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A crisis of meaning: can 'schizophrenia' survive in the twenty first century?

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Abstract

Both within clinical and wider societal discourses, the term 'schizophrenia' has achieved considerable potency as a signifier, privileging particular conceptual frames for understanding and responding to mental distress. However, its status has been subject to instability, as it has lacked indisputable biological correlates that would anchor its place within the canon of medical diagnosis. Informed by a semiotic perspective, this paper focuses on its recent history: how 'schizophrenia' has been claimed, appropriated and contested – and how this connects with its earlier history of signification. It also explores how the dominance of this signifier has influenced the ways in which people with the diagnosis may find themselves constructed in their interactions with professionals, family and wider society, and hence how they may come to see themselves.

It is argued that, from a point in the 1990s when 'schizophrenia' had achieved an almost iconic status, the term is now subject to greater instability, with concerns and challenges being raised from both within and outside psychiatry. On the one hand, this uncertainty has triggered a 'calls to arms' from those within the psychiatric establishment who see diagnoses such as 'schizophrenia' as crucial to their professional identity and status. On the other, this has created spaces for new conversations and alliances between elements within neurology, psychiatry, social work and other professions, and between these and service users. Some of these conversations are casting doubt upon the validity and utility of 'schizophrenia' as a construct, and are beginning to posit alternative regimes of signification.

A crisis of meaning: can 'schizophrenia' survive in the twenty first century?

'Does a 19th century expression referring to a state of 'split mind' represent a suitable term ... in the 21st century?' Jim van Os (2010)

Throughout much of the twentieth century, medicine provided a dominant framework for speaking about mental health difficulties. Within the language of diagnosis, the term 'schizophrenia' played a pivotal role, not just as a descriptor of certain types of experience, but as an anchor for signifying particular ways of viewing mental distress. In turn, it became a powerful signifier in how mental distress was conceived within everyday discourse – impacting profoundly upon those whose experience it sought to describe and define. It was also appropriated within postmodern theory as a signifier that opens up the fragility of personal subjectivity more generally.[1] However, it has proved to be 'a highly unstable sign',[2] with its meaning and usage shifting over time and questions being raised as to its utility and validity.[3] Building on previous historical work,[4,5] and on semiotic studies,[1,2] this paper examines the recent history and current status of the signifier - in relation to its historical antecedents, prevailing discourses and more recent debates and discursive shifts.

Signifiers and signified

A valuable insight from the deconstruction of language undertaken by the French semiologist Barthes is that linguistic terms, or signifiers, are not simply a neutral reflection of some self-evident reality. Instead, although it may appear that their meaning is anchored by their relationship to some phenomenal entity, their power to signify may actually derive from their positioning relative to other signifiers within a wider chain of signification. This chain may operate so as to 'divide reality' in a certain way and thereby impose a particular order onto what is signified and 'naturalise' this as a culturally embedded and taken-for-granted way of making sense of the phenomenal world.[6] Using this perspective, the psychiatric practice of differential diagnosis may be seen to provide a chain of signifiers that 'divide up' a panoply of unusual and distressing mental experiences, so as to 'create a concrete, cohering entity', imposing an order where, arguably, none exists'.[2] While what is

signified by 'schizophrenia' may be hard to pin down in isolation, a greater degree of certainty is claimed once it is determined that related signifiers in the signifying chain, such as 'dementia' or 'bipolar disorder', can each be ruled out.

Derrida argued that the meaning (and legitimation) of a signifier could be constructed through the operation of 'différance' – both how it *differed* from other related signifiers within its discursive context, and how it *deferred* to a history of pre-existing meanings.[7] For example, the current meaning of 'British' may be constructed through its relationships of difference vis-à-vis other related signifiers, such as 'European', 'Scottish' or 'English', and it may also *defer* to past constructions of 'Britishness', perhaps linked to tropes from the Second World War or the loss of empire. Similarly the current meaning of a diagnostic signifier such as 'schizophrenia' may derive, not just from its *difference* from other diagnostic signifiers, but also from its *deferral* to past significations of 'schizophrenia' or related concepts.

