

The Meteoric Rise of Mental Illness in America and Implications for Other Countries

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Abstract

Over the last 20-30 years, proponents of the medical model have hypothesized that mental illness is the result of a “chemical imbalance” in the brain (i.e., neurological atrophy, Breggin, 2011). In spite of the fact that no scientific evidence exists to support this hypothesis, the medical model’s claim that mental illness is the result of neurological malfunctioning has been widely disseminated by the pharmaceutical industry and by the medical community, in general, across the western world (Breggin, 2006; Healy, 2015). As a direct result of the widespread acceptance of the chemical imbalance hypothesis, millions of men, women, and children are prescribed daily doses of dangerous and addictive psychiatric drugs for a plethora of mental illnesses that, just a generation ago, were unheard of (Baughman & Hovey, 2006). This paper will challenge the current medical model’s definition of mental illness, will offer a theoretically sound alternative to psychiatric drug treatment, and will explore in depth the cultural, economic, historical, ideological, and social correlates that can be intrinsically linked to the meteoric rise in psychiatric illness across much of the western world.

Keywords: mental illness, psychiatric illness, psychiatric diagnoses, rise in psychiatric illness

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Introduction

Throughout much of the western world, proponents of the “chemical imbalance” hypothesis have insisted that mental illness is the direct result of the biological malfunctioning of the human brain. Furthermore, proponents of this hypothesis have postulated that in order to control behaviors defined as “mental illness,” psychiatric drugs must be administered on a daily basis, and in many cases, it is recommended that these drugs be continued throughout the life course (Baughman & Hovey, 2006; Stolzer, 2008). While it is certain that psychiatric drugs can decrease specific symptoms, the fact remains that psychiatric drugs do nothing, whatsoever, to cure any abnormality present in the human brain (Healy, 2015; Szasz, 2011). According to the scientific literature, psychiatric drugs “work” by altering the chemical structure of the brain by overstimulating specific neurotransmitters, or by preventing the brain from manufacturing its own specific neurotransmitters such as norepinephrine, serotonin, and dopamine (Breggin & Cohen, 1999). According to Breggin (2006), every classification of psychiatric drug causes brain dysfunction and has been found to negatively impact emotional responsivity, self-awareness, and overall cognitive functioning.

Historically speaking, treating human behaviors such as sadness, worry, lethargy, disinterest, anxiety, accelerated activity level, and short attention spans with psychiatric drugs is a relatively recent phenomenon. Throughout the

majority of human history, behaviors that have recently been classified as symptoms of “mental illness” were considered a normative part of the human life course (Stolzer, 2013). From the 1600s until the 1960s, psychiatric illness was extremely rare in America. Furthermore, throughout the vast majority of American history, prescribing psychiatric drugs to control behaviors such as defiance, sadness, worry, messiness, fidgeting, high activity levels, and inattentiveness in pediatric populations was unheard of (Stolzer, 2013). In spite of published data that documents that the diagnosis of mental illness is problematic as there exists no cognitive, metabolic, or any other type of empirical test that can establish the existence of mental illness, Americans continue to consume 80% of the psychiatric drugs distributed worldwide (Baughman & Hovey, 2006; Healy, 2015; Zhong et al., 2013).

According to published data, Attention Deficit Hyperactivity Disorder (ADHD) is the most commonly diagnosed psychiatric illness in child populations in America (Baughman & Hovey, 2006; Stolzer, 2013). However, depression diagnoses are increasing significantly as data demonstrates that since the 1990s, there has been a five-to sixfold increase in the number of American children being prescribed anti-depressant drugs (Leckman & King, 2007). Dramatic increases in all types of psychiatric drug prescriptions have been documented in pediatric populations across the United States (Baughman & Hovey, 2006), and it is not only older children and adolescents that are being prescribed psychiatric drugs. In 2000, Zito et al., provided data which documented that from 1991 to 1995, 2 to 4-year-old American children had a 2.2-fold increase in the rates of antidepressant prescriptions.

The ever increasing rates of antidepressant drug prescriptions in child and adolescent populations is concerning, as the Food and Drug Administration (FDA), as well as Canadian, British, and other European regulators, have all issued public health warnings advising the public that antidepressant drugs significantly increase suicide (and other forms of self-harming behaviors) in child and adolescent populations (Gibbons, Hur, Bhaumik, & Mann, 2006; Physician's Desk Reference Manual [PDR], 2009). Also deeply disturbing, is the fact that there exists no longitudinal data concerning the long-term effects of psychiatric drugs in child and adolescent populations, nor has the efficacy of any psychiatric drug been established in controlled studies (Baughman & Hovey, 2006; Novartis Pharmaceutical Corporation, 2013). In addition, the mode of therapeutic action of psychiatric drugs is unknown at this time, and the safety of long-term use of psychiatric drugs in child and adolescent populations has yet to be determined (Breggin, 2002; Novartis Pharmaceutical Corporation, 2013; PDR, 2009).

Perhaps most disturbing is our collective lack of knowledge concerning the effects that various psychiatric drugs have on the developing Central Nervous System in child and adolescent populations. However, in the limited number of rat studies that are available, significant negative effects have been reported. Ansorge, Zhou, Lira, Hen, and Gingrich (2004) found that inhibition of the serotonin transporter brought on by antidepressant drugs resulted in significant reduction in exploratory activity and major impairment in other forms of sensory perception. Other studies have concluded that early exposure to antidepressant drugs has been significantly correlated with decreased locomotor activity, sexual pathology, visual atrophy, and decreases in natural serotonin production in adulthood (Maciag, Coppinger, & Paul, 2006; Maciag, Simpson, et al., 2006).

