

REVIEW ARTICLE

# Main Debates on the Management of Mental Illness: 1990-2020.

## A narrative review

Paulann GRECH <sup>1</sup>  and Reuben GRECH <sup>2</sup>

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<sup>1</sup> Department of Mental Health, Faculty of Health Sciences, University of Malta, Msida, Malta

<sup>2</sup> Medical Imaging Department, Mater Dei Hospital, Msida, Malta

### Correspondence

Paulann Grech

Department of Mental Health, Faculty of Health Sciences, University of Malta

Postal Address: Department of Mental Health, Faculty of Health Sciences, Room 51, Block A, Level 1, Mater Dei Hospital, Msida, Malta

Email: [paulanngrech@gmail.com](mailto:paulanngrech@gmail.com)

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**Introduction:** Since the introduction of newer psychiatric treatment methods during the 20th century, debates about the effectiveness and appropriateness of such treatment have featured. Advocates among those who promote the sociological, biological, psychological and spiritual understandings of mental illness and its treatment have created tangible tensions with those supporting each position commonly indulging in fierce attacks on the others.

**Aims:** The aim of this paper is to explore some of the principal treatment viewpoints that characterized the late 20th century (1990 onwards) and early 21st century (up till 2020). Ultimately, these debates guided contemporary practice towards a biopsychosocial-spiritual view of mental illness in a move towards holistic person-centered care, which nowadays is the advocated model in many health systems.

**Methods:** The authors undertook a literature search in order to locate published debates on psychiatric treatment during the late 20th century (1990 onwards) and the early 21st century (up till 2020).

**Results:** Debates emerging from 36 articles were identified and synthesized in a narrative review.

**Conclusions:** Exploring the various debates that have characterized mental health care serves as a crucial reflective exercise on what needs to be considered when claiming that contemporary care is based on a holistic and person-centered approach. In this view, critical evaluation is needed so as to avoid repeating the coercive and inhumane mistakes of the past.

**Keywords:** psychiatric treatment, critical psychiatry, medical model, individual-community model, person-centered approach

## Introduction

Advances in psychopharmacology and psychological therapies have been significant in improving the quality of life for some of the individuals who were experiencing symptoms synonymous to a mental illness (Choo et al., 2019). A multitude of clinical trials as well as convincing patient narratives have shown that mainstream psychiatric treatment – mainly drugs such as antipsychotics, antidepressants, anxiolytics and mood stabilizers – conferred a significant beneficial effect (see Reid, 2013; Leucht et al., 2012; Jamison, 1995). Medical guidelines, such as those issued by the National Institute for Health and Care Excellence (NICE), recommend and guide the use of

drugs and psychological therapies in most of the psychiatric conditions found in the *DSM* and *ICD*. Furthermore, there seems to be a consensus on the move towards less restrictive community care, with hospitalization being left as a last resort (WHO, 2018). Still psychiatric treatment has been characterized by a history of opposing views, theories, debates and a confusing and non-conclusive ocean of clinical trials.

The aim of this paper is to explore some of the historical perceptions related to the treatment of symptoms that mental illness causes. We have divided the paper into two parts – the first segment (1) concerns opposing views on the appropriateness and effectiveness of psychiatric treatment. The second section (2) explores some contemporary alternative person-centered and holistic approaches in mental health. This paper includes debates linked to the Medical Model as well as those that characterize the Individual-Community Model. The terms used by the authors during the different debates shall reflect those used by the particular source that is being cited in that specific debate. However, the authors of this paper lean towards the Individual-Community Model as a theoretical framework.

## Methods

The authors undertook a literature search in order to locate published debates related to psychiatric treatment that featured during the late 20th century (1990 onwards) and early 21st century (up till 2020). This was an era characterized by the introduction of new psychiatric medication and methods of treatment – some of which are still in use in contemporary psychiatry and mental health care. Key terms were identified by carrying out focussed and expanded searches on the MeSH On Demand interface. The key terms used were *mental disorders*, *survivor movement*, *mental health treatment*, *mental illness management*, *psychiatric medication*, *critical psychiatry*, *mental illness debates* and *mental health services*. These were then entered in selected databases, namely The Cochrane Central Register of Controlled Trials, EMBASE, MEDLINE and PsycINFO. We used filters and limiters accordingly to limit the results in terms of relevance and the time limit of the search was set to 1990–2020. The Critical Psychiatry Network article database was also searched manually to identify additional sources. These debates emerging from the final 36 articles that were filtered from the results according to set inclusion and exclusion criteria were then synthesized in a journey, which shall be presented in the following section.

