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The Concept of Schizophrenia: Clarifying the Debates and Understanding its Use

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Summary of the Portfolio

Section A is a mapping literature review, aimed at clarifying the nature of the debates around the concept of schizophrenia. It also explicates the role UK clinical psychology has played in these debates. It found that there is a diversity and complexity to the positions taken that reaches across professions, with clinical psychology having contributed both to the resistance and persistence of the concept. An asymmetry within the schizophrenia debates – where those who critique the concept do so explicitly, but the rationale of those who use the concept remains implicit – characterises publications both within, and outside UK clinical psychology.

Section B examines how the concept of schizophrenia is currently used in clinical practice. A Foucauldian Discourse Analysis of eight interviews with mental health professionals identified two main ways of talking about 'schizophrenia': as an object of scientific enquiry, and as a physical condition. The concept was spoken about with great flexibility, however, with participants referring to it in a variety of sometimes conflicting ways. When relaying how they talk to service users about the concept, participants spoke in considerably less flexible ways.

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Section A:

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Abstract

The concept of schizophrenia has been contested since its inception. Over the last decades, criticism of the concept has become increasingly mainstream and publications have progressively advocated abandoning it, and using alternatives. Despite this, most mental health research on the topic continues to use the concept and this use remains the topic of heated debate. This mapping literature review clarifies the nature of the schizophrenia debates, and explicates the role UK clinical psychology has played in these. It found that there is a diversity and complexity to the positions taken that reaches across professions. Clinical psychology has contributed both to the resistance and persistence of the concept of schizophrenia and publications that continue to use the concept conceptualise it in a variety of ways. An asymmetry within the schizophrenia debates – where those who critique the concept do so explicitly, but the rationale of those who use the term remains implicit – characterises publications both within, and outside UK clinical psychology. The review concludes with clinical and research implications, including the need to further explore how the concept is currently used in clinical practice, and with what consequences.

Keywords: Schizophrenia, clinical psychology, critical psychology, debate, psychiatric diagnosis

Introduction

The Schizophrenia Debates

The diagnostic category of schizophrenia has been the subject of

intense controversy and debate almost since its inception (Woods, 2011). For a long time,

critiques of the diagnosis focused primarily on epistemological and ideological issues with

the concept of mental illness more generally (e.g. Szasz, 1961; Laing, 1960). Influential as

these were, their direct impact on mainstream mental health services and research was limited

at the time: an overwhelming majority of research studies continued to use the diagnosis of

schizophrenia as an independent variable (Sarbin & Manusco, 1980) and little changed with

respect to how the concept was used in mainstream clinical practice (Bentall, 1992).

Over the last three decades, this has changed. As criticisms of the concept of

schizophrenia shifted in focus to its scientific validity (Lidz & Blatt, 1983; Rose et al., 1984;

Bentall, 1988; Ross & Pam, 1995; Boyle, 1990; 2002a), the concept was subjected to

unprecedented levels of criticism, with concerns about its validity, usefulness and potential

harmfulness being raised within, and outside of mental health professions (Tew, 2017).

Since then, the continuing absence of robust evidence for biological causes of

'schizophrenia'[1] (Kingdon, 2007; van Os, 2010: Deacon, 2013), in combination with research

linking behaviours and experiences associated with it to non-biological factors (Folsom &

Jeste, 2002; Werner et al., 2007; van Nierop et al, 2014; Longdon & Read, 2016; Bailey et

al., 2018), have prompted even major voices within the psychiatric establishment to challenge

its validity (van Os, 2010; Insel, 2013). Additionally, alternative conceptualisations of the

phenomena traditionally considered symptoms of schizophrenia are on the rise (Escher &

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[1] For this paper, 'schizophrenia' is not assumed, but rather seen as a concept, the use of which requires explanation. As noted by Hook & Parker (2002), it is difficult to talk about a concept without implying that it exists independently of its use. To avoid making such implications, 'schizophrenia' is put in quotation marks, but only where the sentence otherwise assumes its existence.

Romme, 2011; DuBrul, 2014; Cooke et al., 2017; Johnstone & Boyle, 2018), along with several movements championing these conceptualisations (Adame , 2014; Corstens et al., 2015; Rashed, 2019).

Not everyone has welcomed these developments, however. In 2008, the *British Journal of Psychiatry* published a "wake-up call" to the profession of psychiatry. Here, Craddock et al. describe how a recent rise of psychosocial approaches in the NHS has been accompanied by "the creeping devaluation of medicine" (p. 6). They highlight potential consequences of "the scepticism of some psychiatrists towards biomedical explanations of illness" (p.7), which they characterise as "collusion, or at least (…) acquiescence" (Craddock et al., 2008).

Major voices in the field have suggested that "renaming schizophrenia" may cause "the person, rather than the illness" to be held accountable for what are considered symptoms of schizophrenia (Lieberman & First, 2007). Lieberman (2015) has also expressed concerns that the rise of alternative conceptualisations of schizophrenia "may lead some patients to doubt the veracity of the diagnoses that they have been given" (p.3). Others have warned that moving away from psychiatric diagnosis will "return us to the dark ages" (Tyrer, 2014).

Clearly, different professionals hold very different views on the extent to which the concept of schizophrenia is scientifically valid, clinically useful or even potentially damaging. The existence of such differing views affects professionals working in services, people receiving services and research into the phenomena associated with diagnosis of schizophrenia.

The debates on the concept of schizophrenia have sometimes been presented as a dispute between the professions of psychology and psychiatry, in which the former critiques the concept of schizophrenia and the latter defends it (Rashed, 2019). Others have suggested that psychology plays an active role in the continued use of the concept, for example by using

it as an independent variable in research or by using it to make decisions about treatment and support (Boyle, 2002b; Johnstone, 2011; Woods, 2011).

Aims

The aim of this paper is to clarify the nature of the debates around the concept of schizophrenia and to explicate the role that UK clinical psychology has played, and continues to play, in these debates. In doing so, it aims to answer the following questions:

- What are the different positions currently taken in the debates and how do these positions relate to each other?

- What has been the role of UK clinical psychology and psychological research within the schizophrenia debates of the last 30 years?

- What are the implications of the above for future research on the concept of schizophrenia, and the surrounding debates?

This paper aims to meet these aims in two separate, but connected parts. Firstly, a mapping review (Grant & Booth, 2009) reviews publications which, over the last 30 years, have explicitly or implicitly taken a position in the schizophrenia debates. Mapping reviews, as defined by Grant and Booth (2009), aim to "map out and categorize existing literature on a particular topic" (p. 97). They may do so according to population group, setting or theoretical perspective. Given the nature of the research questions, this paper adopts the latter approach and maps out publications according to the positions they take in relation to the concept of schizophrenia.

After having mapped out the main positions taken in the schizophrenia debates, the paper examines the role UK clinical psychology has played in these debates. First, it outlines the critiques from within the discipline and the way these were received. Then, a second

mapping review on schizophrenia research maps the literature published in four major UK clinical psychology journals, over the last 30 years. Using the framework identified in the first part of the review, it maps out these publications according to their positions taken, either explicitly or implicitly, in relation to the schizophrenia debates. In doing so, it explores the ways in which the discipline has contributed to the use of the concept, as well as the ways in which it has resisted this use.

Positioning Statement

Within the discipline of psychology (Willig, 2013) it is widely accepted that all research – including literature reviews – requires researchers to take a position in relation to the topic under review. This is perhaps especially true for the topic under review, here. By writing about schizophrenia as a concept – rather than an illness – the researcher has already positioned themselves critically in relation to the idea of schizophrenia as an illness (Burr, 2003). This review thus does not stand outside the schizophrenia debates, but is necessarily a part of it.

Method

The first part of the review explicates the different positions taken in the schizophrenia debates. It does so by organising relevant literature according to the theoretical position it takes in relation to the concept of schizophrenia.

An electronic search of PsychINFO, Web of Science and PubMed was carried out. The following search terms were used: ('schizophren*') AND ('critic*' OR 'critiq*' OR 'debate*' OR 'contest*' OR 'concept*') AND ('valid*' OR 'useful*' OR 'harm*') OR ('caus*' 'neurolog*' OR ('neuro*' OR 'gene*' OR 'herit*' OR 'ill*' OR 'disease'* OR 'disorder*').

To be included, papers needed to either take an explicit position in the schizophrenia debates, for example by arguing against the concept's validity, or an implicit position, for example by assuming its existence without explicating this assumption. Though recent publications were prioritised, less recent publications were also included to illustrate the long-standing nature of the debates. As is common for a mapping review (Grant & Booth, 2009) – and necessary given the large amount of literature on the topic – the review did not aim to be comprehensive. Because mapping reviews do not seek to assess publications for quality, but rather identify trends and categorise publications based on these trends, no formal quality assessment tools were used (Grant & Booth, 2009; Sangachin & Cavuoto, 2016). For more detailed information on the search terms used, databases searched and inclusion criteria, see Appendix A.

Review

Clarifying The Schizophrenia Debates

This section maps out the different positions taken in the schizophrenia debates in the last three decades. As is common in mapping reviews, the publications yielded by the search have been organised into groups. What follows is an outline of the assumptions and claims made about 'schizophrenia' by authors within each group of publications. Each group's engagement with the other groups, and their relation to the wider debate, are also explicated.

It is worth emphasising that the different groups identified here do not map neatly onto discrete parts of the literature – literature on the topic is diverse and by dividing it into groups, some simplifications and omissions have necessarily been made (Grant & Booth, 2009). The positions outlined here are therefore better seen as guidelines in understanding trends in the literature, than as discrete categories with clear borders. For more detailed information on how research and articles were grouped together, see Appendix A.

The Coordinates Of The Debate

Those Who Assume The Validity Of The Concept Schizophrenia. The first group of publications – decidedly the largest – assumes the existence of an illness called schizophrenia. It conceptualises this illness as standing in a causal relationship to the behaviours and experiences defined as its symptoms in DSM-5 (American Psychiatric Association, 2013) or ICD-10 (World Health Organization, 2015). In other words, this body of research invokes an illness called schizophrenia as a potential explanation for why people sometimes behave in the ways described in these manuals. The main aim of this research is to elucidate the nature and causes of schizophrenia, so that successful treatment and prevention of the presumed illness may follow. It pursues this aim mostly in genetic (e.g. Henriksen, et al., 2017; Ota et al., 2019; Guangzao et al., 2020), neurodevelopmental (e.g. Owen, et al. 2011; Weinberger, 2017; Al-Shammari et al., 2018), neurological (e.g. Cheng et al., 2015; O'Donovan et al., 2017; Kong et al., 2019) and cognitive terms (e.g. Fioravanti et al., 2012; Kahn et al., 2013; Cadena et al., 2018). The group is theoretically diverse and includes those who see schizophrenia as an umbrella term for several distinct illnesses, to be differentiated in the future (e.g. Jablensky, 2006; Keshavan et al., 2009; Dywer et al., 2018) and those who see schizophrenia as existing on a continuum (e.g. Owen & McDonovan, 2017)

Some research within this group makes explicit suggestions regarding the nature of schizophrenia – suggestions that range from 'developmental disorder' (Walsh et al., 2008) to 'neurodevelopmental disorder' (Al-Shammari et al., 2018) to 'cognitive illness' (Kahn & Keefe, 2013) to 'neurological disease' (Jian et al., 2017) to 'complex genetic disorder' (Ohi et al., 2011). Some papers, especially those which characterise schizophrenia as genetic in nature, state outright that schizophrenia is a medical condition, or make direct analogies with medical conditions. For example, Gottesman and Erlenmeyer-Kimling (2001) suggest that:

"Schizophrenia is a genetic disease in the same sense as diabetes mellitus (Type-I or insulin dependent) and coronary artery disease (leading to heart failure) are genetic diseases." (p. 94).

Some publications in this group consider the causes and aetiology of schizophrenia to be unknown – often suggesting that these matters will become clear in time. Trepanier et al. (2016), for example, suggest that "the underlying cause" of schizophrenia "remains to be elucidated" (p. 1009). Maruta and Matsumoto describe "the aetiology of schizophrenia" as "yet to be discovered" (2019, p. 264).

What unites this diverse group of publications, is that its research is conducted as if data supporting the validity of 'schizophrenia' have already been presented and accepted. As such, this literature does not respond to or mention critiques of the concept of schizophrenia. Strictly speaking, this group thus does not directly participate in the schizophrenia debates, since it assumes the existence of schizophrenia to be either already established or self-evidently true.

Those Who Advocate a Name Change. The second group of publications, which has grown substantially over the last two decades, argues in favour of a name change for 'schizophrenia' (see Lasalvia et al., 2015, for an overview). As in the first group, publications in this second group assume that the term schizophrenia refers to an existing illness. However, they also argue that this illness should be renamed because of the stigma[2] associated with the term (Levin, 2006; Kingdon et al., 2008; Takahashi et al., 2009; George & Klijn, 2013; Lasalvia, 2018). Some papers within this group argue that the current term is not sufficiently medical. Levin (2009), for example, suggests that a new name should reflect "the neurobiological nature of schizophrenia" to "assist in breaking the bad news of this

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[2] Use of the term 'stigma' in this context is contested. It is used here because it is the terminology of the literature being discussed. However, it has been suggested that words like 'discrimination', 'hatred' or 'bigotry' are more suitable (Chamberlin, 2001; "The word 'stigma' should not be used in mental health campaigns" – Smith, *The Guardian*, 2014)

devastating diagnosis" (p. 397). The name proposed by these authors is "Neuro-Emotional Integration Disorder" (NEID). This stands in contrast to others within this group, who prefer "psychosocially descriptive terms", on the basis that these "have [been] found to be more acceptable to patients and perceived as less stigmatizing by others" (Kingdon et al., 2013, p.297).

