Journal of Mental Health Counseling
Volume 31/Number 4/October 2009/Pages 283–308

PROFESSIONAL EXCHANGE

The Loss of Client Agency into the Psychopharmaceutical-Industrial Complex

Thomas L. Murray, Jr.

The psychopharmaceutical industrial complex (PPIC) and its adherence to the disease model pervades mainstream culture and greatly impacts psychotherapy. Consequently, the effects of the PPIC may have resulted in some psychiatric consumers adopting disease-model messages in ways similar to cult indoctrination. Consumer adoption of the disease model can create obstacles to treatment when hope is fundamental. In this article, I draw parallels between cult indoctrination and PPIC techniques and note similarities between cult members and consumers who are vulnerable to losing their identities to the PPIC. Suggestions for the profession of mental health counseling and those working with these consumers conclude the article.

More than $24 billion worth of antidepressants and antipsychotic drugs were dispensed in 2008—almost a 48-fold increase since 1986 (Pringle, 2006; Elias, 2009). Such expenditure would employ 240,000 psychotherapists earning an annual income of $100,000 to provide 6 million hours of psychotherapy averaging 25 client-hours a week. These figures do not include what would be possible using the additional revenue generated by the sales of antianxiety, hypnotic, and psychostimulant medications.

How has the disease model for emotional disorders become the dominant discourse causing so many people to use neuropharmaceuticals as the best defense against emotional and behavioral symptoms? The purpose of this article is to offer an explanation, although not an absolute one, to account for how clients come to accept the disease model of emotional distress and to offer suggestions for working with them.

Thomas L. Murray, Jr. is affiliated with the University of North Carolina School of the Arts in Winston-Salem. Correspondence concerning this article should be addressed to Thomas L. Murray, Jr., Ph.D., Director of Counseling and Disability Services, University of North Carolina School of the Arts, 1533 South Main Street, Winston-Salem, NC 27127. E-mail: murrayt@uncsa.edu.

Several assumptions guide the examination of this question:

1. Psychiatry is part of a larger system, the psychopharmaceutical-industrial complex (PPIC), which is primarily driven by capitalism.
2. Power dynamics are inherent in the doctor-consumer relationship.
3. The many subsystems of the PPIC are motivated by good intentions, but their behavior and its consequences may not reflect the goodness of those intentions.
4. Under certain conditions consumers can adopt explanations for their diagnoses that make them impervious to other explanations in ways similar to cult indoctrination.

In using these assumptions to answer the question, I will describe the PPIC, the parallel between the PPIC and cult-like phenomena, and how cult susceptibility factors mirror characteristics of psychiatric consumers. I conclude this paper with suggestions on how to reconstruct the loss of self that is a product of the PPIC.

THE PSYCHOPHARMACEUTICAL-INDUSTRIAL COMPLEX

Duhl and Cummings (1987) identified the emergence of a mental health complex that has parallels with the military-industrial complex described by President Eisenhower (1960) and the medical-industrial complex identified by Relman (1980). Breggin (1991) used the term psychopharmaceutical complex to describe the economic influences therein. Though these authors provide important contributions to our understanding of the flow of resources among these entities, there has not been a comprehensive conceptualization to describe the process that involves our clients' interaction with the PPIC and the effects thereof.

The PPIC is a symbiotic system composed of the American Psychiatric Association (primarily administrative and research psychiatry), the pharmaceutical industry, public relations and advertising firms, patient support organizations (e.g., the National Alliance on Mental Illness [NAMI] and Children and Adults with Attention Deficit/Hyperactivity Disorder [CHADD]), the National Institute of Mental Health (NIMH), managed care organizations, and the flow of resources and money among these groups.

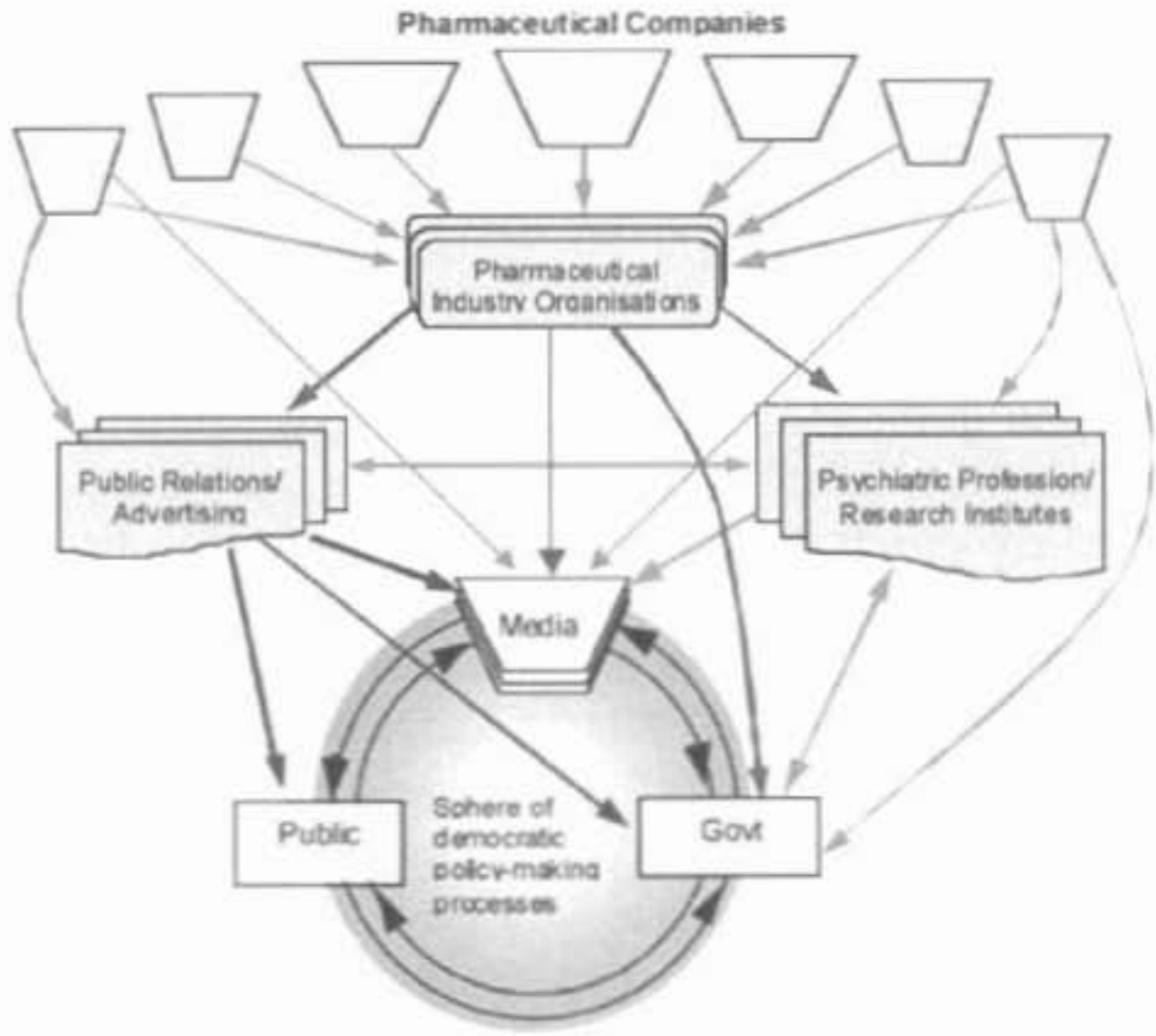
To further understand the PPIC, a systemic perspective provides a conceptual framework in which the focus is on *what* happened and *how, when,* and *where* it happened, avoiding any preoccupation with *why* it happened (Bowen, 1978). In other words, throughout this paper, I will address the processes involved in the PPIC, acknowledging that there are no saints or sinners but that all parts are interdependent entities motivated by survival needs (how to make a profit and

how to make more profit—capitalism). Proceeding without blaming is especially important given the volatility and emotional intensity that the PPIC evokes. Therefore, as with all systems and their subsystems, a metaview provides a different perspective about how these parts become interdependent and speak a common language.

So that the PPIC can survive and thrive within a capitalistic society, the system has organized itself around a single simple assumption: mental disorders are a *chronic* condition resulting from a *diseased* brain that *requires* expert medical treatment in the form of mass-produced pharmaceuticals (Kuppin & Carpiano, 2006). This belief system gives purpose to all parts of the system. Pharmaceutical companies develop a continuous flow of medications and provide funding to NIMH and patient support organizations like NAMI and CHADD, both of which rely on the pharmaceutical industry for funding, directly and indirectly. In turn, NIMH and patient support organizations endorse the disease model and its effects (medication research and education). Patient support organizations, with funding from the pharmaceutical industry, lobby policy makers to fund psychiatric research through NIMH. The psychiatric establishment depends increasingly on the pharmaceutical industry not only for education and promotional materials (continuing education credits, honorariums, lunches, free office supplies, and medication samples) but also for the flow of consumers who need medication evaluations and management for their "chronic disease." The pharmaceutical industry relies on academic psychiatrists to produce evidence that supports their medications. Academic psychiatry depends on the pharmaceutical industry for research grants, draws up treatment protocols, and sets the agenda for the psychiatric profession specifically and the mental health profession in general. Insurance companies rely on pharmaceuticals to contain costs (and limit psychotherapy sessions), and reimbursement depends on a diagnosis of a diseased brain. Figure 1 illustrates how this system operates.