## Results and Discussion

### The Effectiveness of Psychiatric Drugs

#### *A Crusade Against Drug Effectiveness*

During the mid-late 20th century, the introduction of psychiatric drugs marked what is often considered to be the new era for mental health. Bestowed with the title “pharmacological revolution”, it stood as a remarkable technological achievement and played a role in downsizing psychiatric asylums. In his review of the “psychiatric revolution”, Scull (2010) noted that the introduction of these new medications was not the only factor responsible for the demise of the traditionally oppressive psychiatric system. Others such as fiscal considerations and deliberate adjustments in state policy significantly drove deinstitutionalization. Psychiatric drugs, however, completely changed the practice of psychiatry as well as its status in society. Chlorpromazine and similar antipsychotic drug types were the first ones to be introduced, providing psychiatry with a treatment type that was simple to administer although it was ultimately responsible for iatrogenic illness. The phenothiazines lessened the severity of symptomatology and provided relief for some patients. In this view, these drugs received an eager welcome by professionals and patients especially when considering that before their introduction, psychiatric treatment had merely consisted of social restraint. Quickly, these drugs became a major source of profit for the industry notoriously termed “Big Pharma” which had discovered the benefits linked to the marketing of drugs that had the potential to change people’s moods (Scull, 2010). The introduction of Prozac was another milestone in the revolution and such a successful one that it changed many perspectives on mental disorder. However, the new drugs were not magical cures that provided a permanent solution to psychiatric problems. Gradually, doctors and other reviewers raised critical stances which birthed the emergence of widespread debates in the medical and social world.

The effectiveness of psychotropic drugs has been one of the most controversial areas over the years. Figures like Moncrieff (2013a, 2013b), Healy (2016) and Breggin (2006) have presented research that contradicts the promoted and evidenced effectiveness of commonly used drug types in psychiatry. Bracken (2012) stated that the evidence that psychiatric drugs function through a placebo effect cannot be contradicted. The author cited two meta-analyses, carried out by Turner and Kirsch, which have concluded that in 80% of the cases explored through individual studies, the improvement seen was very much comparable to that experienced by participants in placebo groups.

Double (2001) acknowledged that reviewing the literature about the effectiveness of psychiatric drugs remains a complex task due to the vast number of studies, different methodologies, and the need to appraise the quality of studies located. Several researchers have endeavored to undertake this process. Double (2001) described how in 1974, Morris and Beck were amongst the first to synthesize the data available by looking at trials published over a 14-year period. Their results showed that in more than half the cases, antidepressants were more effective than placebo. However, Bracken and Thomas (2004) theorized that the main mode of antidepressants' function is through the generation of hope. Since hope may be generated through alternative, less invasive methods, the authors postulated that discourse in mental health should feature issues such as hope, meaning, and values.

Kirsch (2011) reported that a significant difference between placebo and antidepressants is only witnessed in very severe cases of depression. In 1995, Moncrieff had also explored the effectiveness of the mood stabilizer lithium and expressed dissatisfaction due to her observation that results obtained are neither clear nor significantly demonstrated:

Differences between lithium and placebo treatment in several of the trials were probably attributable to discontinuation of lithium increasing the likelihood of manic relapse in placebo treated subjects. In the largest prospective trial, treatment conditions for the two groups were not comparable (Prien et al., 1973), and in another prospective trial only a select group of subjects were considered and results were presented in a way which impedes a proper understanding of the data. (Moncrieff, 1995, p. 571)

In a later trial by Bowden et al. (2000), which is considered as the largest clinical trial in this area, there was no significant difference in the participating individuals' response rates to lithium and to a placebo. In addition to the fact that the effectiveness of drugs has been placed under scrutiny, Evans (2004) also cautioned about the inadequacy of the double-blind methodology that is used in many clinical trials. This is due to several factors. For instance, participating individuals may note that the placebo tablets that they have been taking taste differently from the usual medication. Active medication may also be characterized by side effects that distinguish it from a placebo. Treatment that is regularly used to manage psychosis has also been under scrutiny. In 1998, Thornley and Adams explored the effectiveness of drugs used in the treatment of schizophrenia over the past 50 years. A total of 2000 trials were included in the review. The findings showed that the overall quality of the studies was poor and this may have led to inaccurate overly positive results in relation to the effectiveness of these drugs (Thornley & Adams, 1998). Thomas and Bracken (1999) discussed how rather than viewing drugs as the medical cure, it is advisable to talk and describe the experience of psychosis during a dialogue with the person:

It is often assumed that in irrational states, such as psychosis, there are constraints on a person's ability to act autonomously. This view may be used as justification by a psychiatrist to disregard the patient's treatment preferences. But situations in which a person is irrational in all aspects of thought, will and action are rare. (p. 328)

In 2010, Irving Kirsch compiled his research around this area in a book called *Antidepressants: The Emperor's New Drugs*. His views were similar to that of other leading figures, and he outlined his concern that the drug industry may be a culprit in promoting the pseudo-effectiveness of psychiatric drugs:

The drug effect seemed rather small to us, considering that these medications had been heralded as a revolution in the treatment of depression – blockbuster drugs that have been prescribed to hundreds of millions of patients, with annual sales totalling billions of pounds. (Kirsch, 2010, p.11)

This concern echoes the thoughts of critical psychiatrists in relation to the evidence base underlying the biomedical model. Notably, Kirsch did not shun the use of medical treatment as he realized that this may be of use in particular cases.

In 2013, Peter Breggin, another prominent figure in the effort to limit the abusive prescription of psychotropic drugs, presented a guided system to psychiatric drug withdrawal in his book: *Psychiatric Drug Withdrawal*:

*A Guide for Prescribers, Therapists, Patients and Their Families.* The aim of the book was to offer guidelines to assist the prescriber and therapist in helping individuals to withdraw from psychiatric drugs. Breggin (2013) elucidated how research revealed the danger of long-term exposure to psychiatric drugs due to their relation to obesity, diabetes, heart disease, abnormal movements, and a detrimental effect on the quality of life. These dangers have led Breggin to advise that the best option in modern psychiatry is to encourage withdrawal from psychiatric drugs.

### *Counter Arguments*

Despite the convincing nature of these arguments, which indeed research supports, it is interesting to note that the opposing side of the argument is similarly based on a multitude of studies which seemingly demonstrate the effectiveness of the commonly used drug types in psychiatry (Kohler et al., 2014; Maher et al., 2011; Vieta et al., 2010). Leading figures in this area, such as Leucht et al. (2012) have cautioned against the crusade opposing psychiatric drugs due to the consequences that it can have on patients: “In this context, many psychiatric drugs not only improve the acute episode but also prevent further episodes. Patients with severe, recurrent depression might have 20 episodes in their lifetime, which could be reduced by medication to 10” (p. 103). They argued that controversy about medication effectiveness can result in patients who decide to discontinue their medication – this can easily be a catalyst to suicide or relapse. These researchers devoted considerable effort to proving the effectiveness of psychiatric drugs through various randomized controlled trials and meta-analysis. One particular study involved an overview of 94 meta-analyses in an attempt to demonstrate that the degree of psychiatric drug effectiveness compares well to other drugs used in general medicine (Leucht et al., 2012). In an echo of Moncrieff and Cohen’s views (2009), it has to be said that whilst the consequence of stopping effective medication is acknowledged, it may be equally harmful to mislead individuals into believing that psychiatric drugs are overly effective or can provide a cure. In a chain of publications, Moncrieff distinguished between a *drug centered model* and a *disease centered model* (See Moncrieff, 2013b; Moncrieff, 2010; Moncrieff, 2009). She described how the drug centered model may be more empowering as it views psychiatric medication as an extrinsic substance that mainly works through producing cognitive and emotional suppression:

The disease centred model is captured by the idea that drugs act by correcting or partially correcting an underlying biological lesion, analogous to the way the action of most drugs in general medicine is understood. In contrast the drug centred model suggests that drugs work by inducing their own abnormal brain states. (Moncrieff, 2013b, p. 296)

This suppressed state may be beneficial in certain circumstances, such as in acute psychotic states. However, in an example brought by Moncrieff and Cohen (2009), once the acute episode has been controlled, the person may then decide to stop antipsychotic drug use and instead engage in alternative forms of maintenance treatments (p. 151). This is different and probably more beneficial than adherence to the disease centered model which assumes that psychiatric medication is physiologically corrective.