Over the last two to three decades, there has been a profound shift in Americans' perception of 1. what constitutes a mental illness and 2. the cause of mental illness. For the vast majority of human existence, the thoughts, feelings and behaviors defined recently by the American Psychiatric Association (APA) as indicators of mental illness, were collectively viewed as normative developmental processes across every culture and across historical time (Szasz, 2011). Worry, sadness, vacillating moods, anxiety, lethargy, defiance, disinterest, inattention in the young, fidgeting, running, jumping, and climbing were not collectively viewed as abnormal behaviors caused by brain

dysfunction, but were in fact viewed as integral components of the life course (Breggin & Cohen, 1999). Over a relatively short time period, Americans' perceptions regarding mental illness have changed dramatically as data now indicates that 88% of Americans believe that mental illness can be attributed to biological causes (e.g., a chemical imbalance in the brain) and can be successfully treated with psychiatric drugs (Blumner & Marcus, 2009; Szasz, 1995).

This recent paradigm shift has resulted in millions of Americans being labeled as mentally ill, and has been the impetus for the soaring amounts of psychiatric drugs that are consumed by Americans on a daily basis. Depression is now the most common mental illness in adults in America and accounts for approximately 83.1 billion dollars a year in medical care (Blumner & Marcus, 2009; Greenberg et al., 2003), and for 50 billion dollars a year in workplace related costs (DeRubeis, Siegle, & Hollon, 2008). Prescriptions for antidepressant drugs have tripled in America in the last decade, while prescriptions for psychiatric drugs used to treat anxiety, bi-polar, ADHD, and a myriad of other psychiatric illnesses in infants, children, and adults are increasing exponentially across America (Blumner & Marcus, 2009; Breggin, 2011).

Research has indicated that numerous factors are associated with the changes detected in American belief systems regarding what constitutes a mental illness, and what causes a mental illness. The widespread advertising of psychiatric drugs on television, in hospitals, and in physician offices; the pharmaceutical industry funding the majority of mental health research; the economic alliance that exists between the medical community and the pharmaceutical industry; schools referring children for psychiatric evaluation; public schools receiving federal monies for each child diagnosed with a psychiatric illness; a reduction in insurance coverage for "talk therapy"; physician willingness to prescribe psychiatric drugs; and the widespread acceptance of the "chemical imbalance" hypothesis by the medical community and the general public have all been advanced as possible contributing factors related to the meteoric rise of psychiatric diagnoses in America (Baughman & Hovey, 2006; Breggin, 2011; Stolzer, 2013).

With regard to Europe, mental disorders such as ADHD, depression, and anxiety are often classified together with neurological conditions such as dementia, epilepsy, and multiple sclerosis and are referred to as "neuropsychiatric disorders" or "disorders of the brain," although there is no scientific evidence indicating that any mental disorder is the result of neurological dysfunction (Breggin, 2011; Wittchen et al., 2011). While it is estimated that approximately 13% of global disease can be attributed to disorders of the brain, these global estimations are hypothesized to be of little use for European countries as these types of estimates are heavily skewed by diverse worldwide mental health tracking statistics and the divergent health care systems found across the globe (Wittchen et al., 2011).

Data indicates that in Europe, approximately 38.2% of the adult population suffers from a mental illness. The most frequently diagnosed mental illnesses are anxiety, depression, somatoform and substance abuse disorders (Andlin-Sobocki, Olesen, Wittchen, & Jonsson, 2005; Wittchen et al., 2011). However, it must be noted that in spite of the high numbers of Europeans estimated to suffer from mental illness, only 26% of those thought to be mentally ill receive treatment. Furthermore, among those who did seek treatment, there was a long delay between onset of symptoms and first treatment contact. It has been hypothesized that the disparity between treatment need and actual treatment in European countries is due to 1. underutilization of mental health services 2. under-recognition of mental illness and 3. lack of resources (Andlin-Sobocki et al., 2005; Wittchen et al., 2011).

The trend towards increased psychiatric drug prescriptions in child and adolescent populations has been increasing in many parts of Europe (Hsia & MacLennan, 2009). Currently, about 5% of European children and adolescents have been diagnosed with ADHD and approximately 3% have been diagnosed with Conduct Disorder (Wittchen et al., 2011). According to published data, prevalence rates for both ADHD and conduct disorder are four times higher in younger males. However, data indicates that in adolescence, ADHD diagnosis rates decrease, while the diagnosis rates for conduct disorder significantly increase (Wittchen et al., 2011). While data clearly indicates a significant increase in child and adolescent psychiatric drug prescriptions across many European countries, the fact remains that most psychiatric drugs are not licensed for use in child and adolescent populations (Hsia & MacLennan, 2009).

Numerous studies have reported a significant increase in psychiatric drug prescriptions in child and adolescent populations across continental Europe (Wittchen et al., 2011; Zito et al., 2000). This trend towards prescribing children and adolescents psychiatric medications has been attributed to the accepted custom of treating children displaying ADHD behavioral patterns with stimulant drugs such as methylphenidate, in spite of the fact that the safety and efficacy of psychiatric drugs in child and adolescent populations is unknown at this time (Novartis Pharmaceutical Corporation, 2013; Zito et al., 2000).

Each year, approximately 38% of the total European population suffers from at least one mental disorder (approximately 164.7 million people). Over the past 20 years, a significant increase in psychiatric disorders in child and adult populations has been reported across Europe (Wittchen et al., 2011). The most frequently diagnosed mental disorders across all age groups are: anxiety disorders (69.1 million), depression (30.3 million), somatoform disorders (20.4 million), and alcoholism (14.6 million). In childhood and adolescence, males receive significantly more psychiatric diagnoses and psychiatric drug prescriptions, while in adulthood, women are more likely to be diagnosed with a psychiatric disorder, and, as a result, are prescribed psychiatric drugs more often than men (Wittchen et al., 2011).