All these groups work to provide, in their view, vital services for one another, with the goal being improved mental health for everyone. As a capitalistic system with a drive toward greater profits, modern healthcare has evolved into a sickness care system. For example, the current dynamic is such that the PPIC makes more profit by keeping consumers in the system and stands to lose when consumers discontinue psychiatric medications. There are, of course, consumers who enter and exit the mental health care system successfully and are better because of it. However, my most difficult cases involve clients who have in essence been drawn into the PPIC and have become resigned to the disease model with little sense of empowerment to overcome their emotional problems. These are the consumers who have little self-efficacy and little hope that they have options other than to suffer. And these are the cases about which I want to know more. What is involved in their personal seduction into the complex?

Figure 1. How the Psychopharmaceutical-Industrial Complex Operates



Source: R.G. Gosden and S. Beder (2001),"Pharmaceutical Industry Agenda Setting in Mental Health Policies," in R. G. Gosden and S. Beder, eds., *Ethical Human Sciences and Services, vol. 3,* pp. 147–159. Copyright 2001 by Richard Gosden. Reprinted with permission.

CULT-LIKE PHENOMENA OF THE PPIC

The inference that the practices and effects of the PPIC resemble cult-like phenomena produces a visceral reaction of outright rejection in both professionals and laypersons. Nevertheless, closer examination of the cult literature provides a number of parallels worth considering—most notably, how people become seduced by cults. West (1993) provided a psychiatric conceptualization for understanding the characteristics of cults and the characteristics that explain cult-members' seduction and subsequent indoctrination. West wrote, "Under certain kinds of stress or duress, individuals can be made to comply with the demands of those in power" (1993, p. 1). I looked to this article to understand my clients' apparent resignation to the disease model of mental illness so emphasized in mainstream and professional arenas. As West suggested, the question of power is paramount in this investigation.

Crossley (2004) positioned the power of the psychiatric establishment as being a symbolic power to define, name, categorize and diagnose; to locate particular types of mental distress and deviance within a medical model of illness; and to ensure, on this basis, that individuals falling within these categories are treated "appropriately." I return, then, to West (1993) for insight into a context in which this power manifests itself:

> Cult (totalist type): a group or movement exhibiting a great or excessive devotion or dedication to some person, idea, or thing, and employing unethical, manipulative, or coercive techniques of persuasion and control (e.g., isolation from former friends and family, debilitation, use of special methods to heighten suggestibility and subservience, powerful group pressures, information management, promotion of total dependency on the group and fear of leaving it, suspension of individuality and critical judgment, etc.), designed to advance the goals of the group's leaders, to the possible or actual detriments of members, their families, or the community (p. 8).

Using West's definition of cults as a framework for understanding the PPIC and its impact on these difficult cases, I therefore examine (a) dedication to the disease model of behavioral disorders; (b) unethical, manipulative, or coercive techniques of persuasion and control; (c) dependency development and fear; and (d) the means by which the aforementioned techniques ultimately advance the agenda of the PPIC.

Dedication to the Disease/Medical Model

I propose that there are similarities between cult-like phenomena of a devotion to an idea (West, 1993) and the adoption of biological reductionism (the disease model) by those within the psychiatric profession known as the New Psychiatry movement (Leeman, 2007; Lewis, 2006) and by others (e.g., nonpsychiatric prescribers, mental health professionals, and laypersons). Though the evolution of psychiatry over the last 130 years is beyond the scope of this paper, there are some aspects worth noting. Most importantly, the disease model can be viewed as bookending the story that is psychiatry.

The disease model was the foundation of early psychiatry; after all, Sigmund Freud was a neurologist. However, that model gave way to the psychoanalytic tradition throughout much of the twentieth century. In fact, most psychiatrists were trained in psychoanalysis as part of their medical education. Concurrently, psychiatry began facing an identity crisis, which provided momentum for a pendulum swing at mid-century (Andreason, 2006). Research and administrative psychiatrists wanted to be viewed like their medical brethren and focus on identifying organic causes of psychopathology. The pressure trickled down through the profession and, according to Leeman (2007), frontline physicians "were expected to follow suit" (p. 182). This movement culminated with the third edition of the *Diagnostic and Statistical Manual* (DSM-III; American Psychiatric Association, 1980), which was lauded as more scientific and atheoretical than its predecessors (Andreason, 2006; Lewis, 2006). New Psychiatry provided scientific certainty about the etiology of psychopathology and about the lesser, if any, relevance of sociological and psychological factors (Andreason, 2006).

Because of New Psychiatry's emphasis on the disease model, as well as the drive for professional parity with other medical specialties, the profession is easily seduced by all things claimed as science (Lewis, 2006), especially when

produced by members of the psychiatric establishment and used as a means to advance psychiatry. Thus, New Psychiatry has relied solely on the production and dissemination of medications to relieve human suffering (Wall, 2007), giving little attention to nonpharmacological interventions. In fact, disease model adherents rarely obtain continuing education about nonpharmacological interventions to help people resolve anxiety, suffering, and grief (Lewis, 2006). Psychiatric training programs have either dramatically decreased comprehensive psychotherapeutic education or discontinued it altogether (Drell, 2007), probably driven by capitalistic forces (e.g., more profit is made by providing medication evaluation and management on a 15-minute schedule) and the certainty that emotional disorders are a function of a diseased brain.

Psychiatrist Bruce Lachter, after accepting the certainty offered by the New Psychiatry, recalled an experience of frustration while working with a man who had little insight into his depression. Lachter wrote, "Such powerful knowledge of the facts of the brain gave me just the certainty that this unfortunate patient lacked" (Lachter, 2001, p. 311). Lewis (2006) suggested that such adherents of the disease model are likely to (a) naturalize and reify "mental illness"; (b) feed into the medicalization of deviance; (c) feed into psychiatry as an agent of normalization, state control, and multicultural oppression; (d) feed into the pharmaceutical industry boondoggle; and (f) rest on a natural-science approach to humans that excludes other approaches and multiple approaches. With the certainty that comes with New Psychiatry and its contribution to the PPIC, the disease model allows for a number of approaches to mental disorders that parallel the activities of cults, particularly techniques of indoctrination.

Persuasion Techniques

West (1993) stated that cults use a number of persuasion techniques, such as (a) isolation from former friends and family, (b) debilitation, (c) use of special methods to heighten suggestibility and subservience, (d) powerful group pressures, (e) information management, (f) promotion of total dependency on the group and fear of leaving it, and (g) suspension of individuality and critical judgment. In this section I look at the relevance of these techniques to the PPIC.

Isolation

Cults use isolation to minimize influence from those outside the group who may contaminate the vulnerable beliefs of cult members and to increase dependency on cult leaders. Similarly, evidence suggests that some iatrogenic isolation occurs as a result of the PPIC that has profound consequences for consumers.

The disease model can be quite detrimental for the psychiatric consumer, who becomes increasingly isolated due to the unintended increase in social stigma (Lam & Salkovskis, 2007; Lam, Salkovskis, & Warwick, 2005; Read &

Harré, 2001). The adoption of New Psychiatry's disease model results in the general public believing that psychiatric consumers, who have a brain disease, are dangerous and unpredictable (Read & Harré, 2001). In fact, Herrman (2001) suggested that professionals and lay people are more likely to believe that emotional problems are incurable if they believe that the causes are entirely biological. Such an assumption establishes that a greater authority (psychiatry) must intervene to provide safety and security. Consequently, consumers organize their life around their role as psychiatric consumer (Williams & Collins, 2002) with little hope of recovery.

Psychiatrists are not immune to the isolationism that is a consequence of their adoption of the disease model. Like the general population they experience emotional distress within the prevailing social construction of the disease model; according to Balon (2007), "a considerable number of psychiatrists would not [accept medication for] themselves for depression, possibly because of fear of stigma or fear of a permanent record" (p. 306). In other words, a significant number of the psychiatrists Bolan surveyed would not seek psychiatric care personally for fear of the stigma attached to help-seeking.

Debilitation

Cults use all the techniques listed by West (1993) to emotionally, behaviorally, and socially debilitate members. By disempowering their members, they have continuing significant influence over how the members function. Likewise, I assert, the PPIC has cult-like debilitating effects, particularly with regard to the locus of control and the debilitating effects of psychiatric medications.