What unites this group of publications is that their authors take the term schizophrenia – rather than the concept itself – to be the main issue with the diagnosis (Lasalvia, 2018). In doing so, publications in this group incorporate recent research on the potential harmful consequences of receiving a diagnosis of schizophrenia (e.g. Angermeyer et al., 2011; Thomas et al, 2013; Vass et al., 2017; Larkings & Brown, 2018; Yanos et al., 2020) into the view that the behaviours and experiences associated with the diagnosis of schizophrenia are best explained as symptoms of an illness.

This second group actively participates in the schizophrenia debates and is challenged in two ways. Firstly, they are challenged by those who argue that conceptual issues with schizophrenia are so fundamental that they demand we abandon the concept, not just the term (Brabban et al., 2013). Secondly, they are challenged by those who consider the issue of a name change a matter of "political correctness" (Penn & Nowlin-Drummond, 2001, p.197) or "semantics" (Lieberman & First, 2007, p.108; Tandon et al., 2009, p.13). The latter group has cautioned that renaming 'schizophrenia' may cause people to be held responsible for their problems, and have commended the term's ability to "convey […] specific information about the disorder in question" (Penn & Nowlin-Drummond, 2001, p.202). These authors have also argued that a name change would hinder communication about the phenomena associated with the diagnosis of schizophrenia (Lieberman & First, 2007; Gaebel & Kerst, 2019).

Those Who Critique The Concept Of Schizophrenia. The third group of publications critiques schizophrenia as a concept. Most research in this group challenges the concept by questioning its validity as an object of scientific knowledge. Some authors do this by critiquing specific strands of research used to support 'schizophrenia', such as neurochemical research (Moncrieff, 2009), genetic research (Crow, 2008; Sanders et al., 2008; Fleming & Martin, 2011; Leo, 2016; Fosse et al., 2016; Joseph, 2017) and neurobiological research (Mathalon & Ford, 2012). Others have subjected a range of arguments and research used to support the concept of schizophrenia to critical analysis (Boyle, 1990; 2002a; Bentall, 1992; Read et al., 2013; Pérez-Álvarez et al., 2016). The research in this group engages directly with research in the first group, examining how the existence of 'schizophrenia' came to be assumed, and critiquing the research commonly drawn upon to infer it (Boyle, 1990;2002a;2004; Joseph, 2005; Reavey et al., 2013; Moncrieff & Middleton, 2015; Cromby, 2016; Tew, 2017).

This group also includes research which concentrates on outlining the harmful consequences of being given a diagnosis of schizophrenia (Corrigan & Watson, 2004; Romme & Morris, 2007; Hammersley, 2008; Pitt et al., 2009; Angermeyer et al., 2011; Thomas et al., 2013; Hickey, 2015; Cooke & Kinderman, 2017)[3]. Although publications that critique the concept's validity and publications that outline its harmful consequences overlap, points of contention also exist. Thomas et al. (2013), for example, suggest that "a gulf exists between the experiences of people diagnosed with schizophrenia and the concerns of academics and others currently involved in debates about the merits of different systems of diagnosis" (p. 135) – experiences which their study suggested were "devastating (…) negative (…) harmful and stigmatising." (p.137)

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[3] Note: not all research which concentrates on harmful consequences of being diagnosed with schizophrenia, calls the validity of the concept into question. See, for examples, Kingdon et al., 2008. This research would fall within the second group, which advocates a name change.

Most research in this group explicitly calls for the abandonment of the concept of schizophrenia, favouring different conceptual paradigms for understanding the associated behaviour and experiences (Boyle, 1990;2002a; Bentall; 1990; Poland, 2006; Read et al, 2009; van Os, 2010; Wong, 2014; Cooke & Kinderman, 2017; Guloksuz & van Os, 2018).

What unites this group of publications is that its authors either directly critique the concept of schizophrenia and the research drawn upon to infer it, or implicitly reject the concept by not assuming its existence.

Those Who Explicitly Defend 'Schizophrenia'. The fourth group of publications explicitly defends schizophrenia as a concept and is the smallest by some margin. These publications overlap with research in the first group, but distinguish themselves by responding directly to critiques of the schizophrenia concept. For example, Lieberman and First (2007) state that "the validity of the diagnosis remains to be established" but argue the concept needs to be retained because "its diagnostic reliability and usefulness are indisputable" (p.108). This argument – that the concept is clinically useful, even if it may be lacking in validity – has been made in several publications over the last decades (Tandon et al., 2009; Lawrie et al., 2010; Gaebel et al., 2013).

Other defences of the schizophrenia concept also refute the idea that it lacks validity (Pearlson & Folley, 2008; Torrey, 2011). In 2011, Torrey published a particularly strongly worded defence of the concept in which he asserts it has become "overwhelmingly clear in the last two decades" that "schizophrenia is a disease of the brain" (p. 466). In the article, Torrey engages with alternative terms suggested over the last 2 years, including the terms 'lived experience' and 'survivor'. He argues that "Using terms for schizophrenia that imply that it is not a disease is also inherently inconsistent at a personal level(…)" because "Most individuals with schizophrenia, including those promoting terms such as 'people with lived experience', are receiving medical disability benefits". He goes on to argue that "if they do

not believe that they really have a disease, they should not apply for, or accept, such benefits"
and concludes his article by suggesting terms as 'survivor' or 'people with lived experience'
are best "consigned to the junk heap of lexicographic history" (p. 467).

Others have defended schizophrenia as a concept by asserting that it *is* an illness, but
not in the ways it is usually suggested to be. Kahn, for example, in an article entitled "Why
the concept of schizophrenia is still alive and kicking" (2018), argues that schizophrenia is
best conceptualised as an illness marked by 'cognitive decline', rather than as an illness
marked by 'psychosis' – conceptualised this way, he argues, the concept regains the validity
and utility that others have questioned.

What unites this group of publications is that they contain explicit defences of
schizophrenia as a concept and as such, make at least some reference to critiques of it.
Authors of these publications thus actively take part in the schizophrenia debates.

'Schizophrenia' and psychology

Today, the schizophrenia debates in the UK are sometimes framed as a dispute between
psychology and psychiatry (e.g. Rashed, 2019). However, a closer look at literature published
in leading clinical psychology journals over the last decades shows a more complex picture.
Over this time, leading voices in clinical psychology as well as the major professional body
of the discipline, have taken up positions in all groups except the 'explicit defence' group.

Until about 30 years ago, Clinical Psychology in the UK had little involvement in
debates about schizophrenia as a diagnosis – debates which mostly focused on
epistemological and ethical issues with the concept and which originated mainly from within
psychiatry (e.g. Szasz, 1960). Broadly, UK clinical psychology assumed the existence of
schizophrenia at this time (Woods, 2011). Although there were some psychological theories
aiming to explain schizophrenia (e.g. 'Expressed Emotion', see Hooley, 1985), the

behaviours and experiences associated with the diagnosis were mostly considered to be medical in nature and cause. Therefore, they were either thought unsuitable to be understood or responded to in psychological terms (e.g. Halter et al., 1992; Lefley & Cutler, 1988) or suitable only to be understood in terms of 'cognitive deficits' (e.g. Green, 1986; Bullen & Hemsley, 1987; Frith & Dome, 1983).

Challenges to the concept

Over the last three decades, this has changed. One antecedent for this change is that biological and genetic research failed to find 'biomarkers' for schizophrenia[4] (van Os, 2010; Insel, 2013; Deacon, 2013; Tew, 2017). Additionally, research linking its supposed symptoms to non-biological factors – such as social inequality, racism, trauma and stressful family environments – grew substantially, starting in the 90's (e.g. Williams et al.,1992; Mullen et al., 1993; Sugarman & Craufurd, 1994; Aro, 1995; Gomme, 1996).[5] The rise of research linking 'schizophrenia' to childhood abuse and trauma in this period is particularly striking (see Larkin & Morrison, 2006, for an overview). At the time, John Read suggested that this rise constituted "arguably [the] largest challenge since its inception" of "the entire construct of schizophrenia" (Read, 1997, p.4).

The same period saw a rise in research indicating that experiences such as voice hearing, commonly thought to be typical symptoms of schizophrenia, were in fact very common in the general population (Romme & Escher, 1989; Barret & Caylor, 1998; Posey &

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[4] Or,, in fact, for any other category of mental disorder. As David Kupfer, chair of the DSM-5 taskforce, put it: "We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting" (APA, 2013)

[5] The evidence linking behaviour and experiences associated with the diagnosis of schizophrenia to social factors and life experiences has only grown further since its initial rise in the 90's. Examples of factors include economic inequality (Werner et al., 2007; Fusar-Poli et al., 2017), homelessness (Folsom & Jeste, 2002), childhood trauma (van Nierop et al, 2014; Bailey et al., 2018) and urbanicity (van Os et al, 2014).

Losch, 1983). This research, which has continued to grow (Lawrence et al., 2010; Beavan et al.,, 2011; Powers et al., 2016), has inspired the formation of several new assessment methods and interventions (e.g. Romme & Esscher, 2012; Culpitt, 2018) as well as user-led movements which conceptualise hearing voices as "not the consequence of a diseased brain, but more akin to a variation in human behaviour, like being left-handed" (Intervoice, 2017).

Psychology and the schizophrenia debates

It is during this period that UK clinical psychology became actively involved in the schizophrenia debates. Leading voices within the discipline started publishing detailed and comprehensive critiques of the validity of the schizophrenia concept, as well as suggestions for how research on phenomena associated with the diagnosis might proceed without it (Bentall, 1988; Boyle, 1990;2002a).

Over the last three decades, these and other critiques have been increasingly incorporated into mainstream psychology (Parker, 2015). This is perhaps most clearly illustrated by a shift in position of the profession's representative body, the British Psychological Society (BPS). In 2011, for example, the BPS published a response to DSM-5 proposals which expressed concerns about the medicalisation of difference. This response concentrated on problems with diagnosis generally, but also explicitly mentioned "concerns about the scientific validity and utility […] particularly relevant to the diagnosis of schizophrenia" (p.6).[6] This was followed, in 2013, by a position statement by the Division of Clinical Psychology of the BPS which addressed "significant conceptual and empirical limitations" of diagnosis in general and called for "a paradigm shift in relation to the experiences that these diagnoses refer to" (p.1). In 2014, the Division of Clinical Psychology

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[6] Others within the discipline expressed an opposing view (not specific to the diagnosis of schizophrenia) and questioned the motivations behind the statement, see a blog post by Salkovskis (2014)

officially addressed the issue of schizophrenia at length for the first time. It did so by publishing a report entitled *Understanding Psychosis and Schizophrenia* (Cooke et al., 2014)*,* which set out various alternative ways of viewing the experiences commonly seen as symptoms of schizophrenia. The report asserted, for example, that these experiences can be "understood and treated in the same way as other psychological problems such as anxiety or shyness" (p.6).

Finally, in 2018, the BPS published a framework explicitly created to form "an alternative to the more traditional models based on psychiatric diagnosis". The Power Threat Meaning Framework (Johnstone & Boyle, 2018) aims to provide a "new perspective on why people sometimes experience a whole range of forms of distress, confusion, fear, despair, and troubled or troubling behaviour" without invoking 'mental illness' or 'mental disorder' as explanations for such behaviour (p. 343).

Over the last decade, psychology's main professional body has thus explicitly challenged schizophrenia as a scientific concept, encouraged its members not to use the term and suggested alternative ways of understanding associated experiences. Mainstream clinical psychology thus appears to have been strongly influenced by the third group of research previously outlined – the group which challenges schizophrenia as a concept and calls for a reconceptualization of the experiences and behaviour commonly associated with it. This is, of course, not to say that psychological research within the UK has abandoned the concept of schizophrenia altogether. Mainstream clinical psychology is diverse in its domains of study, methodological paradigms, underlying assumptions and functions, and its contributions to schizophrenia research are no exception (Parker, 2006).

In fact, even the schizophrenia critiques which have arisen within psychology over the last three decades, cover a range of theoretical perspectives. Some aspects of these critiques – themselves firmly situated in the third group as outlined above – may be seen as falling under

the heading of 'critical psychology'. Critical psychology, by definition, positions itself as being outside of mainstream psychology. In fact, it takes mainstream psychology and its functions and assumptions as an object of research and critique (Parker, 2007). A long-standing area of this research has concentrated on the discipline's positivist roots (Holzkamp, 1983; Parker, 2015). Another, related strand of critique suggests that mainstream psychology formulates its explanations of behaviour and experiences at the level of the individual. Critics argue that this obscures the importance of social factors, such as economic inequality (Boyle, 2011). The ways in which mainstream psychology is said to do this includes, but is not limited to, the use of diagnostic categories and intra-psychic attributes as explanations for human behaviour (Boyle, 2007; Cooke, 2008; Johnstone, 2011; Parker, 2015).

The role of psychological theory and research

 The following section summarises and evaluates the ways in research in mainstream psychology has – or has not – responded to the schizophrenia debates as outlined above. It follows the same methodology as previously outlined – that of a mapping review (Grant & Booth, 2009). It is based on an electronic search of four major UK Clinical Psychology journals: *British Journal of Clinical Psychology; British Journal of Psychology; British Journal of Social and Clinical Psychology; Psychology and Psychotherapy: Theory, Research and Practice*. For more detailed information on the methodology employed, see Appendix B.

 Focus on intra-psychic Factors

Some areas of psychological research do not seem to have been influenced by the schizophrenia debates. In such research, the existence of schizophrenia is assumed and its characteristics are conceptualised, primarily, in psychological terms. Most of these

publications concentrate on 'cognitive deficits' or different kinds of 'bias', which are conceptualised as symptoms of schizophrenia (Buck et al., 2016). Common examples include the tendency of people with schizophrenia diagnoses to "jump to conclusions (JTC)" (Moritz & Woodward, 2011), deficits in "Theory of Mind (ToM)" (Langdon et al., 2017) and "empathic and socio-emotional processing deficits" (Varcin et al., 2019). Other examples are research on "Impaired autobiographical memory recall" (Barry et al., 2019) and a lack of "resilience to suicidal thoughts" (Harris et al., 2019). Attempting to explain why people diagnosed with schizophrenia behave in particular ways and what psychology might do to help, these publications refer primarily to factors located within people's minds – such as impaired cognitive functioning, impaired memory and (lack of) mental resilience.

