gained a better understanding of the condition. As a result, there is now a growing acceptance that autism is a neurodevelopmental disorder with specific features. Thus, without relabelling the disorder, the public education which has raised public awareness of autism has achieved a significant reduction in the stigmatization of the disorder. Such a change in the climate has led to promotion of parents' access to care for their child with autism provided by mental health professionals, acceptance of diagnosis and help-seeking behaviours of adults with the disorder.

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. Nevertheless, renaming schizophrenia can be taken as a good first step, because such an action would draw people's attention and be in the media spotlight, which provides an unprecedented opportunity for the public education to foster better understanding of the disorder, as we have experienced in Japan. It is noteworthy, however, that campaigns against stigma, such as promulgating biological factors as a cause of the disorder, have had limited or even adverse effects (Crisp *et al.* 2000; Angermeyer & Matschinger, 2005). Thus, careful considerations are required when information on schizophrenia is provided via the media. Overall, it is advisable to seriously consider renewing the term of schizophrenia in countries where it is still used despite the fact that it conveys unfairly untoward images. However, introduction of a new name ought to be coupled with campaigns or programmes in the context of the public education that incorporate appropriate information that does not lead to misunderstanding of the condition.

Declaration of Interest

None.

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Forum

Renaming 'schizophrenia': a step too far or not far enough?

George & Klijn's paper (2013) will undoubtedly be met with controversy from those who believe there really is a definable mental 'illness' called 'schizophrenia' and that the diagnosis leads to effective treatments. Some will see the objection to the schizophrenia label as being 'anti-psychiatry' and a step too far. Others, however, will feel this paper does not go far enough, merely suggesting the replacement of one term with little reliability and validity with another.

There is no doubt that for many, the diagnosis of schizophrenia can be as debilitating as the associated symptoms. The internalization of stigmatizing public and professional perceptions of schizophrenia as an irreversible brain disease associated with violence and unpredictability can impact on identity, self-esteem, self-efficacy, hope and social functioning (Livingston & Boyd, 2010). Similarly, it is clear that internalized stigma can deter help-seeking and contribute to social exclusion. The impact of identifying with the diagnosis can in itself have a detrimental impact on recovery (Link *et al.* 2001). Although it is important to recognize that for some people the diagnosis confers benefits including naming the problem and providing a means of access to support (Pitt *et al.* 2009), the implied permanence and severity of the supposed condition can be debilitating. A key question in all this is whether changing the name would be enough in itself

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to change public attitudes and reduce self-stigma, while hopefully maintaining any potential benefits, or would such stigma become re-aligned with the new diagnostic term.

Some organizations have grown tired of waiting for official abandonment of the term. In both the UK and New Zealand family organizations that used to call themselves the *Schizophrenia Fellowship* have changed to *Rethink* and *Supporting Families*, respectively. In 2012 the membership of the *International Society for the Psychological Treatments of Schizophrenia* voted overwhelmingly to change its name to the *International Society for Psychological and Social Approaches to Psychosis*. In Japan, the name change was linked to an educational campaign which is likely to have contributed to the change in attitudes.

Beyond the many studies finding that use of the label increases negative attitudes (Read *et al*. 2006) research repeatedly demonstrates that beliefs about the *causes* of schizophrenia play a significant role in stigmatizing attitudes. The most recent review found that in 28 of 31 studies bio-genetic causal beliefs are related to negative attitudes and that in 24 of 26 studies psycho-social causal beliefs were related to positive attitudes (Read *et al.* in press).

There is a significant overlap in symptoms (and it could be argued, causes) between PTSD and schizophrenia (Morrison *et al.* 2003). At times of diagnostic uncertainty, and despite the stigma linked to PTSD, many of those with psychosis would prefer this diagnosis or one of 'complex trauma' as an acceptable explanation and description of their experiences. Interestingly, Moskowitz & Heim (2012) argue that when Bleuler suggested 'Dementia praecox' be renamed to 'Schizophrenia', he was not only challenging the assumed chronic deteriorating nature of the condition but, influenced by Janet, was acknowledging the dissociative aspect of psychosis, that presently we would consider to be trauma induced. This psychological element of schizophrenia was unfortunately neglected until recent times. The portrayal of schizophrenia as purely a bio-genetic condition has contributed to the high levels of associated stigma (Read & Harre, 2001; Angermeyer & Matschinger, 2003).

