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Correspondence

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Salience dysregulation syndrome: a patient's view

Jim van Os has done us a service in bringing to attention the unsatisfactory nature of the concept of schizophrenia.[1] He argues that the scientific evidence for the category is weak and that the present label is highly stigmatised. He suggests that a new concept – salience dysregulation syndrome – be assessed with regard to its clinical utility and patient acceptability. (Compare with Sato.[2])

The term 'syndrome' is understandable as a constellation of symptoms rather than just one symptom. For example, I am susceptible to schizophrenia but have never heard voices and never hallucinated. That does not mean I cannot be diagnosed as having schizophrenia.[3] My problem as a patient is that the terms 'salience' and 'dysregulation' are unfamiliar medical jargon.

If an alternative concept is to replace the construct 'schizophrenia', it needs to be acceptable to patients; that, van Os and I agree on. It needs to be understandable, neutral in tone, and without any misleading negative associations. Salience dysregulation syndrome meets the latter two criteria, but not the first. To me and other patients with whom I have discussed van Os's proposal, the suggested terminology is obscure.

1 van Os J. A salience dysregulation syndrome. *Br J Psychiatry* 2009; **194**: 101–3.

2 Sato M. Renaming schizophrenia. A Japanese perspective. *World Psychiatry* 2006; **5**: 53–5.

3 George B. Schizophrenia. A personal account. *Social Work Today* 1987; **18**: 12–3.

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Author's reply: I agree that the term 'salience' may appear obscure at first glance but let us analyse the issue in more detail. The term 'schizophrenia' is stigma-inducing because it confusingly and mystifyingly refers to a disease that is characterised by a 'split mind' – a psychological state that the public cannot personally relate to. This is different from, for example, depression, as virtually every member of the public knows that depression is about a negative emotional state that they themselves may also experience on a daily basis, albeit to a lesser degree. Say we were to call schizophrenia 'reality distortion syndrome' or 'integration dysregulation syndrome'. Although the meaning of the words would certainly be clear to the general public, the problem is that these names may paradoxically also result in stigma because the people cannot relate to a universal psychological function of 'reality' or 'integration'. How long will people talk to somebody at a party who 'cannot see reality' or is 'not integrated'? In other words, I do not think that it is the degree of immediate and easy recognition that is important for a new name for schizophrenia, but (a) the potential of the new name to teach the general public about the experiences we call psychotic, based on (b) a scientifically valid model and (c) an aspect of psychological experience that everybody can relate to. The reality is that this is never going to be easy and cannot be solved by an appealing name alone. Salience is about how internal or external stimuli can become attention-grabbing and how this, if it is not willed, can lead to perplexing experiences that result in a search for an explanation that we subsequently call delusions. There may be some explaining to do, but maybe not an impossible message to convey.

In conclusion, I feel it is not so much important whether or not a new name is immediately clear to everybody, but whether it has got potential to make people recognise it as relating to an aspect of psychological experience that is universal. Salience may be a vehicle to teach the general public about the experiences we call psychotic. The second issue is that it may be important to move on from criticising the term schizophrenia to systematically proposing alternatives. The reason that the cogent scientific reasoning by people such as Herman van Praag,[1] Mary Boyle,[2] Richard Bentall[3] and Ian Brockington,[4] and many others did not have an impact on DSM–IV and ICD–10 may be because an alternative was never proposed. This is why I started with an alternative, not just a criticism of the term schizophrenia.

1 van Praag HM. About the impossible concept of schizophrenia. *Compr Psychiatry* 1976; **17**: 481–97.

2 Boyle M. *Schizophrenia: A Scientific Delusion?* Routledge, 1990.

3 Bentall RP, Jackson HF, Pilgrim D. (1988) Abandoning the concept of 'schizophrenia': some implications of validity arguments for psychological research into psychotic phenomena. *Br J Clin Psychol* 1988; **27**: 303–24.

4 Brockington I. Schizophrenia: yesterday's concept. *Eur Psychiatry* 1992; **7**: 203–7.

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Immigration and borderline personality disorder

The study by Pascual *et al*[1] is interesting and shows a lot of effort by the researchers, who reviewed thousands of cases despite the limitations of research methodology. However, I wonder what prompted the authors to think that immigration could be a risk factor for borderline personality disorder?

Unlike functional illnesses such as depression and schizophrenia, which can develop at any age and can have lots of predisposing factors, personality disorders develop during the early years of childhood and adolescence with most of the personality traits well established by adulthood.

Most of the immigrant groups in this study[1] are from low- and middle-income countries and it is not surprising that fewer people from this group were diagnosed with borderline personality disorder as compared with the indigenous population. We know that the prevalence of personality disorders is greater in high-income/Western countries.[2]

If we look at the features and diagnostic criteria for personality disorders, using either DSM–IV or ICD–10, we broadly see two main factors at the base of most of the symptoms: poor coping mechanisms and maladaptive behaviours. Factors commonly seen in Western/ high-income countries which contribute to such traits