People who believe that they control their own destiny have an internal locus of control. It is generally understood that such people have greater health, success, and well-being (Marshall, 1991). Similarly, an external locus of control—the belief that one has little control over one's circumstances—has been linked to psychopathology (Smith, Pryer, & Distefano, 1971). One would assume that New Psychiatry would highly encourage an internal locus of control. However, an internal locus of control has been linked with poor insight into one's psychiatric diagnosis (Williams & Collins, 2002). If consumers are to be considered insightful, they must agree with the perception of the evaluator (Diesfeld & Sjöström, 2007). As applied in New Psychiatry, insight is qualified as the acceptance of a diseased brain about which the consumer has little independent control (i.e., an external locus of control) and, by extension, for which medical intervention and authority is required.

Not only is PPIC unintentionally debilitating psychologically but, Breggin (2006) suggests, much debilitation results from the actual medications prescribed for psychiatric disorders because these suppress normal brain functioning. Breggin proposed that psychiatric consumers undergo a

spellbinding effect—intoxication anosognosia—from psychoactive medications. Anosognosia, a neuropsychological term, is the lack of awareness of one's deficits (Adair, Schwartz, & Barrett, 2003). According to Breggin, intoxication anosognosia explains the persistence that psychiatric consumers demonstrate when they continue psychiatric medications even when mental and behavioral side effects become severe and disabling. Mental health providers may be most familiar with this phenomenon as part of substance abuse treatment. As Moncrieff (2007) wrote, "In chronic alcoholism and other substance dependencies, it is also recognized that people deny the degree to which their substance use is adversely affecting their functioning and their relationships" (p171). Relating this phenomenon to psychiatric medications, many consumers may not identify subtle but equally serious side effects because of inadequate informed consent (Breggin & Cohen, 1999).

Breggin (1997) detailed 11 brain-disabling principles in his book, *Brain-disabling Treatments in Psychiatry.* Four principles directly address the issue of medication-induced debilitation: (a) all psychopharmaceuticals disrupt normal brain function without improving brain function; (b) all psychopharmaceuticals work by causing generalized brain dysfunction, affecting both emotional and cognitive functioning; (c) psychopharmaceuticals "help" by impairing higher human functions, including emotional responsiveness, social sensitivity, self-awareness or self-insight, autonomy, and self-determination; and (d) psychopharmaceuticals produce the same disabling effect on all people, with or without psychiatric diagnoses. Readers should note that Breggin's writings are not widely accepted among psychopharmacologists, New Psychiatry adherents, and others who value the disease model as a useful lens through which to understand human suffering. Nevertheless, increasingly the literature seems to provide support for his principles (Jackson, 2005; Murray, 2006).

Subservience and Suggestibility Techniques

Cults portray members as victims of the greater oppressive society and promise them respite through the cult indoctrination process. Moreover, members can develop pseudoidentities if the only way to obtain relief and understanding is to adopt the characteristics demanded (West, 1993). Similarly, Williams and Collins (2002) and McCay and colleagues (2006) argue that psychiatric consumers are prone to engulfment: the lifestyle of a psychiatric consumer (and the related psychosocial interventions) result in consumers relinquishing significant personal authority to the medical authority, a parallel to cult indoctrination. This process is facilitated when practitioners refer to consumers by their diagnoses (e.g., "He's bipolar/schizophrenic/OCD"), which conveys permanency and limits the prospect of hope and recovery.

The PPIC uses a number of suggestible techniques to further the disease model agenda, with each subsystem participating in its own way. For example,

Murray (2006) reviewed a number of ways psychiatric researchers suggest greater support and efficacy for psychiatric medications, including publishing the same results in multiple journals to give the appearance of more empirical support. Recently, the drug maker Merck & Company gained considerable attention, although for a nonpsychiatry journal, for working with publisher Elsevier to distribute an industry-sponsored, non-peer-reviewed journal that mirrored more reputable counterparts (Associated Press, 2009).

Other means are especially pronounced when occurring within the context of consumers becoming dependent, as in cults, on their providers for meeting both physical and psychological needs if they are to survive (West, 1993). For example, there is a prevailing assumption, supported by minimal evidence, that untreated psychosis damages the brain (Lieberman, Sheitman, & Kinon, 1997; Wyatt, 1991), which has led psychiatric practitioners to develop treatment compliance strategies.

Treatment compliance. West (1993) defined brainwashing as "any procedure employed to induce compliant behaviors" (p. 2). The PPIC emphasizes medication compliance among psychiatric consumers. In fact, a number of theoretical and programmatic initiatives (e.g., motivational interviewing) have been used to persuade consumers first to submit to psychiatric medication and then to stay on it (Fernandez, Evans, Griffiths, & Mostacchi, 2006; Ginsberg, 2006; Kavanagh, Duncan-McConnell, Greenwood, Trivedi, & Wykes, 2003; Rüusch & Corrigan, 2002). For example, nurses are encouraged to work toward medication adherence and use a variety of methods for increasing compliance (Fernandez et al.). Consumers may also be told, "The reason you feel sad all the time is because you're not taking your medication," as a means to persuade a consumer to become compliant. This circular logic avoids any implication that mood may be the result of negative life experiences.

Other suggestibility techniques occur when prescribers inform consumers that if the medication is discontinued, the disease will return. When consumers discontinue the medication, they often experience withdrawal symptoms that mimic symptoms similar to the diagnosis, thus creating a confirmatory bias. They return to medication to alleviate the withdrawal symptoms, which reinforces beliefs in the disease model (Glennmullen, 2005). These and similar approaches have the effect of invalidating the person's experience by discounting environmental contributions. Moreover, the assumption is that it is not necessary to make changes to the environment because medication is enough.

However, recovery may be jeopardized when consumers expect too much from their medication. Basoglu, Marks, Kiliç, Brewin, and Swinson (1994) found that consumers who attributed their recovery to the power of the medication and felt less confident of their ability to manage the symptoms were at greater risk of relapse. Those who attributed improvement to personal strength and resources experienced fewer relapses. Furthermore, Biondi and Picardi

(2003) found that consumers who predicted that remission and medication were related had higher relapse rates, and those who did not believe that the two were linked did not relapse. In fact, none of the participants who held the latter view relapsed after medication was discontinued to observe for the effect. Though the sample size was extremely small, the findings raise important treatment considerations. Biondi and Picardi (2003) wrote, "Working on patients' attributions with the aim of favoring a shift toward a more internal orientation is considered essential in the treatment of phobic patients" (p. 110). I would argue that more research needs to examine this thoroughly in terms of all psychiatric diagnoses for which medication is considered.

One final note about treatment compliance: A significant difference between cults and the cult-like phenomenon of the PPIC is that the latter suggests that consumers are oppressed by their own defective biology (e.g., biochemical imbalances, genetic disorders, or pathophysiology of the brain; Murray, 2006; Wahl, 1999), for which expert authority and treatment is needed. Cults, on the other hand, focus on the impact of an external oppressor. Thus, unlike cult members, psychiatric consumers can never find freedom from the oppressor, because the oppressor is within.

Powerful Group Pressures

Conformity is a powerful process that molds the beliefs of individuals to reflect those of the group (Kassin, 1998). Cults capitalize on this group process as well as being impacted by groupthink (where members of a group convince themselves that their beliefs are correct). Groupthink can suppress personal doubts without the person realizing that this is happening (Kassin). Finally, "group members harbor an illusion of invulnerability, an illusion of unanimity, and an exaggerated belief in the morality of their views" (Kassin, p. 505). Likewise, the PPIC uses "science" to create a protective shield from critical examination of its fundamental assumptions and excludes anyone who may express these criticisms (Kirk & Kutchins, 1992; Lewis, 2006)—particularly when the criticisms come from within the group (Caplan, 1995). This ultimately leads to the appearance of unanimity. Those professionals who do not adopt the disease model are kept from contributing to the discourse (Malik & Beutler, 2002).

Group pressures also exist in other areas of the PPIC—most notably within patient support organizations. Typically these organizations, also known as advocacy coalitions, are highly supportive of the disease model of mental illness, which corresponds with many consumers' acceptance of the model—after all, the PPIC often uses the model to explain the etiology of symptoms (Crossley, 2004). However, unbeknownst to most people there is a symbiotic relationship between the pharmaceutical industry and patient support organizations like the NAMI and CHADD (Ginsberg, 2006). Many corporations are

instrumental in promoting these grassroots organizations for their perceived credibility among consumers (Beder, Gosden, & Mosher, 2003). In fact, Rose (1991) wrote, "Any institution with a vested commercial interest in the outcome of an issue has a natural credibility barrier to overcome with the public, and often with the media" (p. 28). Once established, patient support organizations like NAMI and CHADD get up to 91 percent of their funding from the pharmaceutical industry (Ginsberg). This creates a powerful team advocating for simplistic biological explanations for mental disorders (Healy & Le Noury, 2007; Smoyak, 2004), as well as giving the appearance of widespread consensus. Those organizations that criticize the industry or the disease model may experience a loss of industry support (Ginsberg). Any cursory examination of newsletters and brochures from these organizations yields very little evidence that consideration is given to plausible nondisease theories of etiology.