Another area in which the schizophrenia debates seem to be absent from psychological theory, are undergraduate textbooks. Recently, a review of 30 often used Clinical Psychology textbooks in the UK examined their representation of scientific knowledge. It found that "key controversies in metascience" – such as those involved in the schizophrenia debates – were "simply ignored" in almost all the reviewed books (O'Donohue & Willis, 2018). Additionally, most of these textbooks are organised according to diagnostic categories, which critics have suggested indicates the existence of a "fundamental, if unintentional, psychiatric bias in psychology undergraduate mental health teaching" (Cromby et al., 2008, p.88)

Incorporation into existing models

Social causation versus social selection. Although there are areas of clinical psychology research which have not responded to the schizophrenia debates, there have been responses in other areas.

One such response, it has been suggested, has been to incorporate evidence of links

between schizophrenia and social factors, into traditional ideas about schizophrenia as an illness (Boyle, 2002b; Boyle, 2011). Broadly speaking, there have been two ways of doing this: by conceptualising social factors as consequences, or as causes of the experiences and behaviour associated with the diagnosis (Bentall & Varese, 2012).

These two competing ways of incorporating social factors into theories of schizophrenia are referred to as the 'social causation hypothesis' and the 'social drift hypothesis' (Mossakowski, 2014).[7] The former suggests that social factors, such as poverty and racism, can lead to the experiences and behaviour associated with the diagnosis of schizophrenia. The latter, conversely, suggests that the experiences and behaviour associated with the diagnosis of schizophrenia cause people to 'drift' into lower social classes or poverty. During the initial rise of research on social factors and 'schizophrenia', many publications explicitly supported the latter hypothesis (e.g. Eaton, 1980; Weyerer, 1994). More recently, as further research indicated robust evidence for the causation hypothesis (e.g. Bentall et al., 2012; Cooper, 2005; Werner et al., 2007; Harrison, 2011), this has shifted (see Massakowski, 2014, for an overview). Though the social drift hypothesis is still frequently invoked, including within psychological research, this is often implicit. Perry et al. (2011), for example, examine the effect of social exclusion on "individuals with schizophrenia". In doing so, however, they examine only the social exclusion that follows a diagnosis of schizophrenia – concluding that the "negative impact of social exclusion lasts longer in individuals with schizophrenia" (p. 339).

The vulnerability-stress hypotheses. As outlined above, there is now a considerable research body supporting the social causation hypothesis. That is to say, a considerable body of research supports the idea that people's circumstances and biographical context play a causal role in the development of the experiences that lead to a diagnosis of schizophrenia.

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[7] Also 'social selection hypothesis', see Blane et al., 1993

As Bentall & Varese (2012) have pointed out, however, supporting the social causation hypothesis does not equate to giving up on the idea of schizophrenia. In fact, it has been suggested that evidence for the social causation hypothesis is often incorporated into existing models of schizophrenia in such a way as to lend more credibility to the idea of schizophrenia as an illness (Boyle, 2011; Johnstone, 2011).

The most well-known example of this is the 'vulnerability-stress hypothesis'.[8] This hypothesis was specifically introduced as an explanatory model for schizophrenia in the 1960's (Meehl, 1962).[9] In essence, the hypothesis asserts that there is a subgroup of people who have a vulnerability to developing 'schizophrenia'. Of this subgroup, a smaller subgroup experiences adverse life events – usually referred to as 'stress' or 'trauma' (Walker et al, 2008; Preussner et al, 2017). According to the hypothesis, stress or trauma act upon people's pre-existing vulnerability to cause 'schizophrenia', which in turn causes the behaviour and experiences associated with it.

In theory, this vulnerability could be conceptualised in many ways. In practice, it is usually conceptualised in biological or genetic terms (Ingram & Luxton, 2005; Mason & Beavan-Pearson, 2011; Magliano et al., 2019).

The most common conceptualisation of vulnerability for 'schizophrenia' is a genetically determined "abnormality in dopamine (DA) neurotransmission" (Walker & Diforio, 1997) – a hypothesis still in use, today (Preussner et al., 2017).

A clear illustration of the way in which this hypothesis operates, can be found in Jones and Fernyhough (2007), who assert that "stress, through its effects on cortisol production, acts upon a pre-existing vulnerability to trigger and/or worsen the symptoms of schizophrenia (…)" (p. 1171). Because the impact of 'stress' or 'trauma' is conceptualised

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[8] Also the 'diathesis-stress' model.
[9] It has since been widely applied to a number of other diagnostic categories, including 'borderline personality disorder' (Cattane et al., 2017), 'depression' (Soler at al., 2019) and 'social anxiety' (Oolofsdotter et al., 2018).

through its impact on the brain – in this case, its impact on cortisol production – the authors

are explicit about the fact that "this model treats stressors as a homogeneous category" (p.

1172). Critics have suggested (Boyle, 2002b; Johnstone, 2011) that this allows 'stress' or

'trauma' to be converted into a biological variable (e.g. cortisol production), with little (Aas

et al, 2019; Preussner et al, 2017; Lange et al, 2016) or no (Jones & Fernyhough, 2007;

Hillman et al., 2017) elaboration on the experiences to which the term refers. Although this

research takes non-individual factors such as sexual abuse, racism, homelessness and

economic inequality into account, critics have warned that not naming these, or attributing a

minor role to them, continues to downplay their importance (Read et al., 2009; Boyle, 2011;

Johnstone, 2011).

Most psychological research does not conceptualise the vulnerability-stress model of

schizophrenia in such a medical way. Critics have suggested, however, that psychological

research is conceptually very similar when it presents a vulnerability-stress hypothesis for

schizophrenia which either exclusively uses intra-psychic variables, or prioritises intra-

psychic variables. For such research, these variables are formulated in psychological terms,

but still internal to the individual – an approach which has been referred to as the

"metaphorical medical model" by critics (McClelland, 2013, p. 124).

Examples include Bailey and Henry (2010) who suggest that "deficits in Theory of

Mind (ToM)" constitute a vulnerability for 'schizophrenia'. Salvatore et al. (2011), make a

similar suggestion and add that "threat anticipation", "cognitive biases" and "poor

understanding of other's minds" act as 'triggers' which interact with this vulnerability. For

these examples, both 'vulnerability' and 'stress' are conceptualised as intra-psychic

attributes.

Others have suggested that traumatic experiences, for those predisposed to

'schizophrenia', cause a particular dysfunction or disturbance (usually cognitive), which in

turn causes the experiences associated with the diagnosis of schizophrenia (Ponizovski, 2013; Driscoll et al., 2016; Peach et al., 2019). Peach et al., (2019) for example, suggest that "in a person with a biopsychosocial predisposition for psychosis, early trauma leads to a basic cognitive disturbance (…) and then to anomalous conscious experiences that include subclinical psychotic symptoms" (p. 155)

Critics, again, have suggested that such research contributes to the perpetuation of traditional models of schizophrenia (Boyle, 2002b; Boyle, 2011; Johnstone, 2011). They argue that, although this research integrates life experiences and context into its explanatory models, it always does so by positioning the environment as secondary to intra-psychic attributes. This, they argue, allows for the real cause of 'schizophrenia' to be conceptualised within the person diagnosed as such (Read et al, 2009). For example, Peach et al. (2018) allow a role for 'early trauma' in the causation of 'schizophrenia', but only to the extent that it, as Boyle (2011) put it, "creates a person who now thinks dysfunctionally, irrationally or idiosyncratically about a seemingly benign or only averagely difficult present" (p. 33). Indeed, a recent review on the topic gives the following example to illustrate the causal mechanisms operating in the 'vulnerability-stress hypothesis': "Thus a relatively benign rebuff by a stranger might be perceived as a threat and elicit a biological stress response in some individuals, but not others." (Preussner et al., 2017 p. 193).

Increased use of 'psychosis'

Another way in which psychological theory has responded to the schizophrenia debates, some have suggested, is by an increased use of the term 'psychosis' (Boyle, 2006; Johnstone, 2011). The term, it is argued, is increasingly used to avoid the problems of validity and reliability associated with the concept of schizophrenia. Another reason provided for its increased use, is that it is thought to have fewer stigmatizing connotations (Johnstone, 2011).

This change in terminology seems confirmed by literature published by the *British Journal of Clinical Psychology* between 2000 and 2020. A recent search yielded 55 articles with 'psychosis' in their title, and 44 articles with 'schizophrenia' in their title. This is a remarkable shift from the preceding 20 years – the same search for this period (1980-2000) yields only 6 titles with 'psychosis', and 51 with 'schizophrenia'.[10]

For some publications using the term 'psychosis', rather than 'schizophrenia', this shift is accompanied by an increased focus on the content and meaning of the experiences associated with it (Murphy et al., 2015). Other publications which use the term 'psychosis', do so much in the same way 'schizophrenia' was used in the two decades before. A recent example includes Nittel et al. (2018), who seek causes for 'psychosis' in the intra-psychic characteristics of their sample, including "emotional instability" and "maladaptive emotional regulation", without mentioning the possible contribution of interpersonal or external factors. Critics have suggested that this 'discourse of deficit', characterises research that uses the term psychosis, as well as research that uses the term schizophrenia (Johnstone, 2011). Examples include "deficits in meta-cognition" (Luther et al., 2016) and "impairments" in "future-directed thinking" (Goodby & McLeod, 2015).

In parallel with the increase of academic literature using the term 'psychosis', several UK charities have made a similar shift. For example, the UK branch of the International Society for the Psychological Treatments of Schizophrenia and other Psychoses has voted to remove the term 'schizophrenia' from its title in 2011. Similarly, UK mental health charity National Schizophrenia Fellowship renamed itself as Rethink and, in 2012, recommended use of "the more general term" psychosis instead (p. 7). At a policy level, most Early Intervention services now use the term 'psychosis', instead of 'schizophrenia' (NHS England, 2016).

It has been suggested that the term 'psychosis' avoids some of the negative

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[10] Search conducted on 25 January 2020

connotations of 'schizophrenia' (Kingdon et al., 2013). However, others have suggested that the term 'psychosis' is at least as problematic as 'schizophrenia' in terms of its validity. In fact, critics have suggested that the term 'psychosis' (Johnstone, 2011) "serves to disguise and defuse fundamental critiques about the nature, purpose and consequences of psychiatric diagnosis" (Johnstone, 2011, p. 105), arguing instead that the experiences currently referred to as 'psychosis' should be understood primarily as "reactions to trauma and abuse"(p.109).

Understandable in terms of meaning

The last decades have also seen a marked increase in publications which present schizophrenia, or the experiences associated with the diagnosis, as understandable in terms of their meaning (Kamens, 2019). Usually, these publications suggest that the experiences and behaviour associated with the diagnosis of schizophrenia are made intelligible when seen in the context of the lives of those diagnosed as such. This research includes, for example, publications on the phenomenology of voice-hearing (Holt & Tickle, 2014; Mawson et al., 2011) and research that links the content of hallucinations to "childhood trauma" (Pearce et al., 2017) and "social deprivation" (Carden et al., 2019). It has been suggested that research which seeks to present phenomena associated with the diagnosis of schizophrenia as "understandable from a psychological perspective" presents a fundamental shift away from the concept of schizophrenia (Kamens, 2019) – the 'symptoms' of which have traditionally been conceptualised as essentially un-understandable (Jaspers, 1963).

One way in which publications have tried to present the behaviour and experiences associated with the diagnosis of schizophrenia as intelligible, has been by referring to them as "normal responses to abnormal circumstances" (Johnstone, 2018, p. 33). This idea is supported by some of those questioning the idea of schizophrenia (e.g. Longden et al., 2012; Dillon, 2011) and connects closely to research which concentrates on links between trauma

and 'psychosis' (e.g. Read, 2012). The idea, of course, does raise the question of what counts

as an "*abnormal circumstance*". Recent publications on the topic seem to suggest 'trauma' –

commonly defined as "actual or threatened death, serious injury, or sexual violence" (Pai et

al., 2017).

There seems to be a broad consensus among those who call for the abandonment of

the concept, that the experiences associated with the diagnosis should be conceptualised as

understandable in the contexts of people's lives (Boyle, 2002a, Johnstone, 2009; Bentall &

Varese, 2012). However, those who call for the abandonment of 'schizophrenia' have

cautioned that the increased emphasis on trauma may inadvertently contribute to the

preservation of the concept. It does so, they suggest, by allowing for a differentiation between

experiences which *appear* to be schizophrenia but in fact are caused by trauma, and 'real'

schizophrenia – which remains thought of as biological in nature (Boyle, 2014).

Discussion

Summary of review

 This literature review had two major aims: to clarify the nature of the schizophrenia debates

and examine the role that UK clinical psychology has played in them. Given the vast amount

of relevant literature, the review has undoubtedly involved various simplifications and

exclusions. Without claiming to be comprehensive, however, it has elucidated several trends.

The first thing to highlight, is the diversity and complexity of the positions taken in

the schizophrenia debates. Many publications on the topic take a position only in relation to

the *term* 'schizophrenia'. These positions range from those who criticise its medical

connotations, to those who do not consider the term to be medical enough. Other publications

take a position in relation to the concept itself – either critiquing its validity, pointing to its

harmful consequences, or both. Most publications which do use the term schizophrenia, do not provide a rationale for doing so. Their assumptions are only rarely made explicit.