Whilst within much of medicine, diagnostic signifiers can be relatively stable, and anchored to distinctive physiological processes, signifiers of mental distress can be inherently more slippery since, despite a considerable research effort, it is still acknowledged that 'very few psychiatric disorders have a biological basis'.[8] In particular, the linkage of the signifier 'schizophrenia' to anything fixed within phenomenal reality has seemed somewhat fragile and open to controversy and contestation.[3;9-10] The term does not reliably connect to any straightforward underlying pathology, and it has proved hard to define an exclusive set of symptoms and a trajectory over time which people with the diagnosis would have in common, and which would clearly differentiate them from others with a different diagnosis or none at all.[11]

Not only do diagnoses *denote* (i.e. describe and categorise) particular constellations of experience and behavior; but they can take on further *connotations* within wider cultural (and professional) contexts. Within the immediate field of mental healthcare, a diagnosis may bring forth specific connotations, such as particular ideas of causation, the meaningfulness or otherwise of current experience, and the possible future ahead. It may also connote a particular status for the professional group which has responsibility for determining diagnosis. Once a signifier such as 'schizophrenia' is established, 'society can very well refunctionalise it',[12] thereby accruing a range of other connotations,[1,2] including ones which serve to stigmatise and construct people as 'other', or to justify policies of segregation or compulsory treatment.

As Sontag observes, any disease (mental or physical) 'whose causality is murky ... tends to be awash with significance'.[13] For people experiencing mental distress, diagnostic signifiers can have a powerful influence both on self-identity and on how they become constructed in their relationships with those around them. Through such processes, the signifier 'schizophrenia', and the meanings and practices

associated with it, may come to influence aspects of the very symptomatology it claims to describe (such as apathy or the blunting of emotional expression).

On the positive side, the term 'schizophrenia' can operate as a social permission to be distressed and to be relieved of excessive responsibility – and many people describe a sense of relief when they receive a formal diagnosis. It can provide 'a means for people to externalise their problems rather than feeling that they [are] personally responsible for them'.[14] Craddock and Mynors-Wallis suggest that, not only may it provide reassurance 'that their situation is not unique', but also, perhaps more controversially, that their experience is no longer 'mysterious or inexplicable'.[15]

Less positively, diagnostic criteria can impose a template of characteristics by which a person's 'difference' is constructed – a template that exists outside of their control. Buying in to the signifier of 'schizophrenia' potentially involves a double process of misrecognition: not only is the unique and mysterious content of people's experience transmuted into a standardised diagnosis, but this signifier may also attract the accretion, within wider social and political discourse, of other undesirable and stigmatising attributes, such as the potential to be an axe-murderer.[16,17] Thus, there can be a major price to be paid, in terms of subjection to a signifier that may not only influence how people are identified by others, but also, potentially, how they come to see themselves – which may, in turn, impact negatively on their symptoms and prospects of recovery.[18] Interestingly, research would indicate that those who refuse to accept the diagnosis of 'schizophrenia' (and are conventionally seen as lacking in 'insight') may be better able to resist internalizing the stigmatizing connotations that may otherwise link to it.[19]

The prior history of 'schizophrenia'

For medicine to stake its claim to 'knowing' about mental distress, a palpable sign would be its ability to divide up the field using a language of diagnosis. Some diagnoses, such as 'depression' or 'anxiety', did little more than re-functionalise descriptive signifiers that were already part of a lay vocabulary and, as such, did not immediately signal a different order of expert (and specifically medical) understanding. More challenging would be the re-imagining of the broad category of madness (or psychosis) into discrete disease entities. Were this to be achieved, this would provide a powerful signification that medicine could claim knowledge of the wider field.

The history of 'schizophrenia' as a signifier starts with Kraepelin's attempt in the 1880s to distinguish something that was different from the dementia of older age - which he termed 'dementia praecox' or 'early dementia'.[20] Located within and deferring to a pre-existing lexicon of medical diagnosis, this sought to signify 'a progressive neurodegenerative disease, which automatically resulted in irreversible

loss of cognitive functions' [21] – one that could be differentiated from 'manic depression' and which could, in turn, be sub-divided into different forms of presentation (such as 'catatonic' or 'paranoid').

In the early twentieth century, Bleuler proposed an alternative nomenclature which sought to capture what he saw as the essence of the experience – a fragmentation of mind.[22] His new signifier, 'schizophrenia', claimed to denote an underlying psychic phenomenon: a 'loosening of associations' that resulted from a 'core organically based psychological deficit'.[23] This single underlying disorder could become manifest in a range of presentations: the 'group of schizophrenias'. Although the signified was only called into existence by its signifier (and could not claim any specific biological referents), the idea of 'schizophrenia' nevertheless connoted a unity between the underlying psychological and the underlying biological that could anchor the emerging specialism of psychiatry. Perhaps more than any other psychiatric diagnostic signifier, it simultaneously conjured up a sense of mystery and made the claim that biological medicine could solve the mystery.