Zito et al. (2008) compared cross national prevalence rates of psychiatric drug prescriptions in children, ages birth through 19 years of age. Zito and colleague's population based analysis found that psychiatric drug prescriptions in child populations were significantly higher in the United States than in the Netherlands and in Germany. In addition, antidepressants and stimulant drug prescriptions were three times greater in the United States than in Germany or the Netherlands, while antipsychotic drug prescriptions were 2.2 times greater in the United States. Zito et al. (2008) concluded that significant differences in psychiatric drug treatment are detectable between youth in America and parts of Western Europe. Differences in laws regarding direct to consumer drug advertising, governmental regulatory restrictions, divergent reimbursement policies, differing diagnostic classifications, and cultural differences regarding psychiatric drugs, were hypothesized to account for the differences (Zito et al., 2008).

The European study of epidemiology of mental disorders has indicated that there is a significant unmet need for treatment of mental illness in Europe (Gaebel et al., 2014). According to the European study of epidemiology of mental disorders (ESEMeD), only 23% of European participants reported seeking treatment for mental health issues over the course of their lifetime. In order to increase mental health assessment and treatment, Gaebel and colleagues (2014) suggest the implementation of the following: 1. establish trust between the service user and provider 2. provide high quality accessible services 3. decrease the stigma attached to mental illness and 4. increase overall public trust of the mental health system (Gaebel et al., 2014).

Although researchers have indicated a high level of unmet needs in the area of mental health assessment and treatment in Europe, the fact remains that numerous studies have reported a significant increase in both psychiatric diagnoses and psychiatric drug prescriptions in child, adolescent, and adult populations in many parts of Europe over the last two decades (Hsia & MacLennan, 2009; Wittchen & Jacobi, 2005).

Method

The data gathered for this paper utilizes the assumptions of the scientific community (i.e., the ideas, rules, and approaches employed by social scientists). Specifically, the data contained in this paper is based on the assumption that knowledge accumulates and that authentic scientific endeavor is built upon past research findings. This paper is meant to show familiarity with the subject matter and to establish credibility by using cutting edge peer-reviewed journal articles as sources. This paper elucidates prior research and builds upon that research to come to specific conclusions. One of the goals of this paper is to integrate and synthesize what is known about the western mental health paradigm and to elaborate on the previous findings. This paper establishes what is known about mental illness (and the treatment of mental illness) and then summarizes these findings. Also provided are alternatives to the current medical model as it relates to mental illness, along with ideas for future directions in the area of mental health with the goal of furthering our collective understanding of emotional and behavioral problems. This paper is cumulative in nature as it builds upon what other scholars in the field have concluded and then takes that knowledge a step further by creating links to an ever changing body of scientific work. The historical piece of the paper is meant to illustrate how the perception of mental illness has changed over time. This paper is a methodological review as it integrates past peer-reviewed research, in order to add to our collective knowledge base.

Discussion

Mental Illness

For decades, scholars have been challenging the central tenets of the medical model as it relates to mental illness. Rosenhan (1973) suggested that many myths surround the constructs of mental health. One of the most prevalent myths is that the “normal” among us are measurably “sane.” Rosenhan goes on to state that there is absolutely no way to empirically establish “saneness” in human populations, and if one cannot establish what constitutes a “sane” individual, how is it possible to label an individual as “psychiatrically disturbed”? Another common myth is that physicians can accurately diagnose a specific mental disorder and that appropriate and efficacious treatment measures will be prescribed (Rosenhan, 1973; Stolzer, 2008).

Szasz has been arguing, for over 50 years, that the medical model’s definition of mental illness is intrinsically and compendiously flawed (Szasz, 1960). According to Szasz (1960), “mental illness” is not an illness at all, but rather, is the result of problems with living that, in most instances, can be traced to early childhood experiences and/or the failure to adjust to particular social situations and societal expectations. Numerous scientists from various fields have challenged the current medical model’s definition of mental illness and have asserted that current therapeutic practice dehumanizes the individual by 1. convincing the individual that their brain is pathological (i.e., chemically imbalanced), 2. by prescribing dangerous and addictive psychiatric drugs, and 3. by refusing to look into the root cause of emotional pain and suffering (Baughman & Hovey, 2006; Breggin, 2011; Stolzer, 2013; Szasz, 2011).

According to [Szasz \(1995\)](#), “Few people realize that diagnoses are not diseases. Diseases are demonstrable anatomical or physiological lesions that may occur naturally or be caused by human agents” (p. 36). Psychiatry is quantifiably distinct from all other branches of medicine as diseases are not discovered, but rather, are voted into existence, and are then included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM; [Baughman & Hovey, 2006](#)). Conversely, psychiatric diseases can be voted out of existence, as was the case when homosexuality was voted out of existence by members of The American Psychiatric Association (APA) in 1978 ([Szasz, 2011](#)). Interestingly, the vast majority of mental illnesses included in the DSM are 20th century inventions (however, it should be noted that the most current, DSM V, includes several new diseases that were voted into existence in the 21st century). None of the diseases outlined in any edition of the DSM can be confirmed by any diagnostic test, nor are there any metabolic, neurological, anatomical, or physiologic markers associated with any mental illness ([Szasz, 2011](#)).

According to the DSM-IV-TR ([American Psychiatric Association, 2000](#)), “These diagnostic criteria and the DSM-IV-TR classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field” (p. xxxvii). This statement clearly acknowledges the fact that behaviors put forth as valid and reliable indicators of mental illness are subjective and are open to a wide range of interpretations, and are subject to a change in formulation as members of the APA see fit. It is also interesting to note that after each disorder outlined in the DSM-IV-TR, a disclaimer is attached to each specific disorder stating, “There are no laboratory tests, neurological assessments, or other assessments that have been established as diagnostic” (DSM-IV-TR; [American Psychiatric Association, 2000](#), pp. 88-89). Stated plainly, this disclaimer illustrates that none of the disorders outlined in the DSM can be definitively established. This is clearly outside of the realm of medical science, as in all medical fields, empirical, quantifiable data must exist before a disease can be confirmed, and before efficacious treatment can commence ([Baughman & Hovey, 2006](#)).