The review has also summarised and evaluated the role that UK clinical psychology has played in the schizophrenia debates. Over recent decades, it seems to have contributed both to the resistance, and persistence of the concept. Critiques of the concept have increased and shifted in focus, and there has been an increase in publications on the topic led by service users. It seems clear that schizophrenia critiques have increasingly influenced mainstream psychology – a change illustrated by the shift in the BPS's position on the issue. Other areas of the discipline, however, continue to use the concept in their theories and research. This includes research that conceptualises schizophrenia in entirely intra-psychic terms, but also research that attributes some role to social factors or life experiences – though causes located within the individual are often privileged. Other psychological research that assumes schizophrenia involves the use of vulnerability-stress hypotheses and the presentation of links with social circumstances as consequences.

Psychological research has also seen a notable rise in the use of the term 'psychosis', which may be seen as a purposeful move away from the concept of schizophrenia. Similarly, there has been a rise in publications which conceptualise experiences associated with schizophrenia primarily in terms of their meaning and connection to life experiences – often concentrating on the role of trauma. Such publications have the explicit support of some critics of the concept, although others have cautioned that the increased emphasis on trauma may inadvertently contribute to the concept's preservation, too.

Limitations

Considering the nature of this review, no formal quality assessment tools were used to assess the individual publications. Although this is standard for mapping reviews (Grant & Booth,

2009), it should be noted that the quality of individual publications may vary considerably in terms of their design and execution.

Additionally, given the amount of relevant literature, this review is not comprehensive. Especially for the first part of the review – which sought to explicate the nature of the schizophrenia debates – a vast amount of literature was returned by the literature search. This meant that a series of limits on the inclusion of publications was imposed for pragmatic, rather than theoretical reasons (Appendix A). Though the researcher actively sought out a range of theoretical perspectives, the review has inevitably also excluded relevant literature.

Another limitation relates to the position of the author (see introduction). By not assuming the existence of 'schizophrenia', but rather approaching the use of the concept as a phenomenon to be explored, this paper – like the publications under review – is part of the schizophrenia debates. This has undoubtedly informed the way in which the publications under review have been summarised and interpreted.

Conclusion and implications

Although critiques of the concept schizophrenia have risen over the last decades, many other publications continue to use it. Those who object to the concept do so for a variety of reasons, which they have laid out in considerable detail. Publications explicitly defending the concept, however, are rare. This asymmetry raises a number of questions.

One such question pertains to whether these critiques really reach those who use the concept, or whether they mostly preach to the converted. This review indicates that, in the case of UK clinical psychology, some criticism *has* reached the mainstream. However, even within the discipline there is disagreement on the issue. This raises questions about how this

disagreement is dealt with in clinical practice, and whether and how service users are made aware of the lack of consensus on the issue.

Accordingly, future research may examine how the concept is currently used, given its contested nature, and with what consequences for those so diagnosed. Such research could be useful in several ways. First, it may help facilitate a deeper understanding of the function the concept continues to play in clinical practice. It may also help to clarify whether – and in what way – the literature mapped out in this review had influenced clinical practice. Finally, by facilitating an increased understanding of *how* the term is currently used, the consequences of this use for service users and professionals may become more visible and, if implicated, amenable to change.

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TITLE PAGE OF PART B

Hanna de Waal

Section B

The Concept of Schizophrenia in Clinical Practice: A Foucauldian Discourse Analysis

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Abstract

The concept of schizophrenia has been the subject of criticism for decades. Recently, criticism has increasingly focused on the concept's validity, and the effect the diagnosis has on those who receive it. Despite the growing criticism, the concept continues to be widely used and retains taken-for-granted status within much of mental health research and practice. How criticism of the concept has influenced the way it is used, is unclear.

This study examines how the concept of schizophrenia is used in clinical practice, by analysing the way it is spoken about by mental health professionals. Eight interviews with mental health professionals across professions were conducted and analysed. A Foucauldian Discourse Analysis identified two main ways of talking about 'schizophrenia': as an object of scientific enquiry, and as a physical condition. The concept was spoken about with great flexibility, however, with participants referring to it in a variety of sometimes conflicting ways. When relaying how they talk to service users about the concept, participants spoke in considerably less flexible ways.

The study raises questions about how the contested nature of the concept is discussed among professionals, and communicated to service users. It concludes by outlining suggestions for clinical practice in light of these questions.

Keywords: Schizophrenia, Foucauldian Discourse Analysis, critical psychology, psychiatric diagnosis

Introduction

This section starts with an introduction to the topic of this study, which is the concept of schizophrenia and issues raised by its use in mental-health practice and research. This is followed by an introduction to Foucauldian Discourse Analysis (FDA), where FDA's conceptual underpinnings and relevance to the issues raised in the first part of the introduction are discussed. Because the underpinnings of FDA form the theoretical framework this study will be drawing from throughout, some time will be spent developing an account of these before moving on to the study's aims and research questions.

Introduction to the topic

Research and scholarship that critiques the concept of schizophrenia has been around for almost as long as the concept itself (Tew, 2017). Early critiques were made mostly on epistemological, moral and political grounds (e.g. Laing, 1960; Szasz, 1961). More recent critiques have also focused on validity and reliability issues, critiquing in detail scientific claims made about the concept (Bentall et al., 1988; Boyle, 1990; 2002a; Moncrieff, 2009; Pérez-Álvarez et al., 2016).

Over the last three decades, such critiques have increasingly permeated mainstream debates in the mental health field (Tew, 2017). Criticism of the concept has been voiced even by those who previously supported it (e.g. Insel, 2013; van Os, 2016), and alternatives have been suggested (e.g. Escher & Romme, 2011; DuBrul, 2014; Cooke & Kinderman, 2017; Johnstone & Boyle, 2018). Several UK national charities and professional bodies – including the British Psychological Society (BPS) – explicitly distanced themselves from its use (e.g. Division of Clinical Psychology, 2011).

These developments have been partly informed by a growing research body suggesting the diagnosis often causes harm to those who receive it (e.g. Angermeyer et al.,

2011; Corrigan & Watson, 2004; Howe, Tickle & Browne, 2014; Romme & Morris, 2007; Thomas et al., 2013). Some positive consequences have also been suggested, such as access to housing and benefit payments (Campbell, 2007) and an alleviation of service-user responsibility (Penn & Nowlin-Drummond, 2001). However, most research describes harmful consequences, including a decreased sense of agency (e.g. Faulkner & Leyzell, 2000), a denial of the meaning behind people's experiences (e.g. Corstens et al., 2014), and social exclusion (e.g. Pitt et al., 2009). These developments have been accompanied by an increase in calls to abandon either the term (see Lasalvia et al., 2015), or the concept (Read et al, 2009; Brabban, Morrison & Read, 2013; Guloksuz & van Os, 2018).

Despite this, many professionals continue to use the concept (Green, 2018; Magliano, 2020). This raises questions about *how* the concept is used, given its contested nature, and with what consequences for those so diagnosed. While research has questioned the concept's validity and outlined its harmful consequences, it is unclear whether or how this has influenced the way the concept is used. This lack of clarity has been related to the concept's taken-for-granted status: because those who use the concept usually take the existence of 'schizophrenia'[11] to be self-evident, critics suggest, questions about the concept's use remain unanswered (Boyle, 2002a).

Understanding how the concept is used is important, considering the far-reaching implications for those diagnosed. Additionally, prominent voices have suggested the concept's use hinders the progress of research on the phenomena associated with it (Boyle, 2002a; Read et al., 2009; van Os, 2016). This use is also linked to the assumption that the concept's associated behaviours are caused by factors *within* those so diagnosed, mainly

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[11] For this research the existence of 'schizophrenia' is not assumed. Rather,, but 'schizophrenia' is seen approached as a concept the use of which requires explanation. As noted by Hook & Parker (2002), however, it is difficult to talk about a concept without implying it exists independently of its use. To avoid making such implications, 'schizophrenia' will be put in quotation marks, but only there where the sentence otherwise assumes its existence.

considered biological in nature (Angermeyer et al., 2003; Magliano, 2017). Many have suggested this obscures well-established links with societal factors – including economic inequality (Fusar-Poli et al., 2017), migration (Bourque et al., 2011), homelessness (Folsom & Jeste, 2002) and childhood trauma (Bailey et al., 2018).

Introduction to Foucauldian Discourse Analysis

Analyses seeking to explore the use of taken-for-granted concepts, it has been suggested (Parker, 2014), need to explicate the assumptions and consequences involved in the way these concepts are spoken about. Approaches enabling such analysis are commonly referred to as 'discourse analysis' (DA) (Burr, 2015). The term 'discourse', here, refers to communications – usually in the form of text or speech (Willig, 2014). DA covers various qualitative research methodologies, whose common denominator is that they accord language a constitutive (rather than descriptive) role in the way people understand and experience themselves, each other and the world they live in (Willig, 2014). Some types of DA focus primarily on the function language plays within, for example, conversations or texts (Wooffitt, 2013). Others move beyond the immediate context of conversations and texts, towards an analysis of the wider cultural context within which language is used. One such approach is Foucauldian Discourse Analysis (FDA), a form of DA that draws heavily on the work of Michel Foucault.

Within FDA, 'discourse' refers not just to language, but to comprehensive social systems grounded in particular (institutional) practices, as well as ways of talking and thinking connected to these (Foucault, 1972). Such discourses shape "what it is possible for one person to do to another, under what rights and obligations" (Burr, 2015, p.68), as well as "what can be intelligibly thought and said about the world and what cannot" (p.71). An example would be legal discourse, within which it is considered legitimate for one person to

confine another based on particular rights, which are accorded to them through a social system deriving its legitimacy from particular practices, institutions and ways of talking and thinking (O'Malley & Valverde, 2014).

FDA is particularly concerned with the discursive processes through which knowledge is formed and gains credibility, referred to as "mechanisms of power" (Foucault, 1990, p.102). Within mental health practice, this includes processes through which psychiatric knowledge gains its status of being scientific, and therefore objective and value free (Gillett, 2012).

Power mechanisms are central to Foucault's work and are conceptualised as operating not just through overtly restrictive practices, but also in subtle and *productive* ways, such that they create the kinds of people ('subjects') who, having internalised certain ideas about who they are, regulate themselves according to rules of dominant discourses (Hook, 2007). Accordingly, FDA is not only concerned with questioning overt manifestations of power, but also with making visible and challenging its more subtle expressions – including those characterised as caring, therapeutic and free from power relations (Iliopoulos, 2012).

Discourses, in FDA, are associated with different ways of acting which are deemed reasonable within them. These ways of acting are called 'opportunities for action' (Willig, 2013). Discourses are also associated with different ways of talking about people, and, accordingly, expectations on how people should behave and understand themselves. These are commonly referred to as 'subject positions' (Davies & Harré, 1990). Opportunities for action and subject positions are closely related, and depend on each other and their wider discursive contexts for intelligibility (Willig, 2013).

FDA recognises that people draw on multiple discourses simultaneously when they speak about a concept ('discursive object'). Discourse analytic research has suggested that this is especially true when speaking about contentious concepts (Parker, 2015; Harper, 2009;

Georgaca, 2014). This is because, when particular discursive constructions are challenged, other discourses must be drawn upon for a concept to maintain credibility. This manifests in increased variability in the way people talk, making the different discourses drawn upon increasingly visible and open to analysis, and making it easier for alternative discourses to emerge (Harper, 2009). This makes FDA particularly suited to analyse language used to talk about concepts that are taken for granted, but also subject to debate (Crowe, 2005; Georgaca, 2014).

Aim and research questions

The aim of this study is to explore how professionals who use the concept of schizophrenia talk about the concept, and with what consequences. The following questions are addressed:

- How is the discursive object of 'schizophrenia' constructed by various mental health professionals?

- What are the wider discursive contexts within which these constructions are being deployed and which make talk about schizophrenia intelligible?

- What subject positions may be created by these constructions and with what implications?

- How do these discursive constructions open or close down opportunities for action, and which practices become legitimate forms of action from within these discursive constructions?

All research questions are connected and, like phenomena they address, depend on each other for their intelligibility. Although they are separated in sections of the analysis where this promotes readability, they are part of a shared discursive process (Willig, 2013).

Epistemological position

This study takes a constructionist position: it does not assume the existence of an entity called 'schizophrenia', but seeks to understand how the idea of such an entity comes to seem self-evident through discursive practices (Burr, 2015). Avoiding the more relativist connotations associated with 'social constructionism', the present approach extends beyond an analysis of language use, and recognises the influence of "social, cultural, economic and material structures" (Willig, 2012, p.12) on how people understand themselves and the world around them.

Methodology

The methodological approach of this study is Foucauldian Discourse Analysis (FDA). As discussed, FDA is focussed on identifying underlying discourses that make what people say intelligible, and give it credibility (Parker, 2014). This makes it suited to the current study, which seeks not only to deepen our understanding of professionals' uses of the concept of schizophrenia, but also to explore the consequences of those uses.

Method

Eight interviews with NHS mental health professionals were conducted and analysed . The interviews lasted about an hour and were semi-structured. This allowed participants to elaborate on topics and introduce themes, while still covering a set of key areas informed by the research questions. Interviews were audio recorded and transcribed, changing or omitting identifying information.

The transcription process already involves decisions which are informed by, and will further inform, data interpretation (Oliver et al., 2005). As is common in FDA (Bucholtz, 2000), interviews were transcribed verbatim, including emphases, interruptions, overlapping

speech and pauses (see Appendix C for a transcription key). Given time constraints, interviews were transcribed by a third party (Appendix D). The researcher then went through these to make corrections.

Sample

Eight participants were recruited. This small sample size was decided upon considering the nature of the analysis, which is usually undertaken with relatively few participants and an extremely detailed analysis of the data (Willig, 2013). Participants worked in NHS mental health services, used the concept of schizophrenia and had worked in their profession, fully qualified, for at least one year. Only participants with experience of working with people with a schizophrenia diagnosis were included. The sample included four consultant psychiatrists, a clinical psychologist, an occupational therapist and two mental health nurses. Participants worked across two psychosis services, a learning disability service, a forensic service and a mental health service for older adults. This ensured the analysis was not specific to particular services or professions. Participants were recruited from across three different English NHS trusts.