These debates on treatment models raged throughout the process of deinstitutionalization that saw the downsizing of several psychiatric hospitals in the late 20<sup>th</sup> century. In Western industrialized nations, the number and size of asylums had increased dramatically over the nineteenth century. These were planned to be humane places where patients could live comfortably whilst receiving treatment, as opposed to the prison-like asylums of the past – a push towards “moral care”. Despite these principles, these asylums became overworked, non-therapeutic, geographically isolated, and uncaring to patients (Wright, 1997). By the turn of the century, rising admissions had resulted in severe congestion, posing several challenges for mental facilities. Funding was often withdrawn, particularly during economic downturns and warfare. Patients were starved to death at asylums because of terrible living circumstances, lack of cleanliness, overcrowding, ill-treatment, and abuse (Fakhoury & Priebe, 2007). Although asylum numbers continued to rise until the 1950s, the first community-based solutions were proposed and provisionally adopted as early as the 1920s and 1930s. Supportive housing as well as specialized teams were among the community services that emerged. Although deinstitutionalization benefited the vast majority of patients, it is not without flaws. Some argued that it was a failed step in the right direction, claiming that contemporary society suffers from a “re-institutionalization” issue (Fakhoury & Priebe, 2007). Thus, deinstitutionalization left some homeless or without care (Eisenberg & Guttmacher, 2010), resulting in the formation of “psychiatric communities” instead of a successful move towards “community psychiatry”.

## Contemporary Alternative Approaches

### *The Psychosis Example*

Dutch psychiatrist Marius Romme has been one of the early 21<sup>st</sup> century pioneers in developing alternative approaches which view symptoms characteristic of psychosis as meaningful, as phenomena that must be explored and understood rather than suppressed or disguised. He posited that accepting and coping with auditory hallucinations – a symptom that is often attributed to a state of psychosis – can enhance one’s quality of life in a better way than simply ignoring the voices (Romme, 2009). Indeed, as a result of his empirical work, he concluded that struggling against the voices only causes them to become stronger. In his publications, such as *Accepting Voices* (Romme & Escher, 1993) and *Making Sense of Voices* (Romme & Escher, 2000), as well as others published in the journal *Mind*, Romme described an innovative approach involving the extraction of meaning from psychosis. This may be painful for some people due to the realization and facing of difficulties. Professionals aim to facilitate this process for the person and guide them by acknowledging that the individual’s explanatory framework may be different from that of the professional’s as seen in the following service user narrative presented by Romme (2007):

Every time, when I was released from hospital and went back to normal life, there was this reduction of possibilities in my life. Nearly ten years later, I was not interested in anything anymore. It took me quite a while to see the relationship between my voices and my life, so I realized that when I was angry and did not express my anger the voices became angry at me. (section 3-4)

This approach is synonymous with the *Hearing Voices Network*, originally founded by Marius Romme in the Netherlands, which has been developed in other countries such as the UK. These movements are concerned with the normalization rather than the medicalization of the psychotic experience and are active in raising awareness about alternative ways of coping: “So, accepting is not concretely accepting everything of the voices as they are perceived, but is the beginning of looking differently at them; normalising them; being with many others who hear voices; creating hope and opening personal possibilities” (Romme, 2007, section 3).

The debate surrounding “medicalization” and “normalization” highlights two different concepts that manifest during the management of mental illness. Medicalization is commonly associated with the medical model, having the primary target of attaching a medical label to the presenting symptoms of mental illness and the provision of medications to eliminate them. In this view, success is measured by the level of symptom reduction. Contrastingly, normalization is concerned with ameliorating the individual’s quality of life, something not necessarily brought about by the elimination of symptoms. Instead, the overarching philosophy is a focus on personal satisfaction and quality of life. Rather than singling out the symptoms as “abnormalities” that need to be medicated, they are viewed as normal variations within the human population that one can learn to manage and live with using various ways. Whilst medication is not excluded from a “normalization” point of view, it is perceived as a means to enhance quality of life rather than as a permanent end (solution) to a medical problem. On the plus side, normalization has been considered as more enabling and a positive move towards humane care as well as the lessening of stigma by increasing mental health awareness. However, it has also led to a rise in misdiagnoses, misperceptions and higher prevalence rates as a result of people mischaracterizing typical feelings like sadness as depression (Frances, 2010).