According to [Szasz \(2011\)](#), diseases of the body have a root cause such as infection, virus, or bacteria, and these diseases can often times be stopped (or stalled) by dealing with the root cause of the disease. In the same way, persons said to have “mental diseases” cannot be cured by psychiatric drugs, but must be treated with respect, dignity and caring in order to understand and deal with the suffering they are experiencing so that they can learn to overcome the obstacles that are preventing them from living a full and joyous life. At the present time, the best that the medical model can do is to offer band-aid solutions in the form of addictive and brain altering psychiatric drugs. While psychiatric drugs may blunt emotional pain and suffering, the fact remains that these drugs do nothing, whatsoever, to alleviate the root cause of mental suffering ([Breggin, 2011](#); [Szasz, 2011](#)).

The Medicalization of the Human Condition

If we look back to the 1950s Diagnostic and Statistical Manual of Mental Disorders (DSM-I) and compare it to each expanded edition of the latest DSM published, it becomes apparent that we are witnessing the large-scale medicalization of the human condition. Across every culture, across every historical time period, and across every mammalian species, life is full of ebbs and flows, of joy and pain, of sorrow and contentment, of disappointment and hope, of death and rebirth. This is life and there is no escape from it ([Szasz, 1994](#)). However, over the last 20-30 years, Americans have become immersed in a medical paradigm that has decreed that worry, sadness, loneliness, isolation, anxiety, inattention, social ineptitude, messiness, rebellion, and running, jumping, and climbing (as well as a myriad of other behaviors and/or feelings) are valid indicators of psychopathology. We, in our advanced scientific societies, have forgotten the wisdom of our ancestors who knew unequivocally that at

each stage, human development is fraught with unique challenges that are not inherently psychopathological, but are indeed normative life experiences (Stolzer, 2011).

Beginning in infancy, in early childhood, young mammals are quantitatively distinct from their elders. They run, jump and climb. They are rambunctious, messy, disorganized, full of exuberance and energy, and are renowned for their incredibly short attention spans. Throughout all of history, these traits, though exasperating and trying for adults, were considered normative across every culture (Kahn & Kellert, 2002). However, as a direct result of the medicalization of human development, these traits are now generally accepted as indicators of a mental disorder referred to as “Attention Deficit Hyperactivity Disorder”, and we, in our advanced scientific societies, have accepted, without question, the legitimacy of the diagnosis.

As human development continues, powerful hormones are released and we go through a time of life called adolescence. Everything is changing; our bodies, our brains, our feelings, our perceptions (Gurian, 2001). Across all cultures, across all mammals, and across all historical time, adolescence has been a turbulent, intense, and vociferous life stage (Bjorklund & Pellegrini, 2002). Sadness, worry, anxiety, insecurity, rebellion, loneliness, social isolation, hormonal fluctuations, and general unhappiness are experienced by many individuals as they traverse through the emotional disequilibrium of the adolescent stage (Keshi, Basavarajappa, & Nik, 2013). As we grow into young adulthood, further pressure is experienced as we seek to make a life for ourselves independent of our parents or other loved ones. Anxiety, depression, worry, role-switching and vacillating moods abound in this stage of human development as we strive to make decisions that have the potential to impact the entirety of our lives (Bjorklund & Pellegrini, 2002). Finances, intimate relationships, academic problems, career concerns, goal setting, and familial pressure have been found to be major sources of stress among young adults (Aselton, 2012). Rather than providing adolescents and young adults with the various tools needed to cope with the ever increasing demands of modern society, medical associations across the western world, and the pharmaceutical industry have been instrumental in disseminating the myth that feelings, thoughts and behaviors experienced during these unique developmental stages are indicators of mental illness (Breggin, 2011; Stolzer, 2011).

Middle adulthood and late adulthood are also unique stages of human development that include their own specific problems. Hormonal changes, anxiety, worry, illness, disability, bereavement, social isolation, empty nest syndrome, relationship problems, sexual concerns, and pondering the meaning of life have all been reported as significant issues affecting adults 50 years of age and older (Shahidi et al., 2011). According to published scientific data, older adults experience a wide range of emotional problems, including depression and anxiety, which are normal parts of the ageing process, and should be treated with person-centered care that empowers individuals rather than convinces them that they are “psychiatrically disturbed” (Beary, 2013; Szasz, 2011).

Clearly, the medical community, the pharmaceutical industry, and scholars from various fields have been quite successful at convincing the American public that what were once considered normative life experiences are now to be defined as valid and reliable indicators of mental illness. This success can be verified by the fact that 70% of Americans take at least one prescription drug every day, while 50% of Americans take two or more prescription drugs on a daily basis. Antidepressant drugs are now the most commonly prescribed drugs in America, as depression diagnoses have dramatically increased among all age groups (Blumner & Marcus, 2009; Zhong et al., 2013). Similar trends have been identified in many parts of Western Europe (Hsia & MacLennan, 2009).

Szasz (2003) categorically states that we can define all manner of human problems as psychiatric diseases, if we so wish. We can delude ourselves into believing that psychiatric drugs cure mental suffering. However, according

to Szasz (2003), solutions exist for mathematical problems and for some medical problems. For mental suffering, there is no solution, only the ability to learn to cope. Only after we admit that psychiatric drugs cure nothing, can we move on to a more humane and scientific paradigm that actually does have the potential to alleviate those behaviors recently defined as indicators of “mental illness,” across the various stages of human development (Szasz, 2003).

The Risks Associated With Psychiatric Drugs

In America, the overwhelming majority of individuals diagnosed as “mentally ill” (i.e., diagnosed with depression, anxiety, bi-polar disorder, ADHD, etc.) are prescribed daily doses of psychiatric drugs (Baughman & Hovey, 2006; Breggin, 2011; Stolzer, 2013). While it is certainly easier to medicate individuals experiencing psychological problems than it is to address the multifarious factors associated with psychological problems, the fact remains that there are serious side effects associated with every classification of psychiatric drug (Breggin, 2011; Stolzer, 2013). Following is a brief summation of the effects associated with some of the most commonly prescribed psychiatric drugs in America.