It was precisely because the signified was so inherently obscure (unlike with more overtly descriptive signifiers such as 'mania' or 'depression') that it was able to take on a particular power within professional and (subsequently) public discourses. As Woods argues, 'schizophrenia' became psychiatry's 'sublime object' through its construction 'in psychiatric writing as opaque, bizarre and resistant to analysis', so that it required ever more 'sophisticated forms of scientific enquiry' in order to unlock its secrets.[24] This set the terms for a project throughout the twentieth century to fix this signifier in terms of biology and to give it greater diagnostic specificity – as with Schneider's attempt to define it on the basis of specific 'first rank' symptoms.[25]

However, another contemporary of Kraepelin, Carl Wernicke, saw the way forward somewhat differently – a perspective that would resurface with renewed force in the twenty-first century:

'Wernicke was critical of Kraepelin's concept of psychiatric disorder as natural disease units. He did not believe that separate routes of investigation (i.e. clinical observation, neuroscience, epidemiology) would converge toward valid disease entities. He asked for a radical paradigm shift: replace psychiatric nosology with a clinical neuroscience that is anchored in our understanding of human brain structure and function'.[26]

The 1960s saw the emergence of the anti-psychiatry movement with its attempt to redefine mental 'illness' as existential crisis (Laing) or 'problem in living' (Szasz).[27] Szasz argued that, not only was 'schizophrenia' a myth, but that it held a particular quasi-religious status within the practice of psychiatry.[28] However, this critique had relatively little influence at the time on the psychiatric mainstream. Somewhat paradoxically, its main impact may have been as a spur to the radical revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental*

Disorders in the late 1970s. Prior to this, the Association had been remarkably pragmatic in its approach, with the preface to DSM-II acknowledging that ‘the Committee could not establish agreement about what [‘schizophrenia’] is; it could only agree on what to call it’ [29].

The emergence of the modern conception of ‘schizophrenia’

With the launch of the third edition (DSM-III) in 1980, this uncertainty of signification was addressed, with a commitment to anchor ‘schizophrenia’ in terms of symptomatology (if not yet aetiology). This marked a paradigm shift in American psychiatry :

‘In a very short period of time, mental illnesses were transformed from broad, etiologically defined entities that were continuous with normality to symptom-based, categorical diseases’.[30]

It is argued that this attempt to fix diagnostic definitions was not ‘a product of growing scientific knowledge’, but emerged instead from wider discursive and economic contexts, including:

- (1) professional politics within the mental health community,
- (2) increased government involvement in mental health research and policymaking,
- (3) mounting pressure on American psychiatrists from health insurers to demonstrate the effectiveness of their practices, and
- (4) the necessity of pharmaceutical companies to market their products to treat specific diseases.[30]

Signifiers that had been relatively ill-defined and free-floating descriptors of mental experience were to be formalised with explicit diagnostic criteria so that they could be clearly differentiated from one another – thereby gaining legitimation through their deferral to (and conformity with) the accepted medical canon of differential diagnosis. The conceit of DSM-III was its substitution of *reliability* (more consistent identification of differences between clusters of symptoms) for *validity* (representing something real and distinct in terms of underlying pathology or process). As Thomas Insel, the former Director of the American National Institute for Mental Health, has argued:

While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been “reliability” – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity’.[31]

The claim to validity for 'schizophrenia' still primarily rested on its deferral to the earlier conceptions of Kraepelin and Bleuler, obtaining much of its gravitas from its association with the self-sustaining idea of a core dysfunction in psychological process that would be of organic origin. Indeed the architects of DSM-III explicitly sought, as far as possible, not to introduce 'new terminology and concepts that break with tradition' [32] - thereby reinforcing the 'continuity hypothesis' in which successive redefinitions of 'schizophrenia' were seen as simply polishing away any 'blemishes and impurities' associated with a signifier 'of a real, recognizable, unitary and stable object of inquiry' [5]. It was this firming up at the level of signification, rather than any breakthrough in research, that laid the foundation for President George Bush's designation of the 1990s as the 'decade of the brain' [33] – a decade in which it was believed that medical research would finally be able to map psychological dysfunction onto a biological substrate of identifiable disease processes.