Procedure

Emails were sent to contacts within 12 mental health services – to the manager, or via an existing contact (Appendix E). Six services did not respond; two explained they do not use the concept of schizophrenia. For four services, the researcher was invited to attend a team meeting to present the study and provide information sheets (Appendix F) and consent forms (Appendix G). Those interested in participating provided the main researcher with their contact details, and individual meetings were arranged. Interviews took place at participants' places of work.

Data analysis

Interview recordings were listened to by the researcher at least twice and interview transcripts were read and reread, to achieve familiarity with the data (Gill, 2000).

FDA does not prescribe any particular methodology, but rather offers a 'tool box' of concepts central to Foucault's work. Parker (1992), however, suggests that those new to the methodology adopt a more structured approach, and such an approach was adopted here.

For the analysis, five steps of FDA as outlined by Willig (2013) were followed. These steps are condensed from the 20 outlined by Parker (1992). Willig (2013) acknowledges this more condensed approach to FDA does not address historical context and genealogy of discursive constructions. However, it does facilitate the identification of different object constructions; wider discourses within which these constructions are situated; an examination of action orientations and subject positions and an exploration of the practices these discourses legitimise. As is common in FDA, discussion and analysis are not fully separate and some discussion takes part within analysis section (Willig, 2013). For more detail on the analytic techniques and key concepts used, see Appendix H.

Quality assurance

All studies require researchers to position themselves in relation to their topic (Harper & Thompson, 2011). Here, the researcher positions themselves critically in relation to the concept of schizophrenia. They do so by approaching schizophrenia as a concept the use of which requires explanation, rather than as an entity that exists independently of how it is used (Burr, 2015). To avoid the researcher's position becoming disruptive, a detailed reflexive research diary was kept (Appendix I), a bracketing interview was conducted (Tufford & Newman, 2012), and a subsequent positioning statement was written (Appendix J). Yardley's

quality assurance framework of qualitative research was consulted to enhance and evaluate the study's quality (Yardley, 2016). For FDA specific guidance, Antaki et al. (2003) and Burman (2004) were consulted. All analytic stages were discussed with a supervisor, to increase the reliability of the analysis.

Ethics

The study was approved by the Health Research Authority (HRA) (Appendix K) and the Salomons Institute Ethics Panel (Appendix L). As specified in the HRA approval letter, an information pack was sent to relevant NHS Research & Development (R&D) departments and approval was given accordingly (Appendix M). One participating trust requested a full capacity and capability assessment. This was conducted and approval was granted (Appendix N).

<center>**Analysis**</center>

Introduction to Analysis

Two main object constructions featured throughout all interviews: 'schizophrenia as an object of scientific enquiry', and 'schizophrenia as a physical condition'. Several competing object constructions also occurred, however, and participants employed the same object constructions with more or less flexibility at different points of the interviews. Therefore, the analysis starts with a section outlining competing object constructions and patterns of flexibility.

It then moves to the two main object constructions – schizophrenia as an object of scientific enquiry and schizophrenia as a physical condition. First, the ways in which schizophrenia was so constructed are summarised. Then, the discourses these constructions were situated in, together with their associated subject positions, possibilities for action and

practices, are discussed. Although the two main object constructions and their associated discourses are discussed separately, they are closely connected. They depend on each other for their intelligibility, draw from shared discursive contexts and, in the interviews, often co-occurred or were employed simultaneously.

Competing object constructions and patterns of flexibility

The two most common competing object constructions of schizophrenia, were 'schizophrenia as a pragmatic construct' and 'schizophrenia as a harmful label'.

When constructed as the former, schizophrenia was spoken about as a concept used mainly for practical reasons. It was referred to, for example, as an instrument to facilitate access to services (P5) or as a term used because of "convention" (P7,P3). This was contradicted at other points in the interviews, however, when schizophrenia was referred to as a "specific mental illness" (P3), a "biological illness" (P7) and being caused by "an underlying disease process" (P5).

The second competing object construction was 'schizophrenia as a harmful label'. Schizophrenia was referred to as such in several interviews (P3,P6,P8) and the main reasons cited for this harm were "stigma" (P3,P6,P8) and "negative connotations" (P3). On two occasions, participants criticised its medical connotations especially (P3,P6). In both instances, this was contradicted elsewhere in the interviews. In a striking example, a participant criticised the "medical model" of schizophrenia and stated that:

Extract 1

"To just label people with such a very powerful, um, term even for the individual (.)

this can be quite destroying."[12]

Within the same interview, however, when the participant relayed how they explain to

patients what schizophrenia is, they compared it to several medical conditions – including

cancer and diabetes (P6).

What these competing object constructions have in common, is that they occurred in

talk exclusively directed at the interviewer. Talk in which participants relayed conversations

with patients, was almost entirely free of competing constructions.

The main object constructions featured both within, and outside the context of patient

conversations, are schizophrenia as an object of scientific enquiry and schizophrenia as a

physical condition. Throughout the interviews, participants moved between more and less

flexible ways of constructing schizophrenia as such. Some flexibility was indicated, for

example, through suggestions that defining schizophrenia is "not an exact science" (P7) and

that "nothing (is) definitively evidence based" (P4). However, when participants spoke about

explaining to patients what schizophrenia is, object constructions were considerably more

fixed. As explicated below, it was here that most direct medical analogies and scientific

research references occurred. Although for some participants, object constructions remained

mostly fixed throughout, in no instances were object constructions less fixed in the context of

patient conversations.

Space precludes consideration of all ways in which schizophrenia was constructed

throughout the interviews. The following analysis therefore concentrates on the two main

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[12] The interviewer's speech is omitted from quotations where these are minor encouragers, such as 'mmm' and 'yes'.

ways in which schizophrenia was constructed – as an object of scientific enquiry, and as a physical condition. In view of the significant clinical implications of talk to patients especially, it pays particular attention to talk which takes place in that context.

Schizophrenia as an object of scientific enquiry

'Schizophrenia' was constructed as an object of scientific enquiry in several ways, throughout the interviews.

The first was through talk about progress *already* having been made towards the scientific understanding of schizophrenia. Occasionally, this was explicitly asserted. One participant stated, for example:

> **Extract 2**
>
> "It's a neurodevelopmental stroke neurodegenerative condition (.) and um (.) I think there's a growing acceptance and understanding that that is the case. Um (.) that wasn't so much the case twenty-odd years ago" (P1)

More commonly, the claim was made via references to particular studies or areas of research, for example "some studies that show that there's chemical imbalances" (P4). Similarly, schizophrenia was referred to as being "down to a chemical imbalance" (P8), as caused by an "imbalance of neurotransmitters" (P1) or as involving "too much of that chemical […] dopamine" (P7) – references made almost exclusively in the context of patient conversations. Here, schizophrenia was thus referred to as an object that has, at least in part, been made intelligible through scientific methodology.

The second way in which schizophrenia was constructed as an object of scientific enquiry, was as an object which science will reveal more about in the future. Examples

include references to "any kind of biological cure or solution (being) still in development" (P4) or the expression of hope that "different researches going on (will) find out the cause of it" (P6). Participants referred to technologies that might make this possible, including "genetics and functional neuroimaging" (P1) and "a really sophisticated kind of PET scan"(P7).

The third way in which 'schizophrenia' was constructed as an object of scientific enquiry, was by contrasting 'scientific' knowledge with ideas or knowledge claims positioned as unsubstantiated and of lesser status, such as "social models of schizophrenia" (P1,P5,P7), "toxic parenting" (P7) and "psychoanalytical ideas" (P7). Here, participants drew upon a distinction between 'hard' and 'soft' sciences in which the former was positioned as impersonal and objective, and the latter as subjective and, as one participant put it "really hard to verify" (P7).

Schizophrenia as a physical condition

Schizophrenia was also constructed as a physical condition throughout all interviews. Here, schizophrenia was not just constructed as having a physical dimension, but as best understood in predominantly physiological terms.

The first way in which this was done, was through explicit statements on the nature of schizophrenia, and the use of medical language. For example, schizophrenia was referred to as a "physical or organic illness"(P7), a "neurodevelopmental condition"(P1,P4), a "biological illness" (P7), or a "biological entity"(P1). Schizophrenia was also described as something doctors can "catch early" (P1,P4), as having "a particular age of onset" (P1,P2,P5), "prognostic factors" (P1) and a "prodromal period" (P4,P1,P5). Terms such as "symptoms", "syndrome", "illness" and "treatment" featured throughout all interviews.

The second way schizophrenia was so constructed, was through analogy with

physical conditions. Diabetes analogies were most common, but the range was varied and included cancer, anaemia, hypertension and multiple sclerosis. Most analogies functioned explicitly as ways to encourage people to take medication (P2,P4 P5,P6,P7). They also functioned to convey the severity of 'schizophrenia', or its chronicity. Almost all such analogies occurred when participants relayed conversations with patients.

The third way schizophrenia was constructed as a physical condition, was through referencing alternative ideas which were positioned as harmful, or blaming. For example, participants referenced "religious ideas" or being "possessed by the devil". These ideas were said to be "unhelpful" because they make it "less likely" that people "see it as an illness and see a doctor" (P2). Similarly, schizophrenia was constructed as a physical condition in contrast to the idea that people are "being lazy and not wanting to do anything" (P4), or that their behaviour is "just criminal" (P2).

The fourth way in which schizophrenia was constructed as a physical condition, was by presenting the influence of non-physical factors, such as stressful life experiences, as exclusion criteria for schizophrenia (P1,P2) or by formulating their impact on patients in a physiological way:

Extract 3

I do view it, I suppose, underminely as a, as as a physical or organic illness that (.) of course environment has an eff- stress- all these, that all these things impact in a (.) on that illness in a sort of, I suppose (.) biological way, when you, when you come down to it. (P7)

Non-physical factors were also cited as possible causes for schizophrenia, but only in people genetically predisposed to developing the condition (P3,P5 P6,P8) and primarily as factors which may cause a 'relapse' in people who have already developed schizophrenia (P2,P7,P8).

When talking about schizophrenia as a physical condition, participants alternated between constructions of schizophrenia as defined by its symptoms, and constructions of schizophrenia as defined by an underlying disease process. Indeed, these two were often conflated, meaning that schizophrenia and the behaviours from which it is inferred were constructed as one and the same object. This became particularly clear when discussing critiques of schizophrenia. Here, participants suggested that those who question 'schizophrenia', also question the reality of its associated behaviours:

Extract 4

P: Some people don't believe it exists at all (…)

I: What do you think about those? (…)

P: (Pause) Yeah, I don't really get that, because I guess I I I see it! ((laughs)) (.) and I treat it and it gets better ((laughs)) so I don't really understand that concept. (P5)

Here, schizophrenia was constructed as a condition which can simply be seen, in the same way that the behaviours from which it is inferred can be seen. This aligned with other participants' accounts, who suggested that those who question schizophrenia's existence must have never seen or worked with a person who has the condition (P7,P8), or who referred to the idea that schizophrenia is not a physical condition as "wacky" (P1), "bonkers" (P1) and "off the wall" (P7).

Discursive contexts: subjectivities, implications for action and practices

Having established *how* schizophrenia was constructed as an object of scientific enquiry and a physical condition, this section discusses the consequences of constructing schizophrenia in these ways. It does do by explicating the wider discourses the constructions are situated in, and which make the ways of talking outlined above intelligible. Although discussed separately, these discourses are closely related and rely on each other for the intelligibility and credibility of the claims made within them.

Discourse of scientific progress

Constructions of schizophrenia as an object of scientific enquiry can be situated in a discourse of scientific progress which has its origins in the natural sciences (Rose, 2018). Within this discourse, objects are discovered and gradually made intelligible through the development of increasingly sophisticated research methodologies. Throughout the interviews, schizophrenia was placed at different points of the timeline of this progress – sometimes presented as known, sometimes presented as yet to be known.

Employing a discourse of scientific progress necessarily involves constructing a certain level of scientific consensus (Mulkay & Gilbert, 1984; Maier et al., 2016). Consensus, by definition, can be said to exist only where there is considerable agreement on a topic. The construction of consensus is therefore of particular interest for objects which are subject to debate. One way in which participants constructed consensus throughout the interviews, was through using the plural construction 'we' when discussing scientific progress that has been, or will be made:

Extract 5

"Well, yeah, particularly if if we know– I mean we already know– and as again you'll

be aware of it, there's a lot of research showing, er, changes in in brain, architecture

(.) both at the macro- central neuroimaging, and and also through er post mortem

studies you know, just in in gross er macro architecture, but also mirco architecture,

and at a functional level neuro in neuroimaging we know that there are abnormalities

(…). So, which is why I consider it a [neuro]developmental disorder" (P1)

Here, the participant starts their sentence with a conditional statement ("if we know"),

but immediately corrects themselves by moving to a direct assertion ("I mean we already

know"), suggesting the existence of a consensus in knowledge about schizophrenia between

themselves and a group of other people. They then go on to include the interviewer in this

group of people ("again you'll be aware of it"). Before specifying what this knowledge about

schizophrenia entails, the participant has thus already established that it is shared not just by

themselves and another group, but by the interviewer. An effect of this, within the

conversation, is that it becomes difficult for the interviewer to disagree with the content that

follows. Since it is already established that there is a consensus, the interviewer's

disagreement would not be a reflection on the legitimacy of the claimed knowledge, but

rather a reflection on whether they are "aware of it".

The way in which the participant and interviewer are positioned, here, is illustrative of

a discursive dynamic that characterises scientific discourse more generally (Olsson, 2010).

Within this dynamic, those who position themselves as having access to particular forms of

scientific knowledge hold considerable power over those who do not (Iliopoulos, 2012; Rose,

2018). This conjunction of authority and expertise resembles the disciplinary mechanisms

analysed by Foucault as 'power/knowledge' (Foucault, 1977). It is especially pronounced

when the knowledge in question pertains to the behaviour and experiences of people, yet is presented as carrying the objectivity and value-freedom associated with the 'hard sciences' (Rose, 2018).