Stimulants

Stimulant drugs are most often prescribed to alleviate symptoms of ADHD, which include fidgeting, impulsivity, jumping, climbing, messiness, and inattention (DSM-IV-TR, American Psychiatric Association, 2000). The vast majority of stimulant drugs are prescribed to American boys ages 2-20 years of age (Baughman & Hovey, 2006). This category of psychiatric drugs includes Ritalin, Adderall and Dexedrine (as well as other stimulant drugs). Stimulant drugs are highly addictive and have been found to cause insomnia, seizures, agitation, irritability, nervousness, confusion, visual disturbances, aggression, disorientation, personality changes, apathy, social isolation, depression, and suicidal feelings (Breggin & Cohen, 1999; Novartis Pharmaceutical Corporation, 2013; Stolzer, 2013). Additional side effects caused by stimulant drugs include violent psychoses, mania, paranoia, lack of empathy toward others, lack of impulse control, acute anxiety, abnormal thoughts, feelings, and behaviors and acute psychoses (Breggin & Cohen, 1999; PDR, 2009). The literature also indicates that all classifications of stimulant drugs impair growth, including brain growth (Breggin & Cohen, 1999; PDR, 2009).

Antidepressants

Antidepressant drugs are most commonly prescribed to treat the thoughts, feelings and behaviors associated with depression, which include loss of interest in social activities, sadness, crying, lethargy, and sleep disturbances (DSM-IV-TR, American Psychiatric Association, 2000). Despite the documented lack of efficacy associated with antidepressant drugs, Americans continue to lead the world in antidepressant prescription rates (Barber, Barrett, Gallop, Rynn, & Rickels, 2012; Healy, 2009). Some of the most commonly prescribed antidepressants include Prozac, Zoloft, Cymbalta, Paxil and Luvox (Breggin, 2011). According to Breggin and Cohen (1999), antidepressants often times produce side effects similar to stimulant drugs which include: anxiety, agitation, manic psychoses, violence, loss of impulse control, obsessive suicidal thoughts, flat affect, loss of empathy, delirium, and brain abnormalities. In addition, the Physician's Desk Reference (PDR, 2009) lists the following side effects for antidepressant drugs: hypomania, hallucinations, personality disorder, agitation, psychosis, hostility, emotional instability, paranoia, confusion, and delusions. (Note that none of the side effects associated with antidepressants are listed as “rare” by the PDR, but rather are listed as “frequent” or “infrequent”). According to the literature, antidepressants can also cause extreme or bizarre thoughts or actions, obsessive violent thoughts, and accelerated agitation (Healy, 2003; Preda, MacLean, Mazure, & Bowers, 2001).

Benzodiazepines/Non-Benzodiazepines

The benzodiazepine classification of psychiatric drugs is most commonly prescribed to treat anxiety, panic attacks, and insomnia (PDR, 2009). Some of the most commonly prescribed benzodiazepines are Ativan, Klonopin, Serax, and Xanax (Breggin, 2011). Side effects associated with this classification of drugs include acute anxiety, cognitive impairment, poor judgment, feelings of disassociation with self or others, and amnesia (PDR, 2009). In addition, benzodiazepines often times cause very serious withdrawal reactions between therapeutic doses and the vast majority of individuals prescribed these drugs experience extreme difficulty when discontinuing these medications (Breggin & Cohen, 1999). Other effects of benzodiazepines include: confusion, paranoia, mania, agitation, rage, unprovoked aggression, uncontrollable violence, depression, suicide, impulsivity, and acute depersonalization (Breggin & Cohen, 1999; PDR, 2009; Rouve et al., 2011).

Antipsychotics

Antipsychotic drugs are prescribed to treat numerous psychiatric conditions, including, but not limited to, psychosis, depression and anxiety (PDR, 2009). Antipsychotic drugs are prescribed at increasing rates in America in child, adolescent, and adult populations, in spite of the fact that published international data has demonstrated that this classification of drugs have low efficacy rates and can cause irreversible atrophy of the brain (Breggin, 2011; Krystal et al., 2011). The mass marketing for antipsychotic drugs such as: Abilify, Seroquel, Zyprexa, Haldol, and Risperidone continues to increase in America, although no data exists to support the pharmaceutical industry's claim that these drugs are efficacious when used at therapeutic doses (Breggin, 2011; Krystal et al., 2011). Side effects of antipsychotic drugs include neurological impairment (that may or may not be permanent), sedation, agitation, bizarre behaviors, apathy, emotional flatness, and severe withdrawal symptoms, as antipsychotic drugs directly impact the frontal lobes and basal ganglia which are responsible for the highest functions of the human brain (Breggin & Cohen, 1999; PDR, 2009; Stolzer, 2013).

Mood Stabilizers

This category of psychiatric drugs includes: Depakene, Depakote, Dilantin, and Lyrica. In addition to being prescribed to treat various psychiatric disorders, Lyrica is now being mass marketed across America as an effective way to treat shingles and diabetic nerve pain (Breggin, 2011). Side effects associated with mood stabilizers include apathy, cognitive dysfunction, abnormal behavior, confusion, delirium, chronic and long term mental impairment, nightmares, anxiety, hallucinations, depression, double vision, visual disturbances, suicide, homicidal ideation and homicidal actions (Longo, 2010; Moore, Glenmullen, & Furberg, 2010; PDR, 2009).

The literature suggests that the serious side effects associated with psychiatric drugs are most likely to occur 1. after the initial exposure to the drug, 2. with changes in the dosage of the drug, 3. when adding another psychiatric drug, and/or, 4. when attempting to discontinue a psychiatric drug (Breggin, 2011). According to Breggin (2006) and Szasz (2011), all psychiatric classifications of drugs chemically alter the structure of the human brain, and in doing so, can cause irreversible damage to the brain. Interestingly, in spite of the multitude of scientific studies, and over 20 international drug regulatory warnings that have documented the serious side effects associated with psychiatric drugs, including but not limited to, personality changes, violent psychosis, hallucinations, homicidal ideation, and suicide, Americans (who comprise 5% of the world's total population) consume 80% of all psychiatric drugs distributed worldwide (Baughman & Hovey, 2006; PDR, 2009; Stolzer, 2013; Zhong et al., 2013).