Group pressures within the PPIC appear to influence what is or is not disclosed to the public. Ginsberg's exposé (2006) of various patient support organizations found that they (a) rarely disclosed their ties with the pharmaceutical industry, (b) were slow to educate their members about new concerns about medications typically used by their members but quick to publicize treatment "breakthroughs," and (c) rarely questioned drug prices. I contend that these influences naturally have an impact on consumer indoctrination. These relationships have recently been the focus of inquiry by United States Senator Charles Grassley (Giles, 2009). Grassley recently requested that NAMI disclose its financial ties with the pharmaceutical industry. The executive director, Michael Fitzpatrick, has since disclosed that 56% of NAMI's operating budget is supported by the industry. This is of great concern in part because NAMI is now the largest purveyor of mental health educational programs in the US, which are generally peer-directed and designed to educate consumers' families, service providers, service users, and community members (Burland & Nemec, 2007). Much of patient education, publications, and other media is highly supportive of the pharmaceutical industry and the disease model; psychotherapy is rarely promoted with any vigor.

Information Management

In addition to the information management already mentioned, the PPIC also manages information elsewhere. Because of the closed systems in which psychiatric information is developed and disseminated (Beder, Gosden, & Mosher, 2003; Jackson, 2005; Murray, 2006), medication information is passed from the pharmaceutical industry to psychiatric professionals. Not only is this information in favor of the drug company (and disparaging about competitive brands), but few consumers are given this (mis)information through the consent process (Schachter & Kleinman, 2004). Moreover, the pharmaceutical industry is very secretive (Lexchin, 2007); it tends to release trial data only when they

support the product (*Lancet*, 2001; Turner, Matthews, Linardotos, Tell, & Rosenthal, 2007). Recently, Vedantam (2009) broke a story that AstraZeneca had buried the findings of a 1997 study on the antipsychotic Seroquel, known as Study 15, which showed increased rates of weight gain and diabetes among the participants. In 2004, growing concerns led the Food and Drug Administration to place a black box warning on antipsychotic medications that highlighted concerns about iatrogenically induced diabetes.

When such important information is suppressed, consent can never be fully informed. As Geppert (2005) acknowledged, "Much of the consent we [psychiatrists] obtain from our patients for pharmacotherapy is woefully uninformed" (p. 55). "As an ethicist, I review many charts and if they were the only evidence available, we could never recreate even the outline of the doctrine of informed consent" (p. 56).

Not only can consumers be misinformed but information management and lack of informed consent can also result in researchers misinterpreting data. For example, Kessing, Hansen, Demyttenaere, and Bech (2005) asked participants about their perceptions about depression and antidepressants. The authors reported that the study's participants had a number of "erroneous" beliefs about their psychiatric treatment, specifically antidepressant usage. For example, 42.2% of the sample had the erroneous belief that discontinuing antidepressants was difficult if they had been taken for a long period. Murray (2006) found considerable evidence to support the beliefs of these participants—antidepressants are associated with a discontinuation syndrome. Kessing and colleagues appeared to have had an a priori bias toward medication and were apparently unaware of the disconfirming literature on psychopharmacology and thus concluded that accurate perceptions were erroneous.

Advertisements. The PPIC includes public relations and advertising firms that market to the pharmaceutical industry, promoting how they can recruit potential customers (Beder, Gosden, & Mosher, 2003). Ronit Ridberg (2006) produced a documentary, *Big Bucks, Big Pharma: Marketing Disease & Pushing Drugs*, which elucidated the relationships between the pharmaceutical industry and advertising firms. Beder, Gosden, and Mosher, as well as Ridberg, explain that mass media work perfectly for the disease model by providing explanations for mental disorders using virtual sound bites that promise quick fixes. If someone has a chemical imbalance, then it makes sense to use a chemical to balance it.

Unlike traditional capitalism, where necessity was the mother of invention, within the PPIC invention is the mother of necessity. With the explosion of new diagnostic categories with each edition of the DSM, there is a presumed need for more medications to treat these disorders. Disease-mongering, a form of mass marketing, is the process of creating a need for a pharmaceutical product without demand for that product fueling its development (Dear & Webb, 2007;

Ridberg, 2006). In short, pharmaceutical production stimulates need through mass advertising (Lewis, 2006). Once the drug is prescribed, consumers may be encouraged to take the drug prophylactically with no hope of future recovery (Healy, 2006).

Total Dependency and Fear

Curtis and Curtis (1993) offered several observations about techniques cults use to ensure member reliance. Primarily, cult members become "strongly conditioned by a powerful type of negative reinforcement, namely adherence to specific beliefs—no matter how irrational—serves to reduce painful affective states" (p. 457). Cults offer a "cure or anesthesia to emotional and physical pain" (p. 457). Many cult members are reminded of the dangers to which they would be exposed if they left the cult. These messages are repeated regularly. It is the *threat* of injury, rather than direct injury by the cult, that maintains a strong hold. It is as if the cult promises to alleviate pain and suffering now and in the future for as long as the member remains a part of the cult. "This seems to involve a rather encompassing cognitive manipulation and structuring process in which previous attitudes, beliefs, and values are radically transformed to match those of their captors" (p. 457).

The PPIC offers anesthesia for emotional and physical pain through psychiatric medications. Consumers are routinely warned about the negative consequences of discontinuing a medication. They are led to believe that their brains may suffer if they discontinue medication or that it will cause undue hardship on their families. Moreover, if they stop taking the medication, the disease will return. Ironically, the withdrawal syndrome that is associated with psychiatric medications is often confused with a return of the original symptoms (e.g., depression). Breggin (2006) also warned that consumers can begin to feel worse after starting medication but identify the side effects as signs of a declining mental condition.

Advancing the Psychopharmaceutical-Industrial Complex

The primary mission of a cult is self-perpetuation (Enroth, 1977). A similar argument can be made about the PPIC. The PPIC must adhere to the disease model as a function of survival, which influences how model proponents explain consumer symptoms, which in turn influences how consumers explain symptoms to those around them (Lam, Salkovskis, & Warwick, 2005). Moreover, as consumers are bombarded with disease model messages through television, magazines, and pharma-sponsored promotional materials, "these various advertising tools work to create a sameness and repetition in the minds of psychiatrists and their consumers. The generalized message is, 'Psychiatrists give you drugs, and that is good'" (Lewis, 2006, p. 57). Of course, it must be noted that most psychiatric medications are prescribed not by psychiatrists but

by other medical doctors, nurse practitioners, and physician assistants (Whitaker, 2007).

Not only does the pharmaceutical industry shape the discourse about mental disorders, but the American Psychiatric Association Press is a major gatekeeper of materials that advance the PPIC, as well as constraining opposing views and ultimately conveying that there is a broad consensus about the disease model (Lewis, 2006). Breggin countered that the claims based on the disease model are "unethical, if not fraudulent, and *serve only to perpetuate the influence of the profession and individual practitioners* [italics added]" (1991, pp. 408–409).

Finally, unparalleled secrecy and conflicts of interest continue with regard to the next edition of the DSM, which is scheduled for release in 2012. Spitzer (2009) reported that the DSM-V drafters have gone to great lengths to keep proceedings from public view and to restrict information about the DSM-V's development. For example, all DSM-V participants must sign confidentiality agreements that prohibit discussion about

> all work product, unpublished manuscripts and drafts and other prepublication materials, group discussions, internal correspondence, information about the development process and any other written or unwritten information in any form that emanates from or relates to [member's] work with the APA Task Force or Workgroup (Spitzer, paragragh 6).

Regarding the task force participants, Cosgrove and Bursztajn (2009) found that 68% report direct pharmaceutical industry ties. Given that diagnosis informs treatment decisions for most mental health professionals, these conflicts of interests are of great concern.

SUSCEPTIBILITY TO THE PSYCHOPHARMACEUTICAL-INDUSTRIAL COMPLEX

If the PPIC's devotion to the disease model uses a number of persuasion techniques to foster its messages, what determines the susceptibility to the messages of those on the receiving end of those techniques? And how does this result in consumers who lose their identities (Czuchta & Johnson, 1998) and accept the messages offered by the PPIC? In this section, I review six factors that Curtis and Curtis (1993) implicated in cult susceptibility. For each I draw parallels with the psychiatric consumer.

Generalized ego-weakness and emotional vulnerability. Galanter (1989) stated that people generally join cults to relieve neurotic distress, obtain contentment, or as respite from perceived social oppression and its intolerable consequences. As a rule, emotional distress is the impetus for psychiatric consumers to seek help. They feel little self-efficacy for managing the problem with their own resources. Not only do psychiatric consumers seek help while

feeling emotionally vulnerable but neuroleptic medications may exacerbate emotional vulnerability through a process called "neuroleptic dysphoria" (Ballard, Basso, Gallagher, et al., 2007; Gerlach & Larsen, 1999). Jackson (personal communication, March 10, 2009) believes that this dysphoria also occurs with anxiolytics and some antidepressants by boosting γ-(gamma) aminobutyric acid (GABA) levels and GABA transmission, as well as blunting dopamine. Cults (Curtis & Curtis, 1993) and the mental health establishment (Levitt, Butler, & Hill, 2006) respond to these periods of ego weakness and emotional vulnerability by offering security, protection, and belonging.

