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Debate about the Concept of Schizophrenia and What Psychiatry Should Do With It

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Description

Interventional Psychiatry is an emerging subspecialty that treats patients with disorders resistant to routine measures by employing advanced treatment modalities and procedures that require expertise beyond the training provided in a general psychiatric residency. Interventional psychiatrists thus require advanced technical, psychiatric, and general medical training and expertise to be able to provide these treatments in a safe and effective manner. In this article, we will discuss our take on the definition of interventional psychiatry, review the modalities included in this field, and suggest training requirements for an interventional psychiatrist. We will also share our experience in providing advanced interventional psychiatry training as a chief residency or fellowship at the Yale New Haven Psychiatric Hospital. 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. 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. 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.

Broader Reflection on the Scientific Foundation of Psychiatry

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 .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, 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. The fact that our medical peers are now also increasingly concerned about “psychiatry’s identity crisis” makes it difficult for traditionalists to apply the old psychiatric defence of relegating the schizophrenia debate to the discredited realm of “*antipsychiatry*”. The time has therefore come to talk about schizophrenia as a symptom of psychiatry itself.

Novel Moral Era of Medicine

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 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. 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. 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.