Alternatives to Psychiatric Drugs

Since the beginning of the human race, human beings have experienced sadness, worry, lethargy, anxiety, hopelessness, heightened activity levels, isolation, fidgetiness, inattentiveness and a myriad of other feelings and behaviors that have, in the 20th century, been defined by western psychiatry as reliable and valid indicators of “mental illness” (Breggin & Cohen, 1999). For the first time in recorded human history, integral emotional and developmental human experiences are medicalized, and indeed have recently been operationally defined as indicators of a “chemical imbalance” in the brain (Szasz, 2011). In spite of the widespread acceptance of the chemical imbalance hypothesis, the definition of mental illness as a brain disorder (i.e., a chemical imbalance in the brain) has been refuted by numerous scientists and by the DSM IV-TR as, at present time, there is no way to measure specific neurotransmitter levels in the human brain (Baughman & Hovey, 2006; Breggin, 2011; DSM-IV-TR, American Psychiatric Association, 2000). If at some future date it becomes possible to confirm neurotransmitter imbalance, there would be absolutely no need for the term “mental illness” as this type of physiological impairment would fall under the general auspices of neurological diseases (Szasz, 2011). However, at the present time, this is clearly not the case as “mental illness” is not confirmed by neurological evidence, but is in fact confirmed using subjective diagnostic criteria put forth by the APA in the form of the most current DSM (i.e., a checklist of behaviors, thoughts, and/or feelings) (Breggin, 2011).

Although the vast majority of physicians, pharmaceutical representatives, and the general public insist that mental illness is the result of biological causes (i.e., the chemical imbalance hypothesis), not one shred of scientific evidence exists to substantiate this claim (Baughman & Hovey, 2006; Breggin, 2011; Stolzer, 2013; Szasz, 2011).

Does human mental suffering exist? Of course, the answer is an unequivocal yes and it has existed throughout human history and across every culture of this, there can be no doubt (Breggin & Cohen, 1999). Are there times when human beings need help in overcoming the psychological obstacles they are facing? Are there times when human beings need help dealing with the problems of living or failing to adjust to social situations and/or societal expectations? Again, the answer is an unequivocal yes (Szasz, 1960). It is undeniably clear that psychosocial problems exist in the human species. No one is disputing this issue. What is being vehemently contested is, 1. the medical model’s operational definition of mental illness, 2. the origins of those behaviors defined as “mental illness”, and 3. the widespread use of dangerous and addictive psychiatric drugs used to control undesirable thoughts, feelings, and behaviors (Breggin, 2011; Stolzer, 2008).

Over the past 20 years, there have been numerous efforts across the public and private spheres to increase the acceptance of the chemical imbalance hypothesis and to advertise pharmacological treatment for those behaviors defined as mental illness (Blumner & Marcus, 2009). However, what has been grossly neglected is the effort to publicize the multitude of data that confirms that interpersonal talk therapy is a highly effective way to manage the thoughts, feelings, and behaviors that have been recently defined as indicators of mental illness. Although there are those with a vested interest in perpetuating the hypothesis that mental suffering is attributable to biological causes, and therefore, requires psychopharmacological intervention, decades of scientific data indicates that talk therapy is as effective, or more effective, than psychiatric drug treatment (Breggin & Cohen, 1999; de Girolamo, 1996; DeRubeis et al., 2008).

Breggin and Cohen (1999) have postulated that it is really pointless to compare talk therapy to the more accepted method of treating mental suffering with psychiatric drugs, as both the effects and the documented outcomes vary dramatically. According to published data, psychiatric drugs “work” by blunting the emotional center of the brain

so that it becomes impossible to access the feelings and thoughts that are at the root of mental suffering. Conversely, person-centered therapy allows the person experiencing problems to contact and accept long-buried experiences, and to learn constructive ways to cope with the problems that they are experiencing (Breggin & Cohen, 1999; Stolzer, 2008). Numerous studies have demonstrated that interpersonal talk therapy is as effective (or more effective) than pharmacological treatment, does not have the short and long-term risks associated with pharmacological treatment, and it reduces the risk of relapse even when the individual has discontinued talk therapy intervention (DeRubeis et al., 2008).

While the stated goal of treating symptoms of mental illness with psychiatric drugs is symptom relief, it must be acknowledged that other effects are documented in the literature, such as demonstrable changes in the brain, specifically, the regulatory processes of the monoamine systems which significantly impacts the neurotransmitters serotonin, dopamine, and noradrenaline (DeRubeis et al., 2008). Changes in these specific neurotransmitter systems are known to cause major malfunctions in the brain, and the long-term effects of these changes on cognition, behavior, and social processing have not been established in clinical trials (Breggin, 2011; DeRubeis et al., 2008).

What has been documented in the scientific literature is that many individuals are 1. not aware of the various treatment options available for those behaviors and/or feelings now defined as “mental illness”, 2. not given any choice as to the various options available, and 3. not aware that interpersonal talk therapy has been found to be more effective than pharmacological intervention in treating the behaviors, thoughts and feelings that are associated with mental illness diagnoses (Saver, Van-Nguyen, Keppel, & Doescher, 2007).

Decades of published scientific data have demonstrated that interpersonal talk therapy is an effective way to manage the symptoms associated with human experiences, now defined as mental illness (DeRubeis et al., 2008; Miskovic et al., 2011). Although this form of treatment is rarely prescribed by medical practitioners, nor is it common knowledge among the general public that this type of therapy is highly effective, the fact remains that interpersonal talk therapy is associated with more favorable patient outcomes than is the more commonly accepted practice of psychiatric drug intervention (Breggin, 2011; de Girolamo, 1996; DeRubeis et al., 2008; Gottdiener & Haslam, 2002). Data has indicated that talk therapy is an effective way to manage the thoughts, feelings, and behaviors associated with a myriad of mental health diagnoses, including, but not limited to, anxiety, panic disorders, depression, bi-polar disorder and obsessive compulsive disorder (Breggin & Cohen, 1999; DeRubeis et al., 2008; Miskovic et al., 2011; Schwartz et al., 1996). Data also indicates that large amounts of rigorous, outdoor physical activity and being engaged in interesting activities significantly reduces, or eradicates, the symptoms associated with ADHD (DSM-IV-TR, American Psychiatric Association, 2000; Stolzer, 2011).