The British context was somewhat different. British psychiatry had adhered to a more pragmatic definition of 'schizophrenia' found in the World Health Organization *International Classification of Diseases* (ICD) version 9. This signification did not pretend the same degree of operational rigour as came with DSM-III, and it was not deployed within mental health services in a way which precluded a broader and more nuanced understanding of mental distress. A nationalised health service meant that there could not so easily emerge a lucrative confluence of interest between pharmaceutical companies, health insurance and biologically oriented psychiatrists to construct disease categories for which particular drugs could be seen as the treatment of choice. Initially DSM-III was treated with some scepticism, but with increasing international collaboration in research, and the globalisation of the pharmaceutical industry, it became more influential and subsequent revisions of the ICD have mirrored subsequent iterations of DSM.

By the mid-1990s, spurred on by apparent breakthroughs in research, the term 'schizophrenia' had assumed an almost iconic status on both sides of the Atlantic as the medical diagnosis that was going to demonstrate that biomedical psychiatry was, at last, going to be able to define an aetiology, treatment regimen and potential cure for the most impenetrable and mysterious of mental disorders. Anchoring the signifier 'schizophrenia' in this way would have sealed the successful colonisation of mental distress by a biomedical approach – and, in turn, lent status to other diagnostic categories that clustered around it and could then defer to it for their legitimisation. This would have rendered irrelevant the potentially more complex search for meaning and understanding of mental distress from a range of personal, psychological and social perspectives.

Although no definitive correspondence had been discovered between the diagnostic construct and a reliable cluster of biochemical characteristics, the anchoring of the signifier was secured by a promise: research would soon reveal the genetic and/or physiological specificity of 'schizophrenia'. There was an interesting collusion

between a range of vested interests, social, economic, professional and political, to proceed as *if* there was a certainty about mental illness: that it would no longer be a troubling threat to the good order of society, but a straightforward disease of the brain that could be controlled by pharmacological treatments. Particular rhetorical devices were deployed, such as 'reification, the use of an empiricist repertoire and the continual evocation of a narrative of scientific progress'.[34]

The most obvious beneficiaries of this biological construction of 'schizophrenia' were the pharmaceutical companies who had been unscrupulous in rebranding the generic major tranquillisers of the 1960s as if they were 'magic bullets' which targeted a specific disease process – and then developed a financially more lucrative range of supposedly even more efficacious 'atypical' medications.[35] Psychiatry stood to gain in terms of power and prestige (and greater perceived equality of status with other medical specialties) – although not all psychiatrists were comfortable with this biomedical turn within their profession. While health insurance was not a significant player in the UK, government (and, in particular, the New Labour government of 1997) found it helpful to go along with the simple message that 'schizophrenia' – constructed as dangerous within the media and wider social discourses – could be contained by a combination of accurate diagnosis, medical treatment and, where necessary, compulsory treatment.

The message that 'schizophrenia' was simply a disease, whose ill-effects would soon be eradicated by advances in medical research, also had an appeal to many family members who might otherwise have felt frightened or overwhelmed. It is perhaps no co-incidence that the signifier 'schizophrenia' was embraced in the title of the key voluntary organization that had provided support and information to family members: the National Schizophrenia Fellowship.

However, those who received the diagnosis of 'schizophrenia' have tended to be less enthusiastic about it for a number of reasons. As a diagnosis without a medical cure attached to it, 'schizophrenia' could feel like a life sentence: a paralysing sign that rendered them passive in terms of their own recovery, with medical experts only offering a prospect of long-term dependence on medication, and little possibility of achieving aspirations such as getting a job or starting a family. Equally debilitating could be the impact of the signifier on personal identities and social relationships. Anti-stigma campaigns predicated on the message that 'schizophrenia' was an illness like any other (such as diabetes) have not led to greater public acceptance. Instead, the evidence would suggest that such campaigns can actually back-fire, with the apparent biological anchoring of the diagnostic signifier tending to construct people as irrevocably 'other' and therefore even more likely to be shunned or excluded.[36]

Such an anchoring of this signifier at the heart of service discourses (and wider social and political discourses) had a major impact at the more intimate level. It sealed a particular way in which people were invited to see themselves, and it set

the terms of social interactions between professionals and service users and, somewhat more insidiously, of those between service users and their family and friends. A generation of psychiatrists and, to a significant extent, nurses, psychologists and social workers, were trained to ignore much of what people were telling them about the content and meaning of their experiences; all that mattered was correctly locating people's presentations within a signifying chain of differential diagnosis.