Psychologist Rufus May advocates a similar approach to Romme’s; May’s main focus is to introduce alternatives to medical labeling and management of psychiatric symptoms, particularly, psychosis. In the documentary *The Doctor who Hears Voices*, produced by Regan (2008), May provided an overview of the “voice dialogue technique” that can be used to engage in a therapeutic relationship with a person who is experiencing auditory command hallucinations. He explained that “supporting people in a force-free way through their spiritual and emotional crises takes resources. Not more resources, just a different emphasis in how they are used.” (May, 2008, paragraph 11). Such symptoms would normally probably merit an admission to a psychiatric hospital were a mainstream approach to be applied:

In terms of care for psychosis, force is at the centre of the state’s approach to treatment. Neuroleptic drug treatment (under the pseudonym anti-psychotic medication) is presented as the treatment of choice for people with unusual beliefs, behaviours or experiences; Treatment of choice for those who have no choice. Most first admissions to psychiatric hospitals are characterised by a ‘try this medication or if you don’t we’ll have to force you to take it’ approach. Maybe we should rename mental health services ‘psychiatric drugging services!’ (May, 2005, paragraph 18)

Earlier in the 20<sup>th</sup> century, this phenomenon of medical force had been explored in depth by Parsons (1951) in his book “*The Social System*”. His main claim was that social control is present in all social relations – this also

applies to the doctor-patient relationship during which the doctor acts as an agent of control. In this relationship, the patient assumes the “sick role” and is expected to follow the doctor’s guidance to recover. This becomes even more accentuated when an illness is more severe and the individual needs to rely on the doctor’s expertise to a higher degree. Since the faking or mismanagement of illnesses can be detrimental to society, the doctor has been given the societal power to be in control of this “deviance” (sickness) and has a duty to assist the patient to return to normality. However, the move towards the 21<sup>st</sup> century brought with it greater access to information, especially through the virtual world. This has led to individuals who are more knowledgeable and who are ready to challenge medical authority, viewing the doctor-patient relationship as a “provider-consumer alliance” rather than as a sacred bond.

Other leading figures in this area include Sandra Escher (see Escher et al., 2003) who has worked with Marius Romme to produce various publications, Patricia Deegan (see Deegan, 2007), Tamsin Knight (See Knight, 2013) and Peter Lehmann (see Stastny & Lehmann, 2007).

### *The Recovery Movement and the Person-Centered Approach*

Bracken (2012) noted that these controversial approaches may bring about changes in the way that psychiatrists and other professionals are trained since it seems as if the only skill needed to engage with those experiencing mental health challenges is the willingness to listen and to respect the individual. One of the most powerful contemporary movements, which may be viewed as lying midway between the critical psychiatry model and conventional psychiatry one is the *Recovery Model*. Warner (2010) explained that this refers to a focus on self-determination, empowerment, and interpersonal support – a focus on collaboration rather than adherence and compliance. Lieberman et al. (2008) added that educational programs, as well as structures such as user-run services and peer support, are important concepts in the recovery model, which constitutes a bio-psycho-social-spiritual model of care. As stated by Deegan (1996):

The recovery model is rooted in the simple yet profound realization that people who have been diagnosed with a mental illness are human beings. Those of us who have been diagnosed are not objects to be acted upon. We are fully human subjects who can act and in acting, change our situation. We are human beings, and we can speak for ourselves. We have a voice and can learn to use it. We have the right to be heard and listened to. We can become self-determining. We can take a stand toward what is distressing to us and need not be passive victims of an illness. We can become experts in our own journey of recovery. (p. 92)