With regard to schizophrenia, researchers have documented that the majority of individuals diagnosed as schizophrenic respond more favorably to relational therapy than to psychiatric medications (Gottdiener & Haslam, 2002). Mosher and Burti's (1994) analysis concluded that for individuals diagnosed as schizophrenic, caring, interpersonal, empathetic, and non-coercive talk therapy was significantly more effective than traditional psychiatric drug therapy and/or hospitalization. In 1996, the World Health Organization (WHO) published data which demonstrated that for individuals diagnosed as schizophrenic, who resided in non-industrialized countries, familial concern and involvement was more effective than psychiatric drug treatment. This same study also concluded that psychiatric drugs have the potential to impede the recovery process, and that living in a highly developed industrialized country is a strong predictor that a patient will never fully recover from the disease of schizophrenia

(de Girolamo, 1996; Whitaker, 2004). Additional research funded by the National Institute of Mental Health (NIMH) concluded that schizophrenic patients who were treated with a placebo were less likely to be re-hospitalized than those patients who were treated with conventional psychiatric drugs (Whitaker, 2004).

Researchers have documented that talk therapy is highly effective because it provides the tools needed to modify thoughts, feelings, and behaviors, and it teaches individuals to question assumptions, learned habits, and the validity of psychiatric labels (Breggin & Cohen, 1999). In addition, interpersonal talk therapy empowers the individual by helping them to gradually face activities and/or thoughts that have been avoided in the past, and by providing new ways to perceive experiences (Keshi et al., 2013). Person-centered talk therapy is focused on providing life-long skills such as emphasizing that thoughts actually do affect behavior; that the individual has the power to control thought patterns; and basic cognitive strategies such as relaxation, meditation, and thought stopping. Although these skills take time to master, data indicates that these skills have been associated with an eradication of a plethora of psychiatric symptoms and a marked increase in life satisfaction and emotional well-being (Keshi et al., 2013; Lee et al., 2007; Szasz, 2011).

With regard to specific forms of talk therapy, Spinelli (2002) argues that, more than any other model, existential psychotherapy brings healing to those who are experiencing emotional distress. Spinelli postulates that symptoms of mental disorders are “direct expressions and consequences of the clients wider stance toward being” (p. 112). In direct contrast to the medical model, existential therapists do not consider it necessary to circumscribe or pathologize the patient’s symptoms. Rather, the existential therapist, together with the client, attempt to unmask and reflect upon the symptoms as intrinsically intertwined with the client’s wider way of being, and in reaching this heightened awareness, authentic healing can commence (Spinelli, 2002).

From the existential vantage point, thoughts, feelings, and behaviors are not indicators of mental illness, but are instead manifestations of the client’s interactions with relationships with the self, with others, and with the wider world in general (Spinelli, 2002). Choice, freedom, courage, and responsibility are inherently linked to emotional well-being (Van Deurzen, 2006). If we are to fully understand the complexities associated with emotional illness, we must first, according to the existential worldview, understand the fundamental processes that underlie emotional distress (Van Deurzen, 2006).

Existential psychotherapy can, and often does, take many forms, yet the root of existential psychotherapy is exploring and validating what is true for the client (Van Deurzen, 1999). The role of the existential therapist is not to provide psychiatric labels or explanations for the client, but to identify together, with the client, the specific problems that are part of the client’s world. The goal of existential therapy is to draw out, clarify, and put into perspective all of the issues that are causing emotional pain, guilt, and/or anxiety. The therapist’s role is to empower the client to accept and come to terms with the innate contradictions that exist in the world (Van Deurzen, 1999).

Another important component of the healing process in existential therapy is to work directly with the client in formulating goals and directions for the future, in spite of the paradoxes and tensions that exist in life (Van Deurzen, 1999). According to the existential worldview, psychiatric drugs and labels do not facilitate authentic healing. To achieve mental wellness, it is necessary for the client to “reclaim personal freedom and a willingness and ability to be open to the world and all its complexity. Authentic living with courage and in humility and learning to reflect for oneself and communicate effectively with others” is the nucleus of existential therapy and clearly distinguishes existential therapy from the reductionist and deterministic medical model that permeates western culture today (Van Deurzen, 1999, p. 13).

Although the pharmaceutical industry and the medical community continue to insist that psychiatric drugs are the most effective way to treat mental illness, the scientific literature continues to document that various forms of intensive, person-centered talk therapy in and of itself, is often times more efficacious than psychiatric drug treatment (Breggin, 2011; DeRubeis et al., 2008; Miskovic et al., 2011; Szasz, 1960; Whitaker, 2004).

Conclusion

Given the unprecedented, meteoric rise in psychiatric drug use in many western cultures, perhaps the time has come to collectively challenge 1. chemical imbalance hypothesis, 2. the scientific validity of the operational definitions of mental illness put forth by the latest edition of the DSM, and 3. the assumptions underlying the meteoric rise in psychiatric drug prescriptions in infant, child, adolescent, and adult populations across western cultures. Is there an alternative to labeling millions of individuals as “mentally ill” and prescribing a plethora of psychiatric drugs to alleviate thoughts, feelings, and behaviors that are, in the modern day era, defined by members of the medical community as symptoms of “mental illness”? Following are examples of ways to empower individuals, to decrease the use of dangerous and addictive psychiatric medications, and to redefine our collective perception of what constitutes a mental illness.