Foucault and those working within his tradition have long commented on the effects of presenting knowledge claims in this way. One effect, it is argued, is that it becomes very difficult to challenge these claims (Rose, 2013). In fact, for challenges to be successful, they must be presented within the same discursive context the knowledge claims are made in – that of science (Landry, 2017). This has serious implications for patients who wish to challenge claims they are presented with. Such challenges, unless formulated within scientific discourse, are likely to be seen as indicative of the patient's lack of knowledge. In a discursive context where power and knowledge are intimately connected, patients thus risk forfeiting power when they challenge claims presented as scientific.

For participants, the employed discourse of scientific progress offered several subject positions (Davies & Harré, 1990). One position was that of the participant with insight into the scientific knowledge that is produced regarding schizophrenia, as in Extract 4.

A more common subject position, was that of the participant without insight into such knowledge. Those speaking from this subject position placed themselves outside the community of scientists who either have uncovered or will uncover the nature of schizophrenia. This was often achieved simply by referring to this community as "they" (P2,P4,P3,P6,P8). Elsewhere, participants explicitly stated that they "don't know the science of it" (P8), "probably need to update my CPD" (P3) or "never studied it properly" (P7).

From this latter subject position, participants rely on the construction of schizophrenia as an object of scientific enquiry. For example, they talk of using this construction to explain to patients what schizophrenia is, and to encourage medication use. In order to do so, however, participants do not seem to need access to the knowledge they refer to. Indeed,

from within this discursive context participants can recognise and treat schizophrenia without knowing about, or relying upon, scientific knowledge about it.

Within the discourse of scientific progress described here, schizophrenia is thus presented as, on the one hand, an extremely complex entity which can be understood only in technical terms, by select communities with access to specialist knowledge. On the other hand, and in the same interviews, it is presented as an easily recognisable object which obviously exists and can be diagnosed and treated even by those who "don't know the science of it" (P8).

Constructing schizophrenia in such a way – as both extremely complex and easily recognisable – legitimises extensive further research into this presumed entity. Simultaneously, it legitimises a clinical practice in which people can be diagnosed and treated independently of how this research progresses. In fact, even if research fails to yield answers regarding the nature and causes of schizophrenia, the clinical implications of this are limited, since schizophrenia is constructed as an object which can be recognised and treated without such answers.

Medical discourse

All object constructions of schizophrenia as a physical condition can, unsurprisingly, be situated within medical discourse. Medical discourse is a broad category, however. Within it, different types of discourse can be distinguished, with different associated subject positions and possibilities for action (Wilce, 2009; Gunnarson, 2013). It is therefore worth differentiating between the *types* of medical discourse employed in the interviews – keeping in mind that participants continuously moved between these, drawing from them sometimes simultaneously and often only moments apart.

A discourse of personal responsibility for health. The first discourse employed when constructing schizophrenia as a physical condition, was a 'discourse of personal responsibility for health'. This discourse is characterised by an emphasis on people's responsibility to manage their own health or, if they are considered ill, to manage their own illness (Roy, 2008; Nordgren, 2010; O'Donnell, 2015):

Extract 6

And they just need to know how to manage it. And we do- I do a lot of analogy- that it's a long-term condition (.) diabetes is a long term condition, hypertension is a long-so do it- analogy to a physical illness. And get people to learn how to manage their illness, and let them see that they can still have a fulfilling life (.) and as long as they can manage their illness they could um fulfil all the goals they want to (P4)

Here, schizophrenia was constructed as a physical condition through analogy with diabetes and hypertension. Specifically, it was constructed as a physical condition which, just like diabetes and hypertension, can be "managed" by those so diagnosed. Two subject positions were created. The first was that of the professional ("we" and "I") whose role it is to "get people to learn how to manage their illness". The professional was thus presented as having expertise regarding the nature of schizophrenia and the way it should be managed, but not as ultimately responsible for carrying out this management.

The second subject position was that of the patient. Their role is to "manage their illness" so they can "fulfil all the goals they want to". This subject position is one of a responsible agent, whose responsibility pertains to the management of their own health and development.

This way of talking is associated with what has been called a discourse of 'neoliberal subjectivity' (Türken et al., 2016). Within it, subjects are positioned as having the ability and duty to engage in various forms of self-development and self-improvement, with the goal of meeting societal demands (Rose, 2007). From a Foucauldian perspective, this discourse is associated with some of the most pervasive power mechanisms in modern society, partly because they are so difficult to recognise as such (Burr, 2015). It is an example of what Foucault termed productive power, which operates not by actively restricting or coercing people, but by producing subjects who monitor and work on themselves (Martin & Waring, 2016). Whether this discourse can be employed without moving into discursive contexts where power operates more overtly, depends on whether those spoken about understand themselves as they are encouraged to – in this case, as having schizophrenia and needing to manage it (Iliopoulos, 2012).

A discourse of person-centred healthcare. The second discourse employed when constructing schizophrenia as a physical condition, was a 'discourse of person-centred healthcare'. Herein, participants positioned themselves as collaborating with patients to produce treatments explicitly referred to as "person-centred" (P2,P3,P4,P7,P8). This discourse is characterised by an emphasis on the individuality of those receiving care, and professionals' duty to accommodate this individuality (Engeström et al., 2003; Sflakidou & Kefalopoulou, 2015).

It was employed, for example, when participants relayed conversations with people who question their diagnosis:

Extract 7

So (.) and it can be– I've definitely got clients who- they don't hear voices [they don't] kind of have any of those like experiences (.) but the negative side of it– their

isolation and things like that (.) that is what schizophrenia is to them so they could be

like why– like how have I got schizophrenia? [I don't] hear voices, I don't like

hallucinate, all these kind of traditional like connotations so that part of it just doesn't

make sense to them (.) but then I think it's really important to kind of link it back to

them and exactly what they're experiencing (P8)

Here, the participant outlined the importance of describing schizophrenia to "clients"

in a way that fits their experiences, especially where these deviate from "traditional

connotations". Two subject positions are created. The first is that of the professional, whose

role is to describe schizophrenia so that people recognise themselves in the description. The

second is that of the "client", who is encouraged to understand themselves as having

schizophrenia.

A person-centred care discourse was also drawn upon when speaking about the

treatments people are offered (P1,P2,P3,P7,P8). There is talk, for example, about a "*menu of

treatment options*" (P3) from which people may choose what they like and reject what they

don't. Most directly, psychological therapy was presented as a way to "*sell*" particular

models to patients (P1).

This way of speaking links to a much-discussed discourse of consumerism, which has

become more prevalent within healthcare in recent decades (Bowers & Goldstein, 2015).

Herein, patients are positioned as consumers, and professionals as those selling and

delivering treatments or ideas. Some have argued this represents a more equal power

relationship between those giving and receiving healthcare, because the preferences of those

receiving healthcare exert influence on the care they receive (Wolf et al., 2017). Others have

expressed concern that this discourse conceals an asymmetric power relationship, in which

power operates through the methods used to encourage people to accept certain ideas or

treatments (Goldstein, 2015; Vinson, 2016). A particular concern has been the lack of opportunity for disagreement and resistance (Vinson, 2016; Pluut, 2016). This is illustrated in Extract 6, where a personalised description of 'schizophrenia' expressly functions to encourage a patient to accept the diagnosis.

A discourse of paternalistic healthcare. The third type of discourse employed when constructing schizophrenia as a physical condition, was a 'discourse of paternalistic healthcare'. This discourse was characterised by an emphasis on professionals' ability and authority to diagnose and treat people, even when these people want neither (Lynch, 2015).

When employing this discourse, participants constructed schizophrenia as a physical condition rendering those diagnosed "unable to recognise that they are ill" (P3). The term 'insight' played a key role here, and was introduced by all participants. A 'lack of insight' was spoken about as integral to schizophrenia and said to be "part of the diagnosis" (P2), "one of the most common symptoms"(P5) and "one of the defining features" (P3).

In this way of speaking, two subject positions were created: the professional was positioned as having expertise about the patient's condition and responsibility for their care, while the patient was positioned as having neither. Accordingly, within this discursive context, treatment decisions must be made by professionals, who are said to act in patients' best interests (Lynch, 2015).

The subject positions within this discursive context stand in apparent contrast to those previously discussed. Within the latter, those diagnosed with schizophrenia are positioned sometimes as responsible agents, sometimes as customers. In either case, they have at least some say in how they are treated. Employing a discourse of paternalistic healthcare, however, suggests that attributing agency depends on whether patients accept how they are encouraged to see themselves – as having schizophrenia. That is, within the medical discourses employed, those diagnosed with schizophrenia are attributed agency and responsibility only

when they "recognise that they are ill" (P3). This is illustrated by the following extract, occurring within a conversation about 'insight':

Extract 8

P5: So I've [got], um, one young man who has a university degree and is very bright, and he becomes very hostile and anti-services when he gets ill (.) we've done a whole big advanced directive about does he want us to wait until he's really ill, or does he want us to intervene early? (.) And when he's well he says I want you to intervene as early as possible

I: Ok (.) and then when he [becomes unwell?]

P5: [So we do] it and he tells us to go away (laugh)

I: Away, ah

P5: Um, but it's been quite helpful to have that dialogue with him when he's well.

Herein, the participant makes a clear distinction between subjects able and unable to make decisions about their treatment. The subject able to make such decisions, is the subject who is "well". In this example, this is further emphasised through a reference to them having "a university degree" and being "very bright". The subject unable to make decisions about their treatment, is "ill" and "hostile and anti-services". Even when the person is "well" however, they only have agency over *when* services will intervene – not whether they intervene.

What is created in this extract and the interviews generally, is a subject position from which people diagnosed with schizophrenia can agree but not disagree with their treatment and diagnosis. This is facilitated by the notion of 'insight', which allows agreement to be attributed to patients, and disagreement to their condition. Within this way of speaking, it

becomes legitimate for professionals to treat people against their will, including "containing [detaining] people" and forcibly administering medication (P3,P7). It connects to legislation, particularly the Mental Health Act 1983, and to institutional practices. As such, it lends credibility to actions and subject positions deemed problematic within other discourses – including those employed in the interviews, here.

Discussion

This section is divided into four parts. The first is a brief summary of findings, outlined in relation to the study's research questions. The second is a theoretical integration of the findings, which discusses these in the context of existing research and scholarship. The third part discusses the study's limitations, and future research recommendations. The fourth outlines implications for clinical practice and the study ends with a conclusion.

Summary of findings

The study aimed to explore how professionals who use the concept of schizophrenia talk about the concept, and with what consequences for those so diagnosed.

Professionals constructed schizophrenia in numerous, sometimes conflicting ways. The two dominant constructions were 'schizophrenia as an object of scientific enquiry', and 'schizophrenia as a physical condition'. Competing object constructions also occurred, including 'schizophrenia as pragmatic construct' and 'schizophrenia as a harmful label'. When participants relayed how they talk to service users about schizophrenia, almost no competing object constructions occurred. Additionally, in this context, the main object constructions were employed less flexibly.

The main object constructions were situated in a 'discourse of scientific progress' and 'medical discourses'. The latter was further divided into 'personal responsibility for health',

'person-centred healthcare' and 'paternalistic healthcare'. Each discourse offered several subject positions. A common thread herein was the creation of subject positions from which those diagnosed with schizophrenia were attributed agency and responsibility, but only when agreeing that they have schizophrenia, are ill or need treatment. That is, from the identified subject positions those diagnosed with schizophrenia were able to agree, but not disagree with how they were encouraged to understand themselves. The concept of 'insight' played a key role here, justifying various institutional practices, including detention under the Mental Health Act 1983.

Theoretical integration

The analysis suggests a remarkable flexibility to schizophrenia as a discursive object. Throughout the interviews, it was referred to as a pragmatic construct, harmful label, physical condition and an object of scientific enquiry. Schizophrenia was sometimes referred to as a disease entity which can manifest in many ways, sometimes as a cluster of symptoms without an underlying entity. At times, schizophrenia and the behaviours from which it is inferred were constructed as one and the same object. These ways of talking occurred across and within interviews, often moments apart.

The flexibility observed here has been highlighted before and suggested to account, in part, for the concept's persistence in the face of sustained criticism (Bentall, 1990b; Boyle, 2002a). Accordingly, the concept has been called a "moving target" (Hedgecoe, 2001, p.901), suggesting that if a particular construction of schizophrenia is challenged, another may be employed instead. This, it has been argued, makes it difficult to engender lasting change to its use (Hedgecoe, 2001; Poland, 2006). Simultaneously, high levels of variability and inconsistency in the way concepts are spoken about have been said to offer opportunities for different, alternative discourses to emerge (Parker, 2015). Previous work has suggested that

the emergence of such discourses may open "spaces for alternative knowledges and practices" (Georgaca, 2014, p. 59), and thereby different ways in which those spoken about may understand themselves.

This makes it especially important to highlight the fixed constructions participants employed when relaying conversations with service users. Indeed, this study suggests that more flexible constructions of the concept may not enter into conversations with service users, even when they *are* employed in other contexts. This has been highlighted by others, who have expressed concern that the lack of consensus about the concept is not communicated to service users (Cooke et al., 2014; Collins & Crowe, 2017). This, it has been suggested, makes it more difficult for service users to challenge an assigned diagnosis. It limits the ways in which those diagnosed with schizophrenia may understand themselves, without actively challenging the claims they are presented with (Georgaca, 2014). Although a discourse of person-centred care was employed throughout, this study supports previously highlighted limitations of this discourse, which become visible when people do not understand themselves as they are encouraged to (Salmon & Hall, 2003).

Limitations and future research

 The study was conducted within time and space constraints, which meant several decisions were made about which parts of the analysis to include in the final report (Appendix I). Without such constraints, the analysis may have included exploration of how participants negotiated tensions between different, competing object constructions, as well a further analysis of the relationships between different object constructions and their discursive contexts.