Doubts and controversies

Over the following decade, the 'schizophrenia gene' eluded discovery, the dopamine hypothesis turned out to be too simplistic a physiological explanation, and the new wave of anti-psychotic medication turned out to be hardly more effective in managing problematic experiences than the major tranquillisers of the 1960s.[37] Alongside this, the emerging Recovery movement increasingly looked beyond medicine for what might enable people to reclaim satisfying and meaningful lives.[38] The status of the signifier 'schizophrenia' started to look a little more fragile.

At a policy level in the UK (as in the promotion of Early Intervention services), mainstream psychiatry increasingly used the broader term 'psychosis' to denote experiences of madness. This did not purport to be a formal medical diagnosis and did not evoke the same connotations as 'schizophrenia' within clinical or wider social discourses. In response to this growing discomfort, the National Schizophrenia Fellowship had rebranded itself as Rethink and, although the signifier returned to prominence with their 'Schizophrenia Commission' in 2011, the latter's report offers it a much less certain linguistic status, recommending that 'the more general term', psychosis, can be preferable.[39]

Another threat to the dominance of the signifier 'schizophrenia' came through the rival discourse of Post-Traumatic Stress Disorder. This had originally emerged as a diagnosis to describe the mental distress experienced by veterans of the Vietnam War, but which was becoming used with increasing frequency, particularly in the USA,[40] with experiences such as childhood abuse and domestic violence being increasingly being cited as causative factors. Here some very similar symptoms (such as hearing voices) were understood as the reactions of ordinary people to extraordinary and overwhelming situations.[41] To muddy the waters further, research findings indicated that a substantial proportion of people with a diagnosis of 'schizophrenia' reported that they were also survivors of trauma.[42,43] This foregrounding of social over biological causation offered a new way of linking to neuroscience that bypassed the role of signifiers such as 'schizophrenia'. For example, the traumatogenic neurodevelopmental model explored the imprint of trauma on brain functioning without the need for any intermediary concept of 'illness'.[44]

This insidious resurgence of explanatory pluralism was met with a call to arms by Craddock and colleagues in the *British Journal of Psychiatry* in 2008. In their ‘Wake-up call’ to the profession, they argued that British psychiatry was facing an ‘identity crisis’ – implicitly situating their professional identity as depending on the survival of signifiers such as ‘schizophrenia’, which marked out their territory as properly medical. They were specifically concerned that the ‘creeping devaluation of medicine ... is very damaging to both the standing and the understanding of psychiatry in the minds of the public, fellow professionals and the medical students who will be responsible for the specialty’s future’.[45] Using similarly emotive language, Tyrer argues that, despite its imperfections, ‘psychiatry without diagnosis will return us to the Dark Ages’.[8]

From within the psychiatric establishment, Lieberman and First still felt able to reject calls for the renaming of ‘schizophrenia’, asserting that ‘schizophrenia is not caused by disturbed psychological development or bad parenting’, but was instead associated with ‘abnormalities in brain structure and function’.[46] However, this flew in the face of a mounting body of evidence that adversities in childhood most certainly did increase the likelihood of such experiences [47,48] and an acknowledgement by some of those involved in the preparation of DSM-5 that ‘not one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes’.[49]

Perhaps the most telling critique of conventional constructions of ‘schizophrenia’ came from a grass-roots self-help movement, the Hearing Voices Network. Here, people came together and shared their experiences of voice-hearing, challenging its status as a ‘symptom’ of a mental illness and asserting their right to make their own sense of who and what their voices might represent – with many choosing to understand their experiences as responses to life circumstances or events.[50] Such a search for meaning outside the strait-jacket of medical diagnosis is also a key feature of the Open Dialogue approach, which is now starting to become more influential in mental health services.[51,52]

In parallel with these developments, some senior figures within psychology and psychiatry had started to question the credibility of ‘schizophrenia’ as a diagnostic entity that actually stood up on its own terms. In the USA, as part of a long sequence of preparatory work leading to the most recent revision of DSM (DSM-5), the Nomenclature Work Group openly queried whether ‘schizophrenia’ could stand up as a categorical diagnosis (either you have ‘schizophrenia’ or you do not). They recommended that consideration be given to a more nuanced dimensional approach in which traits associated with ‘schizophrenia’ could be seen as being on a continuum, part of which would fall within the bounds of normal variation within the general population.[53] Similarly, in the UK, psychologists such as Boyle and Bentall had been arguing that ‘schizophrenia’ had no validity if judged against what had been seen as the accepted criteria for medical diagnosis [9,11] – and that, instead, it was more helpful to structure therapeutic conversations with service users around

what they saw as their specific complaints: perhaps the impact of a malevolent internal voice or an irrational belief.