Ultimately, this is the spirit within the contemporary move towards a person-centered approach, which focuses on offering care that is personalized, coordinated and enabling whilst treating those seeking care (and their loved ones) as individuals and as equal partners (The Health Foundation, 2014). In the 1940s, Carl R. Rogers pioneered the “person-centered approach” in the United States through his realization that the practitioner’s attitudes were just as crucial as his skills (Kirschenbaum, 2020). In this view, therapeutic interactions are potentially successful if the practitioner is able to really embrace the client in the moment, enter the client’s frame of reference, and express an empathetic acceptance to the patient. Rogers used the phrase “client-centered” to define his approach to therapeutic interactions as a result of his intensive attention on the client’s inner experience. His book “Client-Centered Therapy” (Rogers, 1951) bore a significant impact on the helping professions. In one of his writings, he stated that when a practitioner conveys unconditional positive regard and empathic understanding to the extent that the client feels the professional’s genuineness, the “necessary and sufficient circumstances for therapeutic personality change” are present (Rogers, 1957, p. 95). Although Rogers used the term “client-centered”, “person-centered” was considered by others as a better phrase to characterize the therapeutic connection, which is, after all, a relationship between two people and not just one (Kirschenbaum, 2020). After Rogers’ death in 1987, the person-centered movement continued to spread over the globe and has now become one of the leading approaches to mental health treatment in some countries, particularly in Europe. This approach, and the rise of the recovery movement, provided alternatives to the Medical Model, leading the way to a more humane management of mental illness.

## Strengths and Limitations

Whilst quality assurance efforts were employed during the design stage of this narrative account, a number of strengths and limitations characterized the process. The main strengths identified entail the robustness of the search strategy for locating literature on the topic, the critical evaluation of the resulting documents, and the inclusion

of debates emerging from different professional and philosophical viewpoints. Although search keywords were selected to target a wide range of potential articles emerging from different disciplines, it is acknowledged that other potentially important keywords may have been invariably omitted. Finally, whilst the 30-year time span selected was a vital period in the development of contemporary mental health services, important changes that took place during the 1950's could have added further perspective to the debates.

## Conclusion, Implications and Future Directions

On reflection, it appears as if the alternative approaches to biomedical psychiatry that have just been described may add an interesting tangent to the range of psychiatric services and treatment options available in the 21<sup>st</sup> century. However, a paucity seems to exist in the empirical evidence-base related to a number of these approaches, especially when compared to mainstream treatment options such as pharmacotherapy and psychotherapy. This journey through the history of “modern” psychiatric treatment highlights the multifaceted characteristics of mental health and its illnesses, with explanations and treatments lying on a spectrum that features social explanations, biological ones, psychological understandings, and spiritual beliefs. In view of all these considerations, selecting appropriate treatment options depends on feasibility and meaningfulness and not simply on effectiveness and availability. Conclusively, whilst many service providers and health carers claim that their practice stands based on a holistic and person-centered approach, this may not always be the case. This is where the debates and theories that have been explored in the paper may serve as a reflective exercise on the historical debates on mental health care, in a bid to facilitate a critical evaluation of contemporary practice.

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Paulann Grech: conceptualization, design, methodology, investigation, project administration, data management, formal analysis, interpretation, writing original draft, writing review and editing.

Reuben Grech: conceptualization, design, methodology, investigation, formal analysis, interpretation, writing original draft, writing review and editing.

All authors gave final approval of the version to be published and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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The authors have no conflicts of interest to disclose.

### Ethical statement

This manuscript is the authors' original work.

Human participants have been not involved in this study.