Suspension of critical thinking. Cults create an atmosphere in which vulnerable members surrender critical thinking in favor of the psychological relief that cult indoctrination promises. The propensity to do so makes it more difficult for people to critically examine the cult's presumptive benefits because their rational judgment is suspended (Curtis & Curtis, 1993). Similarly, psychiatric consumers unknowingly accept the misleading and deceptive promises inherent in the presumptive benefits of the disease model, especially when such information is delivered by someone with presumed authority (a la Stanley Milgram's obedience to authority experiments, 1963, 1965). For example, anecdotal evidence suggests that psychiatric consumers rarely criticize the chemical imbalance theory despite not having their chemicals measured, as would be done with diabetes, to verify that there is indeed a brain imbalance. Furthermore, suspension of critical thinking may increase the likelihood for engulfment described earlier (see Williams & Collins, 2002).

Inadequate family and social support systems. Cult members experience tenuous, deteriorated, or nonexistent family relations and social support systems, which contribute to their feeling "worthless, isolated, disoriented, helpless, and perhaps terrified" (Curtis & Curtis, 1993, p. 454). Inadequate family and social support increases adherence to the cult by offering amelioration of these feelings and rescue from feelings of abandonment and rejection. Members of cults are also expected to relinquish their identity to the leader, which makes them "disoriented, helpless, and out of control" (Curtis & Curtis, p. 458). Cults isolate members from outside sources of information and instead repeat factually incorrect information to further strengthen indoctrination.

Inadequate family and social support systems have long been linked to emotional disorders, just as strong family and social support has been linked to mental health (Murray, 2005). Psychiatric consumers seek care to relieve emotional pain by being accepted and understood. However, consumers may actually experience increased stigmatization and isolation (Lam & Salkovskis, 2007; Lam, Salkovskis, & Warwick, 2005; Read & Harré, 2001) as a result of the repetitive and factually incorrect monocausal view of mental disorders. Worse, psychiatric medications have been linked to disorientation, helplessness, and impulse control problems (Breggin, 2006; Jackson, 2005; Murray,

2006), which impact the consumer's dynamic relationships with others.

Inadequate means of dealing with the exigencies of survival. Cults offer a "type of shortcut or quick fix for their own survival. Cult members are generally discouraged from developing autonomous, independent, and self-sufficient behavior" (Curtis & Curtis, 1993, p. 454). Psychiatric consumers are routinely told that their very survival depends on their compliance with medication (Healy, 2006). A consumer who suggests no longer needing medication or is ready to decrease the dosage is looked upon with skepticism and alarm by the family or prescriber. In most elements of psychology, this evidence of an internal locus of control is viewed as a vital aspect of mental health; however, within the psychiatric literature, an internal locus of control is linked with "poor insight" and medication noncompliance (Kampman et al., 2002; Voils, Steffens, Flint, & Bosworth, 2005; Williams & Collins, 2002). The PPIC may inadvertently cause more helplessness among consumers through the use of certain medications (Ballard et al., 2007).

Unmanageable and debilitating situational stress and crises. Cults offer "immediate relief through utopian promises" (Curtis & Curtis, 1993, p. 456). People are most vulnerable to the offerings of cults during times of stress and crisis. "It seems logical that individuals suffering from inordinate stress seek out a variety of quick fixes, and will be increasingly vulnerable to the seductive promises offered by cults" (Curtis & Curtis, p. 456).

The PPIC promotes two messages: (a) medications can make one happier, and (b) suffering is useless and therefore should be avoided. Historically, psychiatric medications were used only for the truly debilitated (O'Barr, 2007). Now, the pharmaceutical industry markets and health care providers prescribe psychiatric medications as quick fixes (Whitaker, 2007), "emotional brighteners," or a means to tolerate oppressive relationships or living conditions (Dworkin, 2006; Lexchin, 2006)—in short, for many, psychiatric medications have become "lifestyle drugs."

Intolerable socioeconomic conditions. Those who experience desperate socioeconomic conditions are more vulnerable to cults as an opportunity to experience relief from their situation because they offer practical solutions for survival (Hoffer, 1966, as cited in Curtis & Curtis, 1993). Lewis (2006) identified three major groups who make up the bulk of psychiatric consumers: women, the poor, and minorities. Despite New Psychiatry's almost nonexistent acknowledgement of the socioeconomic oppression these groups endure, experiences of oppression propel the natural inclination to seek relief (Kiesler, 1999; Lewis, 2006). However, Winokur and Clayton wrote, "We [psychiatrists] are not interested in the 'psyche.' We are interested in specific psychiatric illnesses" (1986, pp. ix-x). Such perspectives may lead to prescribing for symptoms that are better served by intervening at the societal level (Kiesler, 1999).

Despite New Psychiatry's ignorance of socioeconomic variables, these

factors do influence mental health and medication usage. This is especially disconcerting when it comes to our most vulnerable population—children. For example, foster children and children of low socioeconomic status have an extremely high rate of psychiatric drug consumption (Brownell, Mayer, & Chateau, 2006). In Oregon 30% of children in foster care are on psychiatric medications compared to 6% of children outside of foster care (Associated Press, 2007). Lagnado (2007) speculated that the pharmaceutical industry markets directly to the poor and elderly because services are paid for by federal and state governments through Medicaid and Medicare. This indiscriminant use of psychiatric medications on our most vulnerable populations—children, elderly, minorities, and women—may make this a fundamental issue requiring greater attention to those who advocate for social justice.

EXITING FROM THE PPIC AND REDISCOVERING SELF

If the parallels between cults and the PPIC are real, then as West (1993) wrote, "At any given time most of their members are either not yet aware that they are being exploited or, having come to realize it, they are unable to express such awareness because of fear, uncertainty, shame, or impairment of will" (p. 17). Therefore, mental health counselors (MHCs) who work with clients resigned to the disease model must develop strategies to expand client awareness. In this section, I identify deconditioning strategies recommended by cult experts and mental health professionals.

Curtis (1982) suggested that the following elements are essential for assisting consumers: (a) identification of unlabeled emotions and beliefs, (b) labeling of unrecognized emotions and beliefs, (c) articulation or getting in touch with contributory emotions and beliefs, (d) expression and discussion of feelings and beliefs, (e) externalization and ventilation of pent-up emotions and beliefs, (f) validation of clients' emotions and beliefs, and (g) acceptance of clients' emotions and beliefs. Curtis and Curtis (1993) added that indoctrinated beliefs are resistant to extinction and require repetition, tenacity, and tolerance during exit counseling.

Czuchta and Johnson (1998) also encouraged mental health professionals to remind consumers that (a) recovery is not only possible but does occur, and (b) mental disorders are a loss of self for which the recovery process includes the rediscovery of self. Strauss (1994) believes that this process has four basic aspects: (1) discovering the possibility of possessing a more active sense of self, (2) taking stock of the strengths and weaknesses of this self and assessing possibilities for change, (3) putting into action some aspects of the self and integrating the results, and (4) using the enhanced sense of self to provide some degree of refuge from the illness (as cited in Czuchta & Johnson).

MHCs are also advised to educate themselves on psychopharmacology and

the ethics thereof (Murray, 2006; Murray & Murray, 2007) as a means to offer support, encouragement, and education to consumers who have had negative experiences with psychiatric treatment. Happell, Manias, and Roper (2004) described a number of these experiences, which included (a) feeling frustrated that there was no indication of the length of time that medication was necessary, thus decreasing the amount of control they felt over their healthcare; (b) psychiatrists prescribing medications under false pretenses and later becoming angry after learning more about the medication; (c) healthcare providers being more interested in medication compliance than observing for and asking questions about side effects; (d) feeling blamed if their symptoms did not improve, and that healthcare providers did not question treatment appropriateness; (e) healthcare providers, particularly in inpatient settings, ignoring the consumer's interest in nonpharmacological treatments and emphasizing medication stabilization; and (f) their opinions and requests for information being "frequently dismissed as symptomatic of mental illness rather than the legitimate claim for knowledge" (p. 247). If consumers present with these or similar experiences, MHCs are advised to proceed using the recommendations of Curtis (1982) described above.

IMPLICATIONS FOR MENTAL HEALTH PROFESSIONALS

The major implications of the issues discussed for MHCs involve (a) reexamining the role of the disease model within mental healthcare, (b) advocating for recovery model approaches as an effective therapy, and (c) addressing misleading or deceptive proclamations within mainstream media.

The mental health profession's commitment to the disease model, and by extension the PPIC, has hurt the profession and those we serve. (Incidentally, psychiatry is the only medical profession with a substantial opposition movement led by psychiatric survivors [Lewis, 2006]). Yet the disease model does have some merit. Psychiatrists, who have expertise in medical conditions, possess the necessary skills to screen for the many conditions that can affect mental health (e.g., infections, intracranial structural defects, endocrinopathies, hypoxia-ischemia, demyelinating disease, autoimmune disease, metabolic abnormalities, dietary abnormalities, or exposure to neurotoxins).

