding the right medication for the right brain disease" cannot be said to represent good scientific evidence. Indeed, 60 years of intense biological research has yielded neither solid nor clinically relevant biology-based distinctions, as pointed out by Kapur, Philips, and Insel (Kapur et al., 2012). Mental health treatments work transdiagnostically in a highly personal, unpredictable fashion, mediated to a large degree by the human capacity to learn from expectation-rich and relational therapeutic rituals, and create perspective under even very difficult circumstances (van Os et al., 2019). The psychiatric gaze, therefore, has the hallmarks of a belief system which is used to make promises to the world outside psychiatry (Dumas-Mallet and Gonon, 2020). It is not evidence-based, nevertheless implicitly accepted as valid, nurturing the core values underlying the psychiatric way of perceiving the world of mental variation and addressing the clinical problems of patients.

A profession whose core values are based on a non-factual belief system runs the risk of becoming cult-like, as it has to find ways to exercise epistemic control of its members, proselytize aggressively against the tide of non-confirmatory scientific evidence and manipulate its messaging to the outside world (Dumas-Mallet and Gonon, 2020). Indeed, institutional power to define "specialist" categories of disease, such as DSM-criteria for schizophrenia, may be considered an instrument to exercise epistemic control *par excellence*. Sixty years ago, observers complained that American psychiatry was a cult of psychoanalysis (Browne, 1964). Now, observers suggest it runs the risk of becoming a "myopic" brain-based belief system (Braslow et al., 2021; Dumas-Mallet and Gonon, 2020; Gardner and Kleinman, 2019; Scull, 2021), refusing to accept the epistemological complexities of brain-mind-context relationships (Kohne and van Os, 2021; van Os and Kohne, 2021). Dynamic reasons may underly this refusal, as the insistence to define mental suffering in "brain" or biological terms may reflect an insecure need to match up to the perceived greater legitimacy of other health conditions like cancer and cardiovascular disease.

3. Schizophrenia and the moral era of medicine

The trap psychiatry has set for itself is that it has become the jealous gatekeeper of "true knowledge" where in fact only uncertainty exists. We propose that psychiatry adopts a more complex and scientific psychiatric gaze that is considerably more agnostic and embraces the epistemological complexities of dealing with mental variation at the brain-mind-context interface (Guloksuz and van Os, 2020, 2021). Professional values have become intertwined with an underlying belief system dictating that the "right way" to perceive schizophrenia involves the construct of a "debilitating genetic brain disease". According to these professional values, it would be "wrong" to adopt a more agnostic view of a psychosis spectrum, even if the scientific evidence clearly favours such a view (Guloksuz and van Os, 2018). The great advantage of adopting a more agnostic – and therefore more scientific –psychiatric gaze is that it would allow psychiatry to become less defensive, and thus more responsive to the values of patients and their families, similar to what happened in Japan.

The Japanese initiative is in many ways remarkable, as it shows that is it possible for a psychiatric association to abandon its position as epistemic gatekeeper and participate in a process of cocreation with stakeholders. This course of action is in line with the novel moral era of medicine, in which medical professionals are focussed on delivering treatments that "make a difference" – meaning it adds value to the life of patients beyond organ measures of symptom reduction. This is particularly relevant for psychiatry, where 80% of randomised controlled trials are focussed on symptom reduction for specific disorders, reflecting what professionals think is important, whereas patients struggle with the personal and difficult trajectory of learning to lead a meaningful life despite ongoing difficulties that do not respond very well to treatments. And while psychiatrists attach great importance to the word "schizophrenia", even though it does not consistently define anything, it has never attempted to structurally engage patients, families and other stakeholders to find out what they think is important in constructing a language for mental suffering and how to best offer assistance to those with need for care.

A more agnostic and scientific psychiatric gaze would allow for recognition of the fact that DSM-5 is not based in science, and that psychiatrists have been allowed to unilaterally impose their value system on the ill-understood phenomenon of human mental variation. In the new moral era of medicine, it is unthinkable that a domain like mental health, which scientifically in essence remains enigmatic and extremely complex and is of tremendous importance to countless user and their families, would be dominated by a distorted belief system and the values of a single profession. There is an urgent need for psychiatry to cocreate novel concepts and language, together with patients, families and other stakeholders, starting with the construct of schizophrenia.

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References

Ahn, W.K., Proctor, C.C., Flanagan, E.H., 2009. Mental health clinicians' beliefs about the biological, psychological, and environmental bases of mental disorders. Cognit. Sci. 33 (2), 147–182.

Berwick, D.M., 2016. Era 3 for medicine and health care. JAMA 315 (13), 1329–1330.

Braslow, J.T., Brekke, J.S., Levenson, J., 2021. Psychiatry's myopia-reclaiming the social, cultural, and psychological in the psychiatric gaze. JAMA Psychiatry 78 (4), 349. https://doi.org/10.1001/jamapsychiatry.2020.2722.

Browne, I.W., 1964. American psychiatry and the cult of psychoanalysis. J. Ir. Med. Assoc. 54, 11–17.

Dumas-Mallet, E., Gonon, F., 2020. Messaging in biological psychiatry: misrepresentations, their causes, and potential consequences. Harv. Rev. Psychiatry 28 (6), 395–403.
Gardner, C., Kleinman, A., 2019. Medicine and the mind - the consequences of psychiatry's identity crisis. N. Engl. J. Med. 381 (18), 1697–1699.
George, BILL, Klijn, AADT, 2013. A modern name for schizophrenia (PSS) would diminish self-stigma. Psychol. Med. 43 (7), 1555–1557.
George, B., Klijn, A., 2014. Psychosis susceptibility syndrome: an alternative name for schizophrenia. Lancet Psychiatry 1 (2), 110–111.
Guloksuz, S., van Os, J., 2018. The slow death of the concept of schizophrenia and the painful birth of the psychosis spectrum. Psychol. Med. 48 (2), 229–244.
Guloksuz, S., Os, J., 2020. Dr. Strangelove, or how we learned to stop worrying and love uncertainty. World Psychiatry 19 (3), 395–396.
Guloksuz, S., van Os, J., 2021. En attendant Godot: waiting for the funeral of "Schizophrenia" and the Baby Shower of the Psychosis Spectrum. Front. Psychiatry 12, 618842.
Kapur, S., Phillips, A.G., Insel, T.R., 2012. Why has it taken so long for biological psychiatry to develop clinical tests and what to do about it? Mol. Psychiatry 17 (12), 1174–1179.
Sato, M., 2017. What have we learned from the name change for schizophrenia? Psychiatry Clin Neurosci 71(3), 153.
Kohne, A.C.J., van Os, J., 2021. Precision psychiatry: promise for the future or rehash of a fossilised foundation? Psychol. Med. 51 (9), 1409–1411.
Scull, A., 2021. American psychiatry in the new millennium: a critical appraisal. Psychol. Med. 1–9.
Sommer, I., Kahn, R., Denys, D., Schoevers, R., Aleman, A., 2015. To abandon the diagnosis of schizophrenia is antipsychiatry of the seventies. NRC Handelsblad, 13 March 2015, Opinion, p 17.
van Os, J., Guloksuz, S., Vijn, T.W., Hafkenscheid, A., Delespaul, P., 2019. The evidence-based group-level symptom-reduction model as the organizing principle for mental health care: time for change? World Psychiatry 18 (1), 88–96.
van Os, J., Kohne, A.C.J., 2021. It is not enough to sing its praises: the very foundations of precision psychiatry may be scientifically unsound and require examination. Psychol. Med. 51 (9), 1415–1417.