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### ORCID

Paulann GRECH  <https://orcid.org/0000-0001-5485-0893>

Reuben GRECH  <https://orcid.org/0000-0002-3518-5880>

## References

- Bowden, C., Calabrese, J. R., McElroy, S. L., Gyulai, L., Wassef, A., Petty, F., Pope Jr., H. G., Chou, J. C.-Y., Keck Jr., P. E., Rhodes, L. J., Swann, A. C., Hirschfeld, R. M. A., & Wozniak, P. J. (2000). A randomized, placebo-controlled 12-month trial of divalproex and lithium in treatment of outpatients with bipolar I disorder. *Archives of General Psychiatry*, 57(5), 481–489. <https://doi.org/10.1001/archpsyc.57.5.481>
- Bracken, P. (2012). Psychiatric power: A personal view. *Irish Journal of Psychological Medicine*, 29(1), 55–58. <https://doi.org/10.1017/S0790966700017638>
- Bracken, P., & Thomas, P. (2004). Hope. *Open Mind*, 130. <https://www.criticalpsychiatry.co.uk/wp-content/uploads/docs/hope-p-bracken-p-thomas-mind.pdf>
- Breggin, P. R. (2006). Intoxication anosognosia: The spellbinding effect of psychiatric drugs. *Ethical Human Psychology and Psychiatry*, 8(3), 201–215. <https://doi.org/10.1891/ehppij-v8i3a003>
- Breggin, P. R. (2013). *Psychiatric drug withdrawal: A guide for prescribers, therapists, patients, and their families*. Springer.
- Choo, C. C., Chew, P. K. H., Ho, C. S., & Ho, R. C. (2019). Quality of life in patients with a major mental disorder in Singapore. *Frontiers in Psychiatry*, 9, 727. <https://doi.org/10.3389/fpsy.2018.00727>
- Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 91–97. <https://doi.org/10.1037/h0101301>
- Deegan, P. E. (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatric Rehabilitation Journal*, 31(1), 62–69. <https://doi.org/10.2975/31.1.2007.62.69>
- Double, D. B. (2001). Integrating critical psychiatry into psychiatric training. In: C. Newnes, G. Holmes, & C. Dunn (Eds.), *This is madness too: Critical perspectives on mental health services* (1st ed., pp 23–34). PCCS Books.
- Eisenberg, L., & Guttmacher, L. B. (2010). Were we all asleep at the switch? A personal reminiscence of psychiatry from 1940 to 2010. *Acta Psychiatrica Scandinavica*, 122(2), 89–102. <https://doi.org/10.1111/j.1600-0447.2010.01544.x>
- Escher, S., Delespaul, P., Romme, M., Buiks, A., & Van Os, J. (2003). Coping defence and depression in adolescents hearing voices. *Journal of Mental Health*, 12(1), 91–99. <https://doi.org/10.1080/09638230021000058>
- Evans, D. (2004). *Placebo: Mind over matter in modern medicine*. Oxford University Press.
- Fakhoury, W., & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: Major changes in the provision of mental healthcare. *Psychiatry*, 6(8), 313–316. <https://doi.org/10.1016/j.mppsy.2007.05.008>
- Frances, A. (2010, April 9). Psychiatric diagnosis gone wild: The “epidemic” of childhood bipolar disorder. *Psychiatric Times*. <http://www.psychiatrictimes.com/articles/psychiatric-diagnosis-gone-wild-epidemic-childhood-bipolar-disorder>
- Healy, D. (2016). *Psychiatric drugs explained*. Elsevier.
- Jamison, K. (1995). *An unquiet mind*. Vintage Books.
- Kirsch, I. (2010). The Emperor’s new drugs: Exploding the antidepressant myth. The Random House Group.
- Kirsch, I. (2011). Antidepressants and the placebo response. *Epidemiology and Psychiatric Sciences*, 18(4), 318–322. <https://doi.org/10.1017/S1121189X00000282>
- Kirschenbaum, H. (2020). The History of the person-centred approach. *The Person-Centred Journal*, 25(1–2).
- Knight, T. (2013). *Beyond Belief: Alternative ways of working with delusions, obsessions and unusual experiences*. Peter Lehmann Publishing.
- Kohler, S., Gaus, S., & Bschor, T. (2014). The challenge of treatment in bipolar depression: Evidence from clinical guidelines, treatment recommendations and complex treatment situations. *Pharmacopsychiatry*, 47(2), 53–59. <https://doi.org/10.1055/s-0033-1364004>
- Leucht, S., Hierl, S., Kissling, W., Dold, M., & Davis, J. M. (2012). Putting the efficacy of psychiatric and general medicine medication into perspective: Review of meta-analyses. *British Journal of Psychiatry*, 200(2), 97–106. <https://doi.org/10.1192/bjp.bp.111.096594>
- Lieberman, J. A., Drake, R. E., Sederer, L. I., Belger, A., Keefe, R., Perkins, D., & Stroup, S. (2008). Science and recovery in schizophrenia. *Psychiatric Services*, 59(5), 487–496. <https://doi.org/10.1176/appi.ps.59.5.487>
- Maher, A. R., Maglione, M., Bagley, S., Suttorp, M., Hu, J.-H., Ewing, B., Whang, Z., Timmer, M., Sultzer, D., & Shekelle, P. G. (2011). Efficacy and comparative effectiveness of atypical antipsychotic medications for off-label uses in adults: A systematic review and meta-analysis. *Jama*, 306(12), 1359–1369. <https://doi.org/10.1001/jama.2011.1360>
- May, R. (2008, April 22). Rufus May - Compassion not compulsion. *Rufusmay.com*. <https://rufusmay.com/2008/04/22/compassion-not-compulsion/>
- Moncrieff, J. (1995). Lithium revisited: A Re-examination of the placebo-controlled trials of lithium prophylaxis in manic-depressive disorder. *British Journal of Psychiatry*, 167(5), 569–573. <https://doi.org/10.1192/bjp.167.5.569>
- Moncrieff, J. (2009). A critique of the dopamine hypothesis of schizophrenia and psychosis. *Harvard Review of Psychiatry*, 17(3), 214–225. <https://doi.org/10.1080/10673220902979896>
- Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory & Health*, 8, 370–382. <https://doi.org/10.1057/sth.2009.11>
- Moncrieff, J. (2013a, August 13). Long-term antipsychotics: Making sense of the evidence in the light of the Dutch follow-up study. *Mad in America*. <https://www.madinamerica.com/2013/08/long-term-antipsychotics-making-sense-of-the-evidence-in-the-light-of-the-dutch-follow-up-study/>
- Moncrieff, J. (2013b, November 21). Models of drug action. *Joanna Moncrieff*. <https://joannamoncrieff.com/2013/11/21/models-of-drug-action/>
- Moncrieff, J., & Cohen, D. (2009). How do psychiatric drugs work? *British Medical Journal*, 338, b1963. <https://doi.org/10.1136/bmj.b1963>
- Parsons T. (1951). *The Social System*. Routledge & Kegan Paul.
- Regan, L. (Director). (2008). *The doctor who hears voices* [Film].
- Reid, I. (2013). Are antidepressants overprescribed? No. *British Medical Journal*, 346, f190. <https://doi.org/10.1136/bmj.f190>

- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95–103.  
<https://doi.org/10.1037/h0045357>
- Romme, M. (2014). *Recovering from voices by changing your relationship*. Retrieved March 30, 2022 from <http://hearingvoicesnetworkireland.ie/wp-content/uploads/2014/12/4.pdf>
- Romme, M., & Escher, S. (1993). *Accepting voices*. Mind Publications.
- Romme, M., & Escher, S. (2000). *Making sense of voices*. Mind Publications.
- Romme, M., Escher, S., Dillon, J., Corstens, D., & Morris, M. (2009). *Living with voices: 50 stories of recovery*. PCCS Books in association with Birmingham City University.
- Scull, A. (2010). A Psychiatric Revolution. *The Lancet*, 375(9722), 1246–1247.  
[https://doi.org/10.1016/S0140-6736\(10\)60532-6](https://doi.org/10.1016/S0140-6736(10)60532-6)
- Stastny, P., & Lehmann, P. (Ed.) (2007). *Alternatives beyond psychiatry*. Peter Lehmann Publishing.
- The Health Foundation. (2014). *Person-centred care made simple: What everyone should know about person-centred care*. The Health Foundation.  
<https://www.health.org.uk/publications/person-centred-care-made-simple>
- Thomas, P., & Bracken, P. (1999). The value of advocacy: Putting ethics into practice. *Psychiatric Bulletin*, 23(6), 327–329.  
<https://doi.org/10.1192/pb.23.6.327>
- Thornley, B., & Adams, C. (1998). Content and quality of 2000 controlled trials in schizophrenia over 50 years. *British Medical Journal*, 317, 1181.  
<https://doi.org/10.1136/bmj.317.7167.1181>
- Vieta, E., Locklear, J., Günther, O., Ekman, M., Miltenburger, C., Chatterton, M. L. P., Åström, M., & Paulsson, B. (2010). Treatment options for bipolar depression: A systematic review of randomized, controlled trials. *Journal of Clinical Psychopharmacology*, 30(5), 579–590.  
<https://doi.org/10.1097/JCP.0b013e3181f15849>
- Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist*, 34(1), 3–5.  
<https://doi.org/10.1192/pb.bp.109.025643>
- WHO (2018). *Mental health: strengthening our response*.  
<https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>
- Wright, D. (1997). Getting out of the asylum: Understanding the confinement of the insane in the nineteenth century. *Social History of Medicine*, 10(1), 137–155.  
<https://doi.org/10.1093/shm/10.1.137>