Another limitation pertains to the nature of FDA, which pays relatively little attention to interpersonal dynamics between speakers (Willig, 2013). However, these dynamics have

undoubtedly influenced how participants answered questions. For instance, whether the interviewer was positioned as a critical outsider or an interested student, will have affected how the interviews developed (Harper, 2009).

Finally, this study analysed professionals' accounts of how they use the concept of schizophrenia in their practice, rather than actual clinical encounters. The analysis thus indicates possibilities for how professionals may speak to service users, rather than a direct analysis of these interactions.

Future research on how professionals speak to service users about the concept of schizophrenia is therefore indicated. This should be done directly, through analysis of the language used in clinical encounters, rather than indirectly, as was done in the current study.

Additionally, future research may explore discourses employed by clinical psychologists specifically. The current sample included a range of professionals, which makes it more difficult to formulate clinical implications specific to the profession of clinical psychology. Research into clinical psychologists' use of the concept may provide further insight.

Future research may also explore the discursive contexts drawn upon by professionals who do not use the concept of schizophrenia. This may include professionals who use the term 'psychosis' instead, which some have suggested involves fewer harmful implications (Kingdon et al. 2017). Others have suggested 'psychosis' is often accompanied by very similar implications (Johnstone, 2011; Boyle, 2014), but further research is needed to explore similarities and differences in how both concepts are used.

Clinical implications

This study raises important questions about how controversies are discussed among professionals and communicated to service users. Given the levels of disagreement on the

topic, there are no easy answers, here. Some have suggested that "Services should take as their starting point that mental health is a contested area and should not insist that service users accept any one framework of understanding" (Cooke et al., 2014, p. 102). This may allow service users opportunity to question their diagnosis, without being positioned as 'lacking insight' and being exposed to institutional practices many have suggested are damaging (Iliopoulos, 2012). It may also counter the sense of lost agency which has been reported in user led research (Pitt et al., 2009).

This study also suggests that some professionals may be reluctant to communicate the lacking consensus to service users, despite discussing this in different contexts. A possible reason for this, supported by the way schizophrenia was constructed in this study, has been termed the 'brain or blame dichotomy' (Boyle, 2013). As Johnstone (2014) put it: "As a society, we seem to find it hard to find a middle ground between 'You have a physical illness, and therefore your distress is real and no one is to blame for it' and 'Your difficulties are imaginary and/or your or someone else's fault, and you ought to pull yourself together'" (p. 2). Finding such a middle ground may be key to moving beyond the deadlock the current schizophrenia debates appear to be in (Harper, 2013). Again, there are no easy answers on how to achieve this. One suggestion may be to look towards contexts in which the dichotomy is less apparent and where the experiences associated with schizophrenia are spoken of neither as an illness, nor as the fault of those who have them (e.g. Corstens et al., 2014). This may facilitate richer discussion between service users and professionals, and among professionals.

Conclusion

Communicating the contested nature of the concept of schizophrenia to service users, may sound simple. However, this study suggests that doing so may have radical implications for those so diagnosed. Discursive scholarship has long suggested that we all draw upon

available discourses to make sense of our experiences, understand ourselves and negotiate

our roles in wider social systems. This study indicates that the discourses people are

presented with when they are diagnosed with schizophrenia, may offer very limited ways of

doing so. Alternatives do exist, however, and this study suggests the time may well be right

for their integration into mainstream mental health services.

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Appendix A – Mapping review methodology (1)

Search terms

('schizophren*') AND ('critic*' OR 'critiq*' OR 'debate*' OR 'contest*' OR 'concept*')
AND ('valid*' OR 'useful*' OR 'harm*') OR ('caus*' 'neurolog*') OR ('neuro* OR
'gene*' OR 'herit*' OR 'ill*' OR 'disease'* OR 'disorder*')

Electronic databases searched

For the first mapping review, PsychINFO, Medline and Web of Science were searched with
the aim of covering both biomedical and psychological literature. For a complementary
search of positions not covered by these databases, an additional Google Scholar search was
conducted.

Inclusion and exclusion criteria

Searches were limited to publications in the English language. In the first instance, all
publications of the last 30 years were included. Later, more recent publications were
prioritised. Empirical literature (qualitative or quantitative) and conceptual literature
(including editorials, news articles, correspondence and peer reviewed articles) were
included. Publications which were not specifically about 'schizophrenia' (but, for example,
'schizotipy' or 'schizoaffective disorder') were excluded. Publications with pertained to
debates around psychiatric diagnosis in general – rather than the diagnosis of schizophrenia
in particular – were excluded. This was done to maintain a specific focus on the
schizophrenia debates, though the author recognises that these are closely connected to wider
debates on the use of psychiatric diagnosis. Publications not related to mental health research
or practice (but, for example, literary or cultural theory) were excluded. For practical reasons,

only those publication which featured the term 'schizophrenia' either in their abstract or title were included.

Additional manual search

For relevant publications, reference lists were used to identify other relevant publications. For these publications, the 'find citing articles' and 'find similar' functions of the databases were also used. Because of the vast amount of literature generated through the search terms, it was not possible to conduct a structured search of all generated literature. In order to create a selection of articles as representative of the wider literature as possible, the steps outlined below were taken.

Grouping of publications

Titles and abstracts were scanned for their position in relation to the schizophrenia debates. This position was sometimes clear from the title, in which case the abstract was not read. For those articles where the position was not clear from the title, the abstracts were read. On the basis of this initial scanning, publications were divided into groups using Nvivo software to organise the publications. 2000 publications were scanned in total. For practical reasons, maximum 50 publications were included for each position. When a new position was found, a new group was created. Initially, publications appeared to fall into two groups (those who critique schizophrenia and those who assume schizophrenia). Further scanning of abstracts revealed a third group of those who critique the term schizophrenia, but not the concept. Of the fourth group, those who actively defend the concept, only one publication was initially found. Further publications were manually sought through reference lists of articles in other groups, and by a complementary Google Scholar search using terms 'Schizophrenia' AND

'Valid' AND 'Useful' AND 'Diagnosis'.

Inclusion in review

The selected articles were fully scanned and sub-categories were created on the basis of this (for example, those who conceptualise schizophrenia as a neurological condition and those who conceptualise schizophrenia as a genetic condition). Recent articles were prioritised but, to illustrate the long-standing nature of the debates indicated by the range of literature found, older publications were also included. Maximum 30 articles were included per group, omitting articles which took a position already taken by at least three other articles (for example, only three articles which conceptualised schizophrenia as a neurological condition were included, even though more were initially identified and organised into groups using Nvivo). For a Prisma-flow chart of the literature search, see Figure 1.
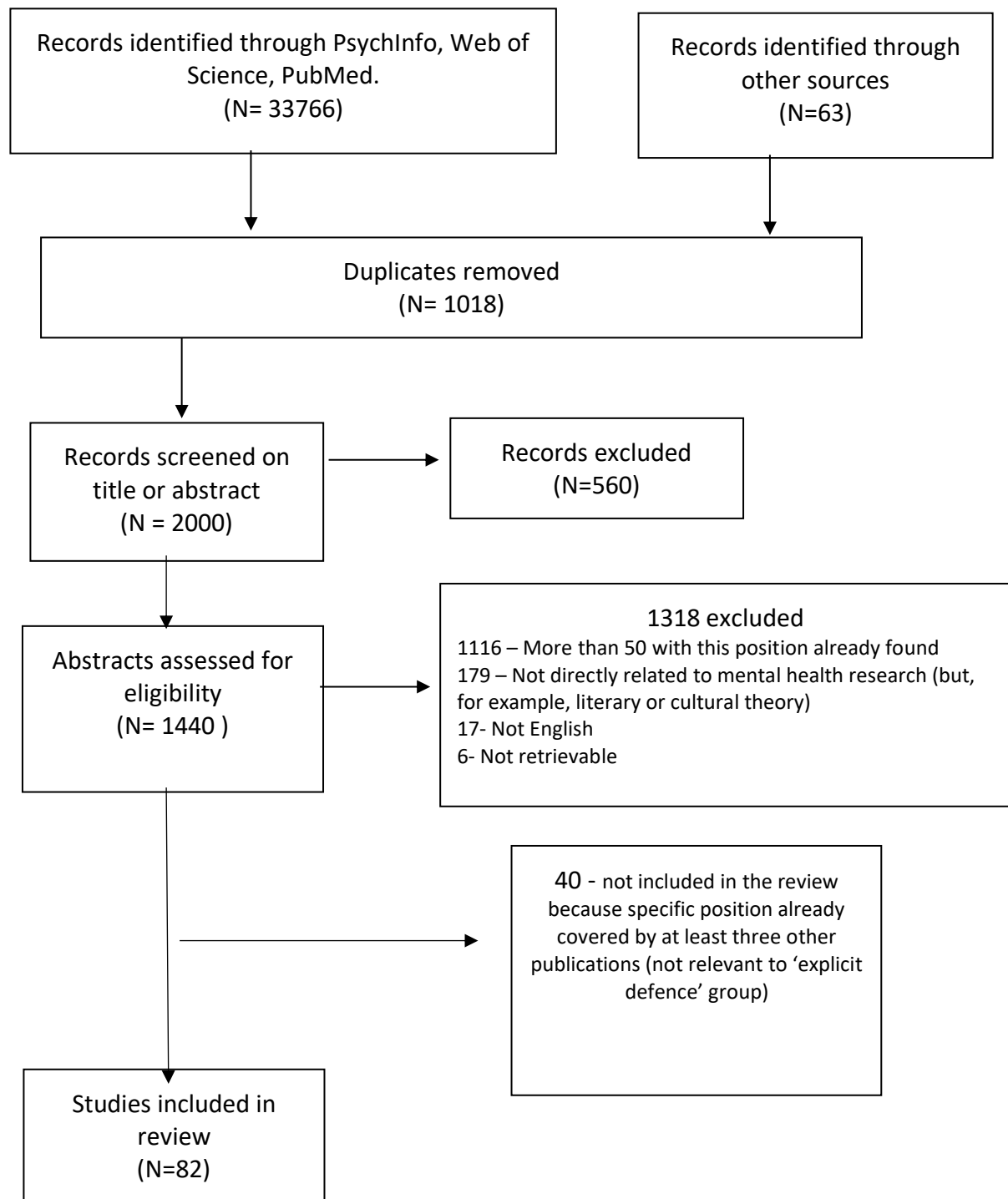
Figure 1. PRISMA diagram outlining screening process (1)

Appendix B – Mapping review methodology (2)

Search terms

 ('schizophren*') OR ('psychos*')

Electronic databases searched

For the second mapping review, the databases of the following journals were searched:

British Journal of Clinical Psychology; British Journal of Psychology; British Journal of Social and Clinical Psychology; Psychology and Psychotherapy: Theory, Research and Practice.

Inclusion and exclusion criteria

Publications of the last 30 years were included. Later on, during the write-up, more recent publications were prioritised. Empirical literature (qualitative or quantitative) and conceptual literature (including editorials and peer reviewed articles) were included. Publications which were not specifically about 'schizophrenia' (but, for example, 'schizotipy' or 'schizoaffective disorder') were excluded.

Grouping of publications

Publications were grouped according to the way in which they conceptualised 'schizophrenia'. Further literature was sought where necessary to place these articles in their theoretical context (e.g., further literature on social causation/ social drift hypothesis), through PsychInfo and Google Scholar.

Inclusion in review

Titles and abstracts of all articles were scanned. Categories were based on these scans and for relevant articles, the entire article was scanned. This was possible because the literature yielded was significantly smaller than that of the first mapping review. Recent publications were prioritised but, to illustrate the long-standing nature of the debates indicated by the range of literature found, older publications were also included. Where enough publications of the same kind were found (max 3 for each position), more recent publications were included, unless the inclusion of older publications served to illustrate the long standing nature of the debates. For a Prisma-flow chart of the literature search, see Figure 2.
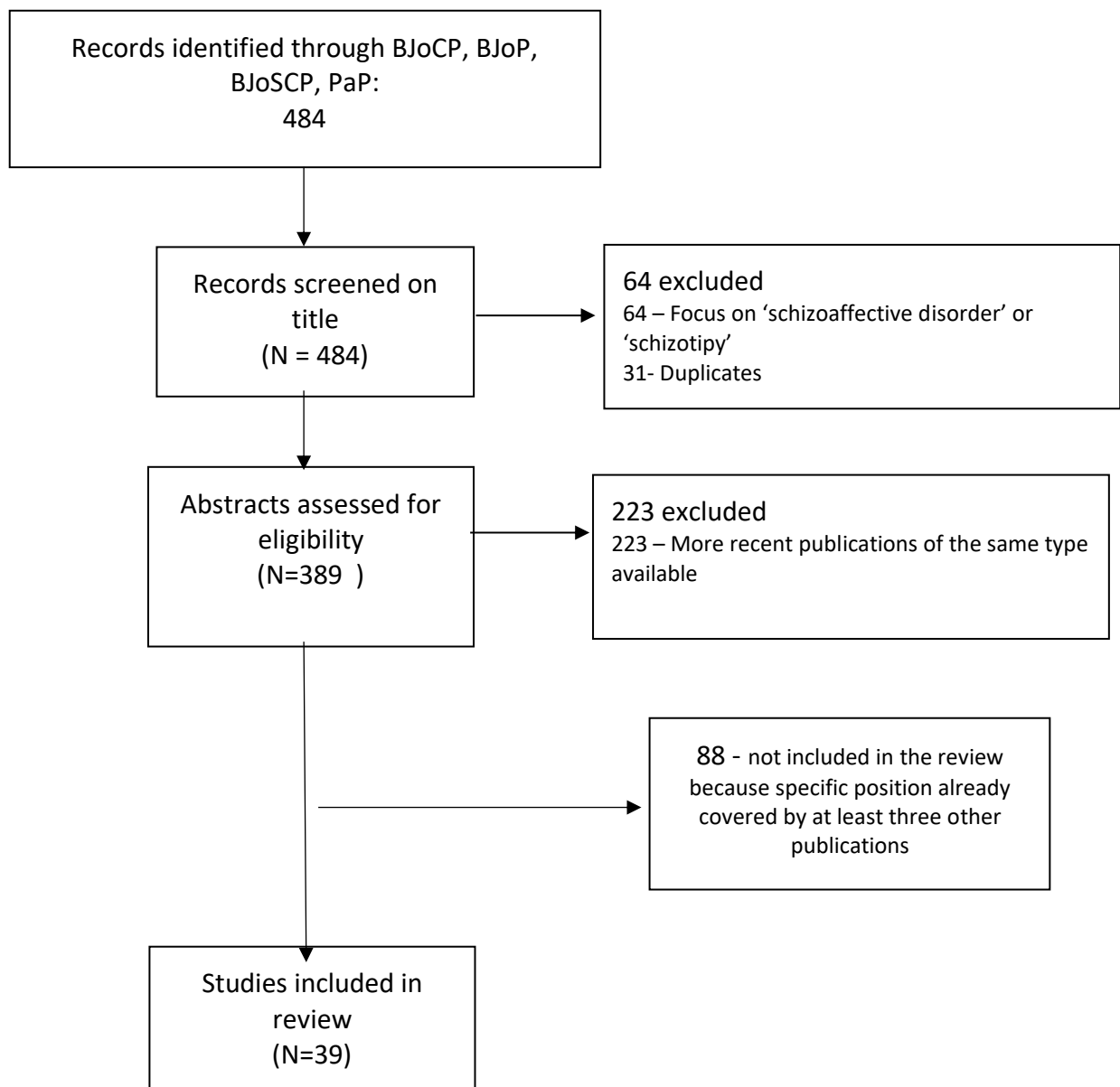
Figure 2. PRISMA diagram outlining screening process (2)