Moreover, psychiatrists and MHCs are in a unique position to advocate for public mental health and illness prevention (Glasser, 2005; Kiesler, 1999; Sowers & Thompson, 2007). For example, psychiatry must draw up a research agenda to help consumers recover from the damage done by neuropharmaceuticals; currently, there is no infrastructure within mainstream medical practice that offers support for discontinuing medication, recovering from its damaging effects, and recovering without medication (Jackson, 2007, personal communication; Sower & Thompson, 2007). The American Association for Community

Psychiatrists (http://www.comm.psych.pitt.edu/) offers a number of areas (leadership, training, and advocacy) in which psychiatry can rehabilitate the profession. MHCs can also take the lead in rehabilitating our profession in similar ways.

Leadership. To my knowledge, no major mental health professional organization (e.g., American Counseling Association, American Psychological Association, National Association of Social Workers, American Mental Health Counselors Association, American Association for Marriage and Family Therapy, and, of course, American Psychiatric Association) has spoken out against the reductionist, monocausal disease model and more forcefully advocated psychotherapy. I press upon the leadership of the counseling profession to lead the way. We have a great heritage grounded in our recognition that behavioral problems are best understood within the context of culture and relationships rather than the belief that clients are flawed by some genetic anomaly or neurodeformity—especially when neither has been shown to exist.

Training. Counselor education training programs must reconsider how we teach issues of psychopathology and psychopharmacology to current students and practicing counselors. Rather than organizing training content solely by DSM nosology, such courses should also provide students with content critical of New Psychiatry (e.g., readings that question the validity and reliability of psychiatric diagnoses, critique the biological etiology, and critique the use of psychiatric medications). However, counselors are best served when they have comprehensive training in behavioral neuroscience, including psychopharmacology, and research methodologies. Such training is necessary to a professional's ability to speak the prevailing language while critically analyzing the data, which may help counselors to offer clients conceptual alternatives.

Advocacy. MHCs are encouraged to examine how best to advocate for the profession by emphasizing the unique contributions we have to offer to our clients and community. To do so may mean shedding our allegiance to the status quo and thinking creatively. Our inability to "provide an equally simple and compelling counter idea" (Leeman, 2007, p. 184) has only contributed to our collusion with the PPIC by (a) minimizing collaboration with one another, and (b) accepting money from the pharmaceutical industry to sponsor professional conferences or to advertise in their publications with little regard for accuracy.

Instead, MHCs are invited to advocate for an empowerment model that emphasizes recovery as possible and expected for even the most serious psychiatric disabilities. The National Empowerment Center (NEC; www.power2u.org), partially funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), has recommended its PACE program: Personal Assistance in Community Existence. The PACE program was constructed in part by examining the heroic accounts of others who have recovered from psychiatric disabilities. These individuals identified key elements in

their recovery, such as (a) having someone around who believed in their recovery and in them; (b) having someone who projected hope; (c) having someone provide a relationship in which they could feel safe and trusted; (d) having a counselor who was "able to be human," which included being open to correction; and (e) learning skills in self-care, forgiveness, taking responsibility, and setting goals.

All these are skills at which MHCs are adept. It is precisely our ability to understand our clients' symptoms psychologically that leads to our successes. Therapists who hold a psychological view have been found to be more effective than those who hold a medical view (Blatt, Sanislow, Zuroff, & Pilkonis, 1996).

Another area where MHCs can advocate for the profession and their clients is by addressing misleading or deceptive proclamations about the etiology of mental disorders within mainstream media. Leo and Lacasse (2007) found that media outlets continue to promote the disease model with little investigative reporting on the merits of disease model assumptions. MHCs are encouraged to write letters to newspaper editors and other media outlets about the misleading inferences that mental disorders are a product of a diseased brain. Finally, MHCs are encouraged to write articles for local newspapers and other publications that promote psychotherapy and the multicausal view of mental disorders.

The latter view acknowledges that complex interactions of psychological, social, and biological factors influence the development of emotional problems. Too often, however, we emphasize one over the other—particularly biological considerations. Because humans are biological creatures, all of our experiences are a function of chemical and electrical processes in our brains. However, this should not be interpreted to mean that our emotional problems are a product of some biological disease, deficit, disorder, or dysfunction; they may merely be understandable reactions to difficult life situations. As with any system, when there is an intervention in any part of the system, the other parts respond accordingly. For example, psychotherapy, like all forms of human interaction, has a direct impact on our biology, including neural plasticity, and our social relationships (Fishbane, 2007; Siegel, 2006).

Ultimately, consumers must be given a diversity of information to become fully informed about their treatment options.

CONCLUSION

Although many consumers enter and exit the psychiatric system without any deleterious effects, too many lose their identity in the process. Once inside, these consumers are confronted with information that cannot be independently verified but that must be accepted in order to receive care, and a new identity must be adopted. Despite being told they have a chemical imbalance, like dia-

betes, or a genetic defect, no biological tests are offered as evidence; nor can consumers prove the disease does not exist. Nevertheless, the consumer is encouraged to try a number of medication cocktails to find the right one. No one suggests that difficulty in finding the right combination may be evidence that there is no biological abnormality. The search for the right medication continues until the symptoms meet the expectation of the prescriber. Thus praise is given to the superiority of the medication rather than the courage of the consumer. Rarely, however, do the symptoms abate forever; thus the cycle begins anew. The cycle is organized around the disease model espoused by the PPIC. Vulnerable consumers become indoctrinated in ways similar to cults where "the [consumer], having to seek definition as acutely sick and helpless in order to achieve a measure of public validation for his illness … submerge[s] himself in the sick definition permanently" (Erikson, 1957, p. 271).

The disease model has failed the mental health consumer by eliminating hope for recovery and increasing social stigma, isolation, and fear. Hill and Bale's (1981) remarks are still relevant today:

Not only has the attempt to have the public view deviant behavior as symptomatic of illness failed, but the premise that such a view would increase public acceptance of the person engaging in such behavior seems to have been a dubious one to begin with. The notion that psychological problems are similar to physical ailments creates the image of some phenomenon over which afflicted individuals have no control and thereby renders their behavior apparently unpredictable (pp. 289–290).

The process of instilling hope of relief from emotional pain and the concept that suffering is not inherently permanent is something important MHCs can offer (Abramson, Metalsky, & Alloy, 1989; Czuchta & Johnson, 1998). However, they may find it difficult to instill hope when working with clients who have become resigned to the disease model. MHCs are called upon not to collude with the PPIC but instead to offer hope that recovery is possible by advocating for and eliciting personal resilience and empowerment. To do this, they must advocate for their profession and develop psychologically relevant ways to help clients expand their awareness of the nature of their emotions and behaviors by rediscovering self and exiting the PPIC.

REFERENCES

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review, 96,* 861–865.

Adair, J. C., Schwartz, R. L., & Barrett, A. M. (2003). Anosognosia. In K. M. Heilman & E. Valenstein (Eds.), *Clinical neuropsychology* (4th ed., pp. 185–214). New York: Oxford University Press.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.).* Washington, DC: Author.

Andreason, N. (2006). DSM and the death of phenomenology in America: An example of unintended consequences. *Schizophrenia Bulletin, 33,* 108–112.

Andreason, N., & Black, D. (2001). *Introductory textbook of psychiatry.* Washington, D.C.: American Psychiatric Association Press.

Associated Press (2007). Oregon legislature holds hearings on foster children and meds [Electronic version]. *The Oregonian.* Retrieved on December 08, 2007, from http://www.oregonlive.com/newsflash/regional/index.ssf?/base/news-22/1196184248610 20.xml&storylist=orlocal

Associated Press (2009). Elsevier unit failed to disclose journal sponsors [Electronic version]. *Forbes.* Retrieved on May 25, 2009, from http://www.forbes.com/feeds/ap/2009/05/07/ap6394349.html.

Bakker, A., Spinhoven, P., van der Does, A., van Balkom, A. J., & van Dyck, R. (2003). Attribution of improvement to medication and increased risk of relapse of panic disorder with agoraphobia. *Psychotherapy & Psychosomatics, 71,* 85–89.

Ballard, M., Basso, A., Gallagher, K., Browman, K., Fox, G., Drescher, K., et al. (2007). The drug-induced helplessness test: An animal assay for assessing behavioral despair in response to neuroleptic treatment. *Psychopharmacology, 190*(1), 1–11.

Balon, R. (2007). Psychiatrist attitudes toward self-treatment of their own depression. *Psychotherapy & Psychosomatics, 76,* 306–310.

Basoglu, M., Marks, I. M., Kiliç, C., Brewin, C. R., & Swinson, R. P. (1994). Alprazolam and exposure for panic disorder with agoraphobia: Attribution of improvement to medication predicts subsequent relapse. *British Journal of Psychiatry, 164,* 652–659.

Beder, S., Gosden, R., & Mosher, L. (2003). Pig Pharma: Psychiatric agenda setting by drug companies. In P. Prosky & D. Keith (Eds.), *Family therapy as an alternative to medication: An appraisal of pharmland* (pp. 193–208). New York: Brunner-Routledge.