- Require that medical providers be trained in non-pharmacological treatment of the human condition (i.e., alternative ways to treat worry, sadness, anxiety, anger, heightened activity levels, etc.) (Stolzer, 2013).
- Demand that medical providers adhere to the doctrine of informed consent by requiring patients (or parents of patients) to read and sign a full disclosure of *all* of the side effects associated with the psychiatric drug(s) they are prescribing (including the side effects suicide, homicide, and unintended death) (Stolzer, 2013).
- Require physicians and other mental health care providers to inform their patients in writing that there is no way to confirm the existence of any mental illness (Szasz, 2011).
- Demand that the economic alliance that exists in America between the pharmaceutical industry and the medical community, be severed immediately (Stolzer, 2013).
- Inform the public that prayer, meditation, change in diet, exercise, contact with nature, and positive interpersonal relationships have all been significantly correlated with decreasing symptoms of mental illness (Breggin & Cohen, 1999; Thomas & Ashraf, 2011).
- Demand that factual and explicit warnings appear on all psychiatric prescription bottles (Stolzer, 2013).
- Demand empirical evidence to substantiate the chemical imbalance hypothesis (Szasz, 2011).
- Demand that the pharmaceutical industry be banned from funding mental illness research and scientific conferences that focus on the cause and/or treatment of mental illness (Stolzer, 2013).
- Require physicians to inform their patients (or parents of patients) in writing of the numerous, potentially life-threatening side effects associated with withdrawal from psychiatric drugs (Breggin, 2011; Breggin & Cohen, 1999).
- Require insurance companies to pay for extensive and long-term interpersonal talk therapy (Stolzer, 2013).
- Ban American policies that allow schools to profit economically from the psychiatric labeling of children and adolescents (Stolzer, 2013).

- Demand widespread advertising and public service announcements that inform the public that interpersonal talk therapy is as effective, or more effective, than psychiatric drug therapy when seeking to alleviate the symptoms associated with mental illness (Breggin & Cohen, 1999; Gottdiener & Haslam, 2002).
- Require physicians to inform their patients that interpersonal talk therapy and placebo pill intervention have been found to be as effective, or more effective, than psychiatric drug treatment (Breggin & Cohen, 1999; Healy, 2009).
- Inform individuals that they can act as agents of change and that they have the power to alter their behaviors, thoughts, and feelings without the use of psychiatric drugs (Laing, 1969).
- Establish official recognition of psychotherapists by the European commission and the European Parliament (Van Deurzen, 1996).
- Expand the scope of psychotherapy research across Europe (Van Deurzen, 1996).
- Increase psychotherapeutic work in relation to refugees from war-torn parts of the world who have suffered torture and other forms of physical and/or psychological oppression (Van Deurzen, 1996).
- Inform the public that psychiatric medications may impede the healing process by blocking access to the emotional processing centers in the brain (Breggin & Cohen, 1999).
- Understand that emotional suffering is an inevitable part of life. Sadness, worry, shame, anger, loneliness, anxiety, emotional numbness, guilt and so on, are normative parts of life's journey (Breggin & Cohen, 1999; Szasz, 1960).
- Understand and respect that the normative, developmental psychosocial processes associated with each stage of human development are not valid indicators of mental illness.
- Understand that "psychiatric drugs are not medications, they are foreign compounds, poisons, each with its greater or lesser potential to harm or kill" (Baughman & Hovey, 2006, p. 221).
- Expose the fact that 80% of psychiatric drugs distributed worldwide are prescribed to Americans (Baughman & Hovey, 2006).
- Enact laws which prohibit all school employees from "practicing medicine without a license by pushing psychiatric diagnoses and psychiatric drugs they are not qualified to discuss" (Baughman & Hovey, 2006, p. 221).
- Inform the public that "normalcy" is never achieved through the use of brain altering chemicals (i.e., psychiatric drugs; Breggin, 2002).

In light of the fact that no scientific evidence exists to support the hypothesis that mental illness is the result of a chemical imbalance in the brain (Healy, 2015; Szasz, 2011), scholars have postulated that in order to understand and cope with the multifarious thoughts, feelings and behaviors that are inherent in the human species, we must look to a more humane and holistic paradigm if our goal is to alleviate the symptoms defined as "mental illness." According to published data, labeling an individual as "mentally ill" and prescribing psychiatric drugs does nothing to increase the probability of mental wellness, but may in fact strip individuals of their self-efficacy by convincing them that their brains are biologically flawed (Breggin, 2011; Laing, 1982). According to researchers, psychiatric drugs have been found to delay the recovery process, to render the individual as a passive, non-entity during

treatment, and to significantly blunt the emotional processing centers of the brain (Breggin, 2011; Laing, 1969; Whitaker, 2004).

Conversely, interpersonal, patient-centered talk therapy is qualitatively and quantitatively distinct from psychiatric drug treatment as it has been found to empower the individual by 1. providing new and innovative ways in which to cope with and accept the problems of living, 2. by convincing the individual that they have the power to change thoughts, feelings and behaviors, and, 3. by instructing the individual that mental wellness can be achieved through determined, active, and passionate commitment to the healing process (Laing, 1982; Whitaker, 2004).

It is a distinct possibility that the recently constructed medical model of mental illness has blocked our collective understanding of the etiology of mental suffering and the recovery process in general by its dogmatic insistence on reductionist and deterministic hypotheses that perpetuate the assumption that mental illness is the result of a pathological brain (Laing, 1982). It is also a distinct possibility that anesthetizing emotional pain and other thoughts, feelings and behaviors that have been deemed as unacceptable, only hinders and prolongs authentic emotional healing (Laing, 1982; Stolzer, 2008). The time has come to challenge the medical model's definitions and accepted therapeutic practices, and to explore the possibility that compendious mental wellness is not achieved by the use of brain altering psychiatric drugs, but by intensive, empowering, person-centered talk therapy and by deep, authentic human relationships that can provide us the tools needed to successfully navigate this journey we call life.

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