Appendix C – Transcription Key

[ ]	Overlapping speech
<u>Under</u>lining	Emphasis
(1)	Length of a pause in seconds
(.)	Pause less than one-tenth of a second
(laughs)	Transcriber's descriptions or comments/ contextual information
( )	Indecipherable
(word)	Transcriber's best guess at what was said
,	Weak, 'continuing' intonation
?	Rising, 'questioning' intonation
.	Falling intonation

I = Interviewer

P1= Participant 1

Appendix D – Third party transcription form

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Appendix E – Recruitment E-mails

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Appendix F – Participant Information Sheet

Canterbury
Christ Church
University

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Date: 01/08/2019
IRAS Project ID: 255766

Information about the research

The concept of schizophrenia: clinician views, discourse and practice

My name is Hanna de Waal and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you. The research study will be carried out by me, under the lead supervision of Ms Anne Cooke. The purpose of this information sheet is to inform you about the nature of the study and your role in it, should you choose to participate.

What is the purpose of the study?

The study is about the diagnostic category of schizophrenia. Through a literature review and a series of interviews, it aims to gain insight into the nature of the ongoing debates around the diagnosis of schizophrenia and the way in which it is currently used in clinical practice.

Why have I been invited?

You have been invited to participate in the study because of your experience of working with people with diagnoses of schizophrenia, and because of your use of this diagnosis in your clinical practice. About 7 to 9 other mental health professionals, across different professions, will be taking part in the study. If you are interested to find out more about the recruitment process, then please let me know.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw from the study at any time, without giving a reason and without consequences.

What will it involve?

For this study, I will interview a total of 8-10 mental health professionals about their experience of, and views on, working with people with a diagnosis of schizophrenia. All participants will be professionals who work in the NHS and have experience in this area. The interviews will last up to 60 minutes and will take place in the summer and autumn of 2019.

If you decide to take part in the study, I will email you to agree a time and a place convenient to you (most likely your current place of work), to conduct the interview and discuss any questions you may have. The interview will be conducted on a one-to-one basis and will be audio recorded. Following the interview, I will transcribe the recording and eliminate all information that could identify you, the service you work in or any others mentioned in the interview. I will then send you this anonymised transcript, so that you can check its accuracy if you would like to do so. Your active involvement in the study will cease after this point. After the study has ended, I will send you a short report of the study and its findings, unless you choose to opt out of this.

What are the possible disadvantages and risks of taking part?

All interview questions will be related to your clinical experience and views as a mental health professional. There will thus be no questions of a personal nature. However, in answering the questions you might be reminded of difficult professional experiences, which has the potential to cause distress.

What are the possible benefits of taking part?

The interviews could potentially be of interest to you, for example as an opportunity to think about and reflect upon your clinical practice, professional views and the wider mental health system within which these exist. Subsequently, being able to see your views integrated with those of other professionals in a wider analysis may prove to be of interest to you.

What if there is a problem?

I will take very seriously and do my best to address any complaint about the way you have been dealt with during the study or any possible harm you might suffer. If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 07497779815 or sending an e-mail to h.m.de-waal208@canterbury.ac.uk. Please leave a contact number and I will get back to you as soon as possible. If concerns remain, you will be offered a meeting with the project's lead

supervisor, Anne Cooke. If following this, you remain unhappy and wish to complain formally, you can do this by contacting Dr Fergal Jones, Research Director, Salomons Institute for Applied Psychology, Canterbury Christ Church University – fergal.jones@canterbury.ac.uk, tel: 01227927114.

Will my contributions and participation be kept confidential?

Yes. As the chief investigator, I will keep your name, contact details and details about the service you work in completely confidential and will not pass this information on to Canterbury Christ Church University or other third parties. I will use your information only to contact you about the study or to make sure that relevant information about the study is recorded for quality purposes. Canterbury Christ Church University will only receive information without any identifying details. The people supervising the research will also not be able to identify you and will not be able to find out your name, contact details or details about the service you work in. The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you told me, I were to become concerned about your safety or the safety of someone else.
All data will be locked in a secure cabinet on university premises. Original recordings will be destroyed after completion of the project. Anonymised data (i.e. the interview transcripts) will be stored securely for 10 years, in line with the Data Protection Act (Data Protection Act, 1998).

Who is organising and funding the research?

The research is organised and funded by Canterbury Christ Church University.

Who has reviewed the study?

This study has been reviewed and approved by NHS Health Research Authority as well as Canterbury Christ Church University, Salomons Institute.

Who is the sponsor for the research study?

Canterbury Christ Church University (CCCU) is the sponsor for this study, based in the United Kingdom. We will be using information obtained during the interview in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. CCCU will keep anonymised information about you for 10 years after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study after analysis of the data, we will keep the information about you

that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting Dr Fergal Jones, Research Director, Salomons Institute for Applied Psychology – fergal.jones@canterbury.ac.uk, tel: 01227927114.

What will happen to the results of the research study?

You will be sent a short report of the study and its findings by e-mail, unless you prefer to opt out of this. It is possible that the results will also be published in article form in an academic journal. This publication may include anonymised quotations from your interview. You will not be identified in any report or publication, unless you have given your explicit consent for this.

Further information and contact details

For more information on the study, please feel free to contact me on the number or e-mail address below.

Email: h.m.de-waal208@canterbury.ac.uk
Telephone: 07497779815

What will happen next?

I would be grateful if you could let me know within the next 72 hours whether you would like to take part in the study. If you need more time to decide or have any further questions, please let me know.

Appendix G – Consent Form

Canterbury
Christ Church
University

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

IRAS Project ID: 255766
Participant Identification number for this study:

Consent form

The concept of schizophrenia: clinician views, discourse and practice

Main researcher: Hanna de Waal
Lead supervisor: Anne Cooke

1. I confirm that I have read and understand the information sheet dated 01/08/2019 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time before data are analysed without giving any reason.

3. I agree for the interview to be audio recorded and for the data to be transcribed.

4. I understand that all data will be transcribed in anonymised form and will be kept confidential.

4. I agree that quotations from my interview may be used in published reports of the study findings in anonymised form.

6. I would like to be sent a short report of the study and its findings.

Date:

Name:

Signature:

Appendix H – Analytic Techniques

After initial familiarisation with the data, the coding process was started. The first stage of the analysis focused on the way in which 'schizophrenia', the discursive object of interest here, was constructed. This involved the identification of all references to 'schizophrenia' – either implicit or explicit (Willig, 2013). These were then grouped into a number of different 'object constructions', using Nvivo software (QSR International, 1999) to highlight and organise the data. The main object constructions used in each interview were then summarised, together with associated subject positions, actions orientations and opportunities for actions.

The second stage of the analysis examined the wider societal discourses within which these different object constructions are situated (Willig, 2013). As a large number of discourses were identified, only those which occurred most frequently and throughout all interviews were selected for further analysis.

The third stage further examined these discourses by examining the 'action orientations' associated with them (Parker, 1992). This was done by asking a number of questions about the identified object constructions, such as 'what are the potential consequences of constructing the object in this way for the speaker, at this point in the interview?' (Willig, p.286). In doing so, it aimed to gain an understanding of the possible functions that various object constructions have within the interviews – for example, the claiming or disclaiming of responsibility.

The fourth stage looked at the subject positions associated with the identified discourses. For current purposes, this mainly concerned the ways in which the 'professional', 'interviewer' and the 'patient' were positioned.

The fifth stage concentrated on the ways in which the identified discourses and

subject positions limit or enable particular opportunities for action. It asked, in other words,

"[which] practices become legitimate forms of behaviour from within particular discourses"

(Willig, 2013, p.388). [1] The sixth step outlined by Willig, which examines how participants

may feel and what they may think, was omitted because it does not fit the research questions

and requires a larger sample (Willig, 2013)

Appendix I – Extracts of Research Diary

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Appendix J – Positioning Statement

In the early stages of this project, I had a number of conversations with my supervisor, Anne Cooke, in which we discussed my position in relation to the topic. The project was initiated by me, and in line with some smaller projects I completed in the context of different degrees. My first undergraduate degree was in philosophy and, while I also did a psychology undergraduate degree later, my academic interests gravitate towards the former. So much so that I moved from Amsterdam to London for it five years ago, to do an MA in philosophy of psychology. While I studied philosophy I spent a lot of time reading Foucault and, as a lecturer said to me at the time, "there's no going back from that!". When I had to update my CV recently, I realised that all the dissertations I've previously written lie at the intersection of philosophy and psychology.

I have moved between the two disciplines for a while and the start of my doctoral training has, in a sense, marked a move back towards psychology. Although Salomons is a relatively critical course – it's one of the reasons I applied – my placements mostly haven't been. It's odd to move back and forth between the very clinical context of my placement and the critical thinking involved in this project. Over the last years I've realised how easy it is to slip into ways of speaking – and acting! – which, as soon as I feel able to reflect on them, find painful and problematic.

I personally find it very alienating to work in clinical and medical setting, and I think experiences of working in such contexts are part of what drives me toward critical approaches. My sense has always been that such settings risk cutting off connections with people, when connection is what is needed most. This sense, I'm sure, reinforces and is reinforced by my more academic interest in the topic.

When it comes to this project, I do not believe that there are any scientific grounds to assume schizophrenia, but see its use as a social and cultural phenomenon. I think it would be

better if people stopped using it although, of course, this immediately raises the question of what this would change if the assumptions underpinning the concept remain the same. The answer is, probably, very little.

The project will be carried out with two supervisors, Mary Boyle and Anne Cooke, who themselves are known for their critical work on the topic. I'm pleased to be in such great company, and to have supervisors who so passionately share my interest in the topic. Their positions will undoubtedly influence the project, too – as well as the way in which it is interpreted by others.

Conversations with Anne have made me think a bit about the risks of the project, and one is to make participants feel criticised, or to seem to be critical 'just for the sake of being critical'. I'd like to avoid both of these, although of course FDA is an inherently critical methodology and the potential for people to feel criticised is always there. My interest is genuinely in trying to understand how to concept functions, why it is still used and with what consequences. What will be crucial in achieving this is to refrain from attempts to locate power within particular people or disciplines, and to refrain from ascribing intentionality to participants – which actually fits very with within a Foucauldian framework.

Appendix K – HRA Ethics Approval Letter

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Appendix L – University Ethics Approval Letter

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Appendix M – R&D Approval

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Appendix N – Extract of object construction development

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Appendix O – Coded Transcript Sample

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Appendix P – Semi-structured interview questions

1. What do you understand the term 'schizophrenia' to mean?

2. Drawing on your experience, how would you describe a typical person with a diagnosis of schizophrenia?

3. Drawing on your experience, can you recall people who you would not consider to be typical, but who were nevertheless diagnosed with schizophrenia?

- For these people, did the diagnosis of schizophrenia still make sense to you? What was it that meant the diagnosis of schizophrenia did or did not make sense?

4. In practice, are there diagnostic criteria for schizophrenia that you consider to be of greater relevance than others?

- Why/ why not?

5. Can you recall a clinical encounter in which you worked with a person who did not have a diagnosis of schizophrenia (yet), but who you thought should have one?

- Can you describe why a diagnosis of schizophrenia made sense to you in that instance?

6. What has it been like for you to work with people who have a diagnosis of schizophrenia?

- Is this different from work with people with other mental health problems?

7. In your experience, what is the most helpful way of telling people they have schizophrenia?

-Based on your experience, how do people tend to respond to being diagnosed with schizophrenia?

-How do you make sense of these responses?

8. What do you consider to be, generally speaking, the best way of helping people with a schizophrenia diagnosis?

- Are there people who form an exception to this and why?

9. Has the way you think about schizophrenia changed over time?

- Do you feel your ideas have been shaped more through your training, or through practice?

- Over the course of your training and career, have you encountered different ideas about schizophrenia? What were these ideas? What are your thoughts about them?

Appendix Q – End of Study Summary Report for Ethics Committees

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