Belmaker, R. H., & Wald, D. (1977). Haloperidal in normals. *British Journal of Psychiatry, 131,* 222–223.

Biondi, M., & Picardi, A. (2003). Attribution of improvement to medication and increased risk of relapse of panic disorder with agoraphobia. *Psychotherapy & Psychosomatics, 72,* 110–111.

Blatt, S.J., Sanislow, C.A., Zuroff, D.C., and Pilkonis, P.A. (1996). Characteristics of effective therapists: Further analysis of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Project. *Journal of Consulting and Clinical Psychology, 64,* 1276–1284.

Bowen, M. (1978). *Family therapy in clinical practice.* New York: Jason Aronson.

Breggin, P. R. (1991). *Toxic psychiatry: Why therapy, empathy, and love must replace medications, electroshock, and biochemical theories of the "New Psychiatry."* New York: St. Martin's Press.

Breggin, P. R. (1997). *Brain-disabling treatments in psychiatry.* New York: Springer.

Breggin, P. R. (2006). Intoxication anosognosia: The spellbinding effect of psychiatric drugs. *Ethical Human Psychology and Psychiatry, 8,* 201–215.

Breggin, P. R., & Cohen, D. (1999). *Your medication may be your problem: How and why to stop taking psychiatric medications.* Cambridge, MA: Da Capo.

Brownell, M., Mayer, T., & Chateau, D. (2006). The incidence of methylphenidate use by Canadian children: What is the impact of socioeconomic status and urban or rural residence? *Canadian Journal of Psychiatry, 51,* 847–854.

Burland, J., & Nemec, P. (2007). NAMI training programs. *Psychiatric Rehabilitation Journal, 31,* 80–82.

Caplan, P. J. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal.* New York: Addison-Wesley Publishing Company.

Cosgrove, L., & Bursztajn, H. J. (2009). Toward credible conflict of interest policies in clinical psychiatry. *Psychiatric Times, 26.* Retrieved March 16, 2009, from http://www.psychiatrictimes.com/display/article/10168/1364672

Crossley, N. (2004). Not being mentally ill: Social movements, system survivors and the oppositional habitus. *Anthropology & Medicine, 11,* 161–180.

Curtis, J. M. (1982). Principles and techniques of non-disclosure by the therapist during psychotherapy. *Psychological Reports, 51,* 907–914.

Curtis, J. M., & Curtis, M. J. (1993). Factors related to susceptibility and recruitment by cults. *Psychological Reports, 73,* 451–460.

Czuchta, D. M., & Johnson, B. A. (1998). Reconstructing a sense of self in patients with chronic mental illness. *Perspectives in Psychiatric Care, 34,* 31–36.

Dear, J. W., & Webb, D. J. (2007). Disease mongering—a challenge for everyone involved in healthcare. *Journal of Clinical Pharmacology, 64,* 122–124.

Diesfeld, K., & Sjöström, S. (2007). Interpretive flexibility: Why doesn't insight incite controversy in mental health law? *Behavioral Sciences and the Law, 25,* 85–101.

Drell, M. J. (2007). The impending and perhaps inevitable collapse of psychodynamic psychotherapy as performed by psychiatrists. *Child and Adolescent Psychiatric Clinics of North America, 16,* 207–244.

Duhl, L. J., & Cummings, N. A. (1987). The emergence of the mental health complex. In L. J. Duhl & N. A. Cummings (Eds.), *The future of mental health services: Coping with crisis* (pp. 1–13). New York: Springer.

Dworkin, R. W. (2006). *Artificial happiness: The dark side of the new happy class.* New York: Carroll & Graf.

Eisenhower, D. (1960, January). [Presidential farewell address.]

Elias, M. (2009, June). Conflicts of interest bedevil psychiatric drug research. *USA Today.* Retrieved June 4, 2009, http://www.usatoday.com/news/health/2009-06-02-psychiatry-drugs-conflicts_N.htm

Enroth, R. M. (1977). Cult/contercult. *Eternity, 27,* 19–22.

Erikson, K. T. (1957). Patient role and social uncertainty: A dilemma of the mentally ill. *Psychiatry, 30,* 263–274.

Fernandez, R. S., Evans, V., Griffiths, R. D., & Mostacchi, M. S. (2006). Educational interventions for mental health consumers receiving psychotropic medication: A review of the evidence. *International Journal of Mental Health Nursing, 15,* 70–80.

Fishbane, M. (2007, September). Wired to connect: Neuroscience, relationships, and therapy. *Family Process, 46*(3), 395-412. Retrieved May 25, 2009, doi:10.1111/j.1545-5300.2007.00219.x

Food and Drug Administration. (2004). Warning about hyperglycemia and atypical antipsychotic medications: FDA client safety news. Retrieved on December 1, 2005, from http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/printer.cfm?id=229

Galanter, M. (1989). *Cults: Faith, healing and coercion.* Washington, DC: American Psychiatric Press.

Geppert, C. M. A. (2005). Uninformed consent. *Psychiatric Times, 22,* 55–56.

Gerlach, J., & Larsen, E. B. (1999). Subjective experience and mental side-effects of antipsychotic treatment. *Acta Psychiatrica Scandinavica Supplementum, 395,* 113–117.

Giles, J. (2009, February 21). Show me the money. *New Scientist, 201,* 26–27. Retrieved May 25, 2009, from Academic Search Premier database.

Ginsberg, T. (2006, May 28). Donations tie drug firms and nonprofits: Many patient groups reveal few, if any, details on relationships with pharmaceutical donors. *Philadelphia Inquirer.*

Glasser, W. (2005). *Defining mental health as a public health issue.* Chatsworth, CA: William Glasser Institute.

Glenmullen, J. (2000). *Prozac backlash: Overcoming the dangers of Prozac, Zoloft, Paxil, and other antidepressants with safe, effective alternatives.* New York: Simon & Schuster.

Glenmullen, J. (2005). *The antidepressant solution: A step-by-step guide to safely overcoming antidepressant withdrawal, dependence, and "addiction."* New York: Free Press.

Happell, B., Manias, E., & Roper, C. (2004). Wanting to be heard: Mental health consumers' experiences of information about medication. *International Journal of Mental Health Nursing, 13,* 242–248.

Healy, D. (2006). The latest mania: Selling bipolar disorder. *PLoS Medicine, 3,* e185.

Healy, D., & Le Noury, J. (2007). Pediatric bipolar disorder: An object of study in creation of illness. *International Journal of Risk & Safety in Medicin, 19,* 209–221.

Herrman, H. (2001). The need for mental health promotion. *Australian & New Zealand Journal of Psychiatry, 35,* 709.

Hill, D. J., & Bale, R. M. (1981). Measuring beliefs about where psychological distress originates and who is responsible for its alleviation. In H. Lefcourt (Ed.), *Research with the locus of control construct (Vol. 2).* New York: Academic Press.

Holley, J., Miklowitz, D. J., & Beach, S. R. H. (2006). Expressed emotion and DSM-V. In S. Beach, M. Wamboldt, N. Kaslow, R. Heyman, M. First, et al. (Eds.), *Relational process and the* DSM-V*: Neuroscience, assessment, prevention, and treatment.* Washington DC: American Psychiatric Association.

Hoffer, E. (1966). *The true believer.* New York: Belmont Tower Books.

Jackson, G. (2005). *Rethinking psychiatric medications: A guide for informed consent.* Bloomington, IN: AuthorHouse.

Joseph, J. (2006). *The missing gene: Psychiatry, heredity, and the fruitless search for genes.* New York: Algora.

Kampman, O., Laippala, P., Väänänen, J., Koivisto, E., Kiviniemi, P., Kilkku, N., & Lehtinen, K. (2002). Indicators of medication compliance in first-episode psychosis. *Psychiatry Research, 110,* 39–49.

Kaplow, J. B., & Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology, 116,* 176–187.

Kassin, S. (1998). *Psychology* (2nd ed.). New York: Prentice Hall.

Kavanagh, K., Duncan-McConnell, D., Greenwood, K., Trivedi, P., & Wykes, T. (2003). Educating acute inpatients about their medication: Is it worth it? An exploratory study of group education for patients on a psychiatric intensive care unit. *Journal of Mental Health, 12,* 71–80.

Kerr, M., & Bowen, M. (1988). *Family evaluation.* New York: Norton.

Kessing, L. V., Hansen, H. V., Demyttenaere, K., & Bech, P. (2005). Depressive and bipolar disorders: Patients' attitudes and beliefs towards depression and antidepressants. *Psychological Medicine, 35,* 1205–1213.

Kiesler, D. J. (1999). *Beyond the disease model of mental disorders.* Westport, CT: Praeger.

Kirk, S., & Kutchins, H. (1992). *The selling of the* DSM*: The rhetoric of science in psychiatry.* New York: Aldine de Gruyter.