The renaming of schizophrenia to the equivalent of a post-traumatic stress reaction would, of course, be unacceptable to those who do not associate their psychosis with life experiences. However, evidence suggests that the majority of people who receive the diagnosis (Dudley *et al.* 2009), like family members and the general public (Read *et al*. 2006), view the causes of psychosis, as being predominantly of psychosocial origin. The heterogeneity within the population who receive a diagnosis of schizophrenia would suggest that there will be multiple aetiological pathways that incorporate many such factors, and preliminary evidence suggests that many service users find labels that allow for this (such as traumatic psychosis and drug-induced psychosis) may be more acceptable (Kingdon *et al*. 2008). This highlights another strong argument for abandoning the term schizophrenia: the lack of construct validity. At present there are no specific features of schizophrenia (symptoms, course, response to treatment and aetiology) that distinguish it from other disorders (Bentall, 2003), which means that the diagnosis has limited predictive power and utility. If as George & Klijn (2013) suggest, schizophrenia is relabelled as a syndrome this would at least openly acknowledge that psychiatry does not see it as a single entity.

The word 'schizophrenia' appears to do more harm than good, more frequently communicating prejudice and misinformation than fact and hope. It is indisputable that the stigma surrounding the term schizophrenia can in itself lead to misery for many with the diagnosis. Despite this, the diagnosis of schizophrenia is unlikely to disappear for a number of years. The APA has continued to endorse schizophrenia as a diagnosis in the revised and updated diagnostic manual DSM-5, due to be published later in 2013.

Some would question the merits of classifying emotions, behaviours and experiences into diagnostic groups at all, although classification and diagnoses are central to traditional medicine. Whether a system that was developed for studying diseases and illnesses has utility beyond primarily physical conditions is questionable. Despite there often being as many, if not more, differences than similarities in those with the same diagnosis, treatment guidelines, service configuration and research tend to be diagnosis specific and individual differences can be overlooked. Some argue that DSM and ICD have led to the medicalization of mental distress. The application of medical terminology such as 'symptom', 'mental illness' and 'disease' to human experience, infers pathology with an identified fundamental biological aetiology. A common complaint of service users is that they are treated as merely a set of symptoms and are not seen as person with a life beyond mental health services. The use of terms such as 'schizophrenic' reflect this practice of identifying individuals by their diagnosis. Therefore, any label that removes some of these disadvantages would be a welcome change.

Declaration of Interest

None.

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Forum

Would a rose, by any other name, smell sweeter?

Methods of psychiatric classification have numerous uses, ranging from the clinical (communication between clinicians, the facilitation of decisions about treatment), to the scientific (selecting participants for research into the aetiology and treatment of mental illness), through to the social and political (keeping statistics about mental health, developing mental health policy). Diagnoses also have unintended consequences, as emphasized by George & Klijn (2013), who argue that the term 'schizophrenia' increases the stigma experienced by psychiatric patients, and that it should therefore be replaced by something else. They cite the experience of Japan, where replacing the term with *Togo-Shitcho Sho* (integration dysregulation syndrome) is claimed to have ameliorated the stigma experienced by patients. While I applaud the overall goal of reducing stigma, and sympathize with authors' suggestion, I think that simple rebranding is unlikely to be enough to achieve what they desire.

The problems of schizophrenia

Schizophrenia has been a contested label for many years (Sarbin & Mancuso, 1980; Bentall *et al.* 1988) not only because it is associated with stigma, but also because it fails to achieve any of the purposes for which it was originally designed. Even in the world of operationalized diagnostic criteria, different definitions of schizophrenia sometimes define different people as schizophrenic (van Os *et al*. 1999). In carefully conducted studies in which patients are followed up over time, patients sometimes move from one diagnosis to another within the psychosis spectrum (Bromet *et al*. 2011) and diagnostic shifts, for example between schizophrenia and bipolar disorder, are probably much more common in the rough and tumble of routine psychiatric care. Statistical analyses of symptoms fail to provide any support for the kind of categorical diagnoses contained within the DSM or ICD systems (Kotov *et al*. 2011). Instead, the psychotic disorders seem best described in terms of five relatively independent dimensions of positive symptoms, negative symptoms, cognitive disorganization, depression and mania (Demjaha *et al*. 2009), although there may also be a superordinate general psychosis dimension (Reininghaus *et al*. 2012), which is also suggested by genetic research (Craddock & Owen, 2005). Importantly, there is considerable evidence that at least some of these dimensions lie on continua with normal functioning (Linscott & van Os, 2010). Not surprisingly, given these findings, there is very little evidence that categorical diagnoses, at least in the psychotic domain, predict treatment response. Patients diagnosed as suffering from bipolar disorder, like those diagnosed with schizophrenia, are now commonly treated with antipsychotic drugs, leading to suspicions that patients with the two diagnoses suffer

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