Instead of research supporting the idea of schizophrenia as denoting a distinct disease, the psychiatrist, van Os, argued that

‘Psychotic disorders appear to be fuzzy in that they blur into normality. The evidence suggests a natural representation of psychotic disorders that is dimensional along a continuum from subclinical expression to psychotic disorder... Therefore, understanding a diagnosis of psychotic disorder becomes understanding the onset of need for care’.[54]

Even in the heartlands of schizophrenia research, there was increasing acknowledgement that the Kraepelinian project to divide up madness into discrete entities was no longer viable. In his editorial for the *Schizophrenia Bulletin* in 2014, Carpenter suggested that the Journal would have to learn to live with the idea of ‘porous diagnostic boundaries’ as ‘the anticipated reconceptualization of mental disorders based on fundamental and differentiated etiopathophysiological knowledge’ had not (yet) been achieved. Most tellingly, he then proposed a way forward that was situated much more in the world of semiotics than science. He argued that:

‘These issues provide an important opportunity and challenge for this journal. *Schizophrenia Bulletin* is an old and honored name. We intend to broaden the mission without damaging the brand’.[55]

By implication, it is not just the *Schizophrenia Bulletin*, but also ‘schizophrenia’ itself that had become a ‘brand’ that owed its significance, not so much to its ability to delineate anything very meaningful in the real, but to its history, its ability to defer back, as an ‘old and honoured name’, to a chain of signification that started with Kraepelin’s Dementia Praecox. However, what was actually to be signified by a more porous ‘schizophrenia’ had remarkably little in common with the original Kraepelinian project. It no longer claimed to denote a disease that was characterised by progressive neurodegeneration or which categorically differed from mania or psychotic depression. Furthermore, the most recent revision of DSM (DSM-5) saw the abandonment of any attempt to delineate sub-types of ‘schizophrenia’ or to privilege Schneider’s ‘first rank symptoms’ within diagnosis.

Thus, despite the attempt to maintain a discourse of continuity and ongoing refinement, it was becoming less and less clear what of substance remained that was actually to be signified by ‘schizophrenia’, beyond a pick-and-mix collection of potentially heterogeneous symptoms. While ‘schizophrenia’ may represent an ‘old and honoured name’ for some elements within psychiatry, such cherished reverence for the term may be less likely to be found among many users of mental health services.

Emergence of alternative modes of signification

If it were stripped of its power as a signifier of altered biology, 'schizophrenia' could lose its place in wider medical chains of signification – and hence many of its current meanings and its ability to dominate the discursive frames in which mental health practitioners operate. Having increasingly fragile claims to ontological validity, its only potential currency would be as a convenient 'shorthand' that encapsulated particular sets of experiences that was helpful for service users, family members and professionals in talking about needs for therapy and care:

'Thoughtful clinicians have long been aware that diagnostic categories are ... justified only by whether they provide a useful framework for organizing and explaining the complexity of clinical experience in order to derive inferences about outcomes and to guide decisions about treatment'.[56]

However, any such benefit associated with the term 'schizophrenia' may be outweighed, for many service users, by its potentially damaging and stigmatising social connotations. One approach has been to seek alternative signifiers to denote the same 'bundle' of experiences – for example, 'integration disorder'[57] or 'psychosis susceptibility syndrome'.[58] An alternative approach that has found some favour with service users has been to break up any over-arching concept of 'schizophrenia' and instead to develop signifiers to denote specific routes of causation, such as 'traumatic psychosis', or areas of challenge in current functioning, such as 'stress-sensitivity psychosis'.[59] Research would suggest that less mystifying signifiers such as these are less likely to provoke a response of social distancing.[60]