Kuppin, S., & Carpiano, R. M. (2006). Public conceptions of serious mental illness and substance abuse, their causes and treatments: Findings from the 1996 General Social Survey. *American Journal of Public Health, 96,* 1766–1771.

Lachter, B. (2001). "Chemical Imbalance": A clinical non sequitur. *Australian Psychiatry, 9,* 311–315.

Lagnado, L. (2007, Dec 4). Prescription abuse seen in U.S. nursing homes. *The Wall Street Journal, 250,* A1–A16.

Lam, D. C. K., & Salkovskis, P. M. (2007). An experimental investigation of the impact of biological and psychological causal explanations on anxious and depressed patients' perception of a person with panic disorder. *Behaviour Research and Therapy, 45,* 405–411.

Lam, D. C. K., Salkovskis, P. M., & Warwick, M. C. (2005). An experimental investigation of the impact of biological versus psychological causal explanations on the cause of "mental illness." *Journal of Mental Health, 14,* 453–464.

Lancet. (2001). The tightening grip of big pharma. April 14.

Leeman, E. (2007). The costs of compliance. *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 35,* 179–187.

Leo, J., & Lacasse, J. R. (2007, November 28). The media and the chemical imbalance theory of depression. *Society, 46.* Retrieved on December 31, 2007, from http://www.springerlink.com/content/u37j12152n826q60/fulltext.pdf

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology, 53,* 314–324.

Lewis, B. (2006). *Moving beyond Prozac,* DSM, *& the New Psychiatry: The birth of postpsychiatry.* Ann Arbor, MI: The University of Michigan Press.

Lexchin, J. (2006). Bigger and better: How Pfizer redefined erectile dysfunction. *PLoS Medicine, 3,* e132.

Lexchin, J. (2007). The secret things belong unto the Lord our God: Secrecy in the pharmaceutical arena. *Medicine & Law, 26,* 417–430.

Lieberman, J. A., Sheitman, B. B., & Kinon, B. J. (1997). Endogenous neurochemical sensitization in the pathophysiology of schizophrenia deficits and dysfunction in neuronal regulation and plasticity. *Neuropsychopharmacology, 149,* 1183–1188.

Malik, M., & Beutler, L. (2002). The emergence of dissatisfaction with the *DSM.* In L. Beutler and M. Malik (Eds.), *Rethinking the* DSM*: A psychological perspective.* New York: American Psychological Association.

Marshall, G. N. (1991). A multidimensional analysis of internal health locus of control belief: Separating the wheat from the chaff? *Journal of Personality and Social Psychology, 61,* 483–491.

McCay, E., Beanlands, H., Leszcs, M., Goering, P., Seeman, M. V., Ryan, K., et al (2006). A group intervention to promote healthy self-concepts and guide recovery in first episode schizophrenia: A pilot study. *Psychiatric Rehabilitation Journal, 30,* 105–111.

Milgram, S. (1963). Behavioral study of obedience. *Journal of Abnormal and Social Psychology, 67,* 371–378.

Milgram, S. (1965). Some conditions of obedience and disobedience to authority. *Human Relations, 18,* 57–76.

Moncrieff, J. (2007). Understanding psychotropic drug action: The contribution of the brain-disabling theory. *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry, 9,* 170–179.

Mueser, K. T. (2002). AAMFT Consumer Update: Bipolar Disorder. Retrieved December 31, 2007, from http://www.aamft.org/families/Consumer_Updates/Bipolar_Disorder.asp

Murray, Jr., T. L. (2005). *An empirical examination of Bowen natural systems theory as it applies to fibromyalgia syndrome.* Unpublished doctoral dissertation, University of Florida, Gainesville.

Murray, Jr., T. L. (2006). The other side of psychopharmacology: A review of the literature. *Journal of Mental Health Counseling, 28,* 309–337.

Murray, C. E., & Murray, Jr., T. L. (2007). The family pharm: An ethical consideration of psychopharmacology in couple and family counseling. *Family Journal, 15,* 65–71.

O'Barr, A. (2007). *Psychopharmacology.* Preconference workshop presented at the annual meeting of the Association of University and College Counseling Center Directors, Indianapolis, IN.

Pringle, E. (2006). Psych drugs—Doctors serve as middle-man pushers. Retrieved on November 25, 2007, from http://www.lawyersandsettlements.com/articles/ssri_offlabel

Rose, M. (1991). Activism in the 90s: Changing roles for public relations. *Public Relations Quarterly, 36,* 29–32.

Rüusch, N., & Corrigans, P. W. (2002). Motivational interviewing to improve insight and treatment adherence in schizophrenia. *Psychiatric Rehabilitation Journal, 26,* 23–32.

Read, J., & Harré, N. The role of biological and genetic causal beliefs in the stigmatization of 'mental patients.' *Journal of Mental Health, 10,* 223–235.

Relman, A. (1980). The new medical-industrial complex. *New England Journal of Medicine, 303,* 996–998.

Ridberg, R. (Producer). (2006). *Big bucks, big pharma: Marketing disease & pushing drugs* [Motion picture]. (Available from the Media Education Foundation, 60 Masonic Street, North Hampton, MA 01060, or available free at http://www.veoh.com/browse/videos/category/educational/watch/v1295461Dz3H5DAs)

Schachter, D. C., & Kleinman, I. (2004). Psychiatrists' attitudes about and informed consent practices for antipsychotics and tardive dyskinesia. *Psychiatric Services, 55,* 714–717.

Siegel, D. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* New York: Guilford Press.

Siegel, D. (2006). An interpersonal neurobiology approach to psychotherapy: Awareness, mirror neurons, and neural plasticity in the development of well-being. *Psychiatric Annals, 36,* 248–256. Retrieved May 25, 2009, from PsycINFO database.

Smith, C. E., Pryer, M. W., & Distefano, Jr., M. K. (1971). Internal-external control and severity of emotional impairment among psychiatric patients. *Journal of Clinical Psychology, 27,* 449–450.

Smoyak, S. A. (2004). The construction of reality or the destruction of the self. *Journal of Psychosocial Nursing & Mental Health Services, 42,* 6–7.

Sowers, W. E., & Thompson, K. S. (2007). *Keystones for collaboration and leadership: Issues and recommendations for the transformation of community psychiatry*. Retrieved on December 5, 2007, from http://www.comm.psych.pitt.edu/finds/TransformationofPsychiatryReport.pdf

Spitzer, R. L. (2009). DSM-V transparency: Fact or rhetoric? *Psychiatric Times, 26.* Retrieved March 16, 2009, from http://www.psychiatrictimes.com/display/article/10168/1385346

Strauss, J. S. (1994). The person with schizophrenia as a person II: Approaches to the subjective and the complex. *British Journal of Psychiatry, 164,* 103–107.

Turner, E. H., Matthews, A. M., Linardatos, E, Tell, R. A., & Rosenthal, R. (2007). Selective publication of antidepressant trials and its influence on apparent efficacy. *The New England Journal of Medicine, 358,* 252–260.

Vedantam, S. (2009, Marth 18). A silenced drug study creates an uproar. *Washington Post,* A01. Retrieved on May 25, 2009 from http://www.washingtonpost.com/wp-dyn/content/article/2009/03/17/AR2009031703786.html

Voils, C. I., Steffens, D. C., Flint, E. P., & Bosworth, H. B. (2005). Social support and locus of control as predictors of adherence to antidepressant medication in an elderly population. *American Journal of Geriatric Psychiatry, 13,* 157–164.

Wahl, O. F. (1999). *Telling is a risky business.* London: Rutgers University Press.

Wall, J. K. (2007, November 3). $2 billion challenge: Lilly under gun to replace aging blockbuster Zyprexa. *Indianapolis Business Journal.* Retrieved on November 25, 2007, from http://cms.ibj.com/ASPXPages/6iframes/FrontEndArticlesDetailPage.aspx?ArticleID=07170&NoFrame=1

West, L. J. (1993). A psychiatric overview of cult-related phenomena. *Journal of the American Academy of Psychoanalysis, 21,* 1–19.

Williams, C. C., & Collins, A. (2002). Factors associated with insight among outpatients with serious mental illness. *Psychiatric Services, 53,* 96–98.

Whitaker, L. C. (2007). Forces pushing prescription psychotropic drugs in college mental health. *Journal of College Student Psychotherapy, 3/4,* 1–25.

Whitaker, R. (2002). *Mad in America*. Cambridge, MA: Perseus Books.

Whitfield, C. (2004). *The truth about mental illness: Choices for healing.* Deerfield Beach, FL: HCI.

Winokur, G., & Clayton, P. J. (1986). *The medical basis of psychiatry.* Philadelphia: Saunders.

Wyatt, R. J. (1991). Neuroleptics and the natural course of schizophrenia. *Schizophrenia Bulletin, 17,* 325–351.

Zahniser, J., Ahern, L., & Fisher, D. (2005, September). How the PACE Program builds a recovery-transformed system: Results from a national survey. *Psychiatric Rehabilitation Journal, 29,* 142–145. Retrieved May 26, 2009, from CINAHL Plus with Full Text database.