There were suggestions from the Work Group revising diagnostic classifications for ICD-11 that they would 'give careful attention to the viability of the term schizophrenia', and that they were 'conscious that an exceptional opportunity exists for WHO to remove the word from the public and professional vocabulary'.[61] However, more recent indications suggest that only the definitions of sub-types will change – with ICD again following the lead of DSM.[62] A more radical response was an international social movement called the Campaign for the Abolition of the Schizophrenia Label which argued that 'the concept of schizophrenia ... has outlived any usefulness it may once have claimed' and that 'the label schizophrenia is extremely damaging to those to whom it is applied'.[63]

Although these potential destabilisations of 'schizophrenia' as a signifier have yet to unseat its dominant status, a more pluralistic space is emerging in which different ways of representing experience are becoming possible - including within the professional discourses of psychology, nursing, social work and, to a significant extent, psychiatry itself.[64,65,66] A recent Maudsley debate addressed the question 'Has psychiatric diagnosis labeled rather than enabled patients?'[67] The

Division of Clinical Psychology of the British Psychological Society issued a position statement that there was ‘a need for a paradigm shift’ away from the use of diagnoses such as schizophrenia ‘towards a conceptual model not based on a “disease” model’[68] – and this was given prominence to a lay audience via a headline in the *Observer* newspaper: ‘Medicine’s big new battleground: does mental illness really exist?’[69] Within this emerging discursive space, there is now more possibility for therapeutic conversations between practitioners and service users to embrace different frameworks for meaning, with those with lived experience having a small but increasing say in how they may wish their experience to be signified.[70]

However, in the longer term, perhaps the greatest threat to the continued dominance of the signifier ‘schizophrenia’ may come, not from service user concerns or critiques emerging from within the mental health professions, but from its apparently polar opposite: the scientific and political advance of neuroscience. As Wernicke had argued a century earlier, instead of trying to infer the existence of a disorder of mind/brain on the basis of regularities in presentation of symptoms (where biological correlates have remained elusive), might it not make more sense to start the other way around with a study of the bio-electrical processes of the brain – and the isolation of potential variabilities within these? Such an approach is gaining traction within clinical psychology and has spawned the suggestion within medicine that psychiatry and neurology should consider a ‘merger’.[71] For good or ill, such an approach has also gained political support on both sides of the Atlantic, with former President Barack Obama heralding (with remarkably little historical insight) a new ‘decade of the brain’ and the *New York Times* front-page headline proclaiming that neuroscience will enable us to see ‘how the brain creates the mind’.[72]

Underpinning this neurological ‘turn’ would be the abandoning of DSM and its replacement by a new classification framework for brain disorders (termed Research Domain Criteria) which would be grounded in neurobiological observation of brain-circuitry rather than clusterings of functional symptoms.[73] While it is likely that advances in brain science may indeed throw light on specific cognitive, emotional or behavioural process, it seems somewhat improbable that it would come up with such a sprawling and inconsistent conception as that of ‘schizophrenia’.

In the shorter term, it is likely that current configurations of professional, economic and political interests may secure the continuance of ‘schizophrenia’ in its present form in the next iterations of DSM and ICD classifications. However, beneath this, tectonic plates may be shifting and, were an effective alliance to be made between neuroscience and those professionals and service users who question its utility or validity, ‘schizophrenia’ as a signifier might become unseated for good. Its likely replacement would be a new regime of signification in which problematic social experiences, such as trauma [44], attachment issues [74] or ‘social defeat’ [75], could be linked to neuro-biological correlates, leading to ways of conceptualising neurodiversity that bypass the idea of illness altogether.[76, 77] Such a new regime could claim legitimacy on the basis of denotive signs with a more transparent

connection to the real (both social *and* neurobiological), rather than having to make a more tenuous claim by deferring to the 'old and honoured name' of 'schizophrenia'.

However, as this paper has shown, the politics of signification in this field are not necessarily benign, with vested interests gaining power and influence through securing particular strategies for dividing up the complex realm of distress experiences and privileging certain systems of mutually reinforcing signifiers. A new regime of signification may not necessarily be any more emancipatory for those with mental health difficulties than that which it would replace. If it secures legitimation on the basis of deferral to the signifiers of 'hard science', rather than (also) connecting to the social and personal experiences of people with mental distress, it may simply provide cover for pharmaceutical companies and technologically-oriented professionals to take charge of the field with new claims of expert authority. As Rose observes, 'all pathways through the brain seem to end in the use of psychopharmaceuticals'.[78]

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