Recovery from Schizophrenia: An Evaluation of Different Treatments and Therapies

By Ben Durkin

Rationale

Schizophrenia is a much feared diagnosis that often results in social stigma, where recovery is often only considered in terms of cessation of symptoms and compliance with medication. This however, is an evaluation of a number of different treatments and therapies that can be applied and how they relate to an expanded concept of recovery. The medical model's dependence on medication is reviewed, as are a number of therapeutic interventions and client-led initiatives. In addition, a commentary on the nature of cultural relativity and the effectiveness of treatment in the developed versus the developing world are also included, to provide greater depth of analysis and open a wider discussion regarding the possible social construction of an often misunderstood experience.

Introduction

Recovery from a mental illness such as schizophrenia can be very hard to define. It is a condition which has both biological and psychological components, it is socially stigmatising and unlike some other mental illnesses, is a condition which becomes an identity as much as a set of symptoms. Originally named dementia praecox by Benedict Morel[1], it was thought to be a form of early-onset dementia that led to consistent decline in mental functioning. Eugen Bleuler[2] provided the current, more clinically descriptive name which refers to disorganised thought processes, lack of co-ordination between thoughts and emotion and a 'splitting' away from reality. Bleuler referred to the schizophrenias, so it may be assumed that he did not

believe the condition to be a single diagnostic entity and the various subtypes that are used in clinical practice today reflect these subtle complexities. However it has been described though, schizophrenia remains one of the most feared and misunderstood diagnoses, that has often been treated with physiologically harmful medical interventions. It is only within the enormous corpus of research on schizophrenia and its treatment, that clues may be found regarding not only its origin, but on how its sufferers can recover or adapt to live meaningful, worthwhile existences in the wider community.

Diagnostic Symptoms

The symptoms of schizophrenia are divided into categories of those which are positive and those which are negative. Positive symptoms are the delusions and hallucinations which are most recognisable to other people as belonging to schizophrenia. Auditory hallucinations are the most common and often take the form of voices that are experienced as belonging to an external source (such as a relative, celebrity, or demon). Visual hallucinations are also quite common and can be quite varied in the way they present, ranging from distorted perspective to seeing people (or entities) that are not visible to others. Whilst these are the most common types of hallucination, it is possible for someone with schizophrenia to have hallucinatory experiences that affect other senses too. Delusions or unusual beliefs may or may not relate qualitatively to these hallucinations and indeed may exist in the absence of active hallucinatory experiences. The most common delusions relate to ‘thought insertion/extraction’ by others or believing that thoughts are being transmitted, though it must be noted that delusions (like hallucinations) can take any form.

Negative symptoms are behavioural deficits which commonly co-exist with the more easily recognisable positive symptoms. Avolition refers to a lack of

motivation or interest in normal, routine activities and many with this symptom will spend a lot of time sitting around doing nothing, inattentive to appearance, hygiene or activities. Anhedonia is a loss of experienced pleasure, which can be either consummatory (in the moment) or anticipatory (expected). There are also a number of different symptoms surrounding the production of speech, which include alogia (reduced quantity of speech), neologia (invention of new words) and word salad (incomprehensible and seemingly random combinations of words). Flatness of affect is a lack of outwardly expressed emotion, which does not however, relate to the experience of emotion and inappropriateness of affect is expression of emotions which are inappropriate for the situation.

The Medical Model

The medical model emphasises the biological nature of schizophrenia, utilizing research data that has been accumulated since the condition was first identified. Before the 1950s the only treatments available were hospitalization, electro-convulsive therapy (ECT) and leucotomy. Only the first of these is still regularly employed as an aid to recovery, as ECT has been shown to be more effective in treating depression than schizophrenia and psychosurgeries such as leucotomy are now considered to be treatments of last resort due to the irreversible effects. Both options have been the subject of malpractice lawsuits regarding involuntary treatment, permanent brain damage and avoidable fatalities. In 1952 the first effective anti-psychotic medication (chlorpromazine) was developed and rapidly became the preferred method of treatment, with a number of additional variants being added to the pharmacological arsenal following that initial discovery.

At the time of Chlorpromazine’s development, very little was known as to why it should be so effective and it wasn’t until Arvid Carlsson discovered

dopamine's significance as a neurotransmitter in the late 1950s[3] that the effects of 'euphoric quietude' and marked reduction in positive symptoms this anti-psychotic caused, could be fully understood. In Britain, psychiatrists observed that heavy use of amphetamine, a substance which stimulates dopamine release, caused psychotic states and in America it was discovered that anti-psychotic medications block the D2 dopamine receptor, an observed correlation which has become the foundation for one of the most enduring hypotheses regarding the possible cause of schizophrenia and the best way to treat it.

The original anti-psychotic medications were a huge step forward in the medical treatment of schizophrenia and allowed many who had been considered too high a risk to leave hospital, to recover sufficiently enough to live in the community. Unfortunately, these anti-psychotics are known to have a number of unpleasant side effects and were ineffective in relieving the negative symptoms associated with schizophrenia[4]. The most unpleasant side effects of anti-psychotic medication are the incurable tardive brain disorders (dyskinesia[5], dystonia[6] and akathisia[7]), which are the direct consequence of damage to the basal ganglia and result in a hyper-reactive neurotransmitter system[8].

The atypical anti-psychotics that have emerged since the late 1970s have largely replaced the older medications and have a somewhat reduced likelihood of causing the tardive brain disorders and affect a wider range of receptors. The first of these atypicals (clozapine) was not originally considered a viable replacement for the conventional anti-psychotics, due to a number of deaths during drug trials from agranulocytosis[9], but this has been mitigated by the use of regular blood tests which can identify possible problems before a patient becomes at risk. Because the atypical anti-psychotics have more wide-ranging effects[10] they have been more successful

at treating both positive and negative symptoms, which means that many schizophrenic patients have a significantly better quality of life.
The continuing clinical dependence on the use of anti-psychotic medications has received much criticism however, from the psychiatrists Peter Breggin[11] (1991) and Marius Romme[12] (1988), psychologist Richard Bentall[13] (2009) and others. Despite the reduced risk of a patient developing tardive disorders, the risk remains unacceptably high even with the atypicals. Most atypicals also have additional side-effects which can have negative consequences, such as medication induced impotence, massive weight gain and a high risk for developing diabetes. If psychotic symptoms are controlled and yet a patient has become both impotent and morbidly obese as a consequence of the medication, this can have a serious impact on confidence and self-esteem, which is counter-productive to the promotion of mental and emotional wellbeing[14]. At present research is being conducted into experimental new forms of medication that affect NMDA receptors[15], either instead of or in conjunction with, dopamine as part of a developing glutamate hypothesis.

As with the dopamine hypothesis, the glutamate hypothesis is the result of observing the effects of street drugs on both normal and schizophrenic subjects. PCP and ketamine block glutamate (NMDA) receptors[16], causing schizophrenia-like symptoms and it is thought that over-production of dopamine may also be responsible for blocking those receptors. These developing treatments, if efficacious, may very well replace those that are currently being used, but as with both conventional and atypical anti-psychotics, the immediate side effects and more long-term effects may very well cause damage to those that take them. Any substance which artificially alters the delicate brain chemistry that regulates day-to-day functioning runs this risk and thus great care must be taken when applying them to the treatment of psychologically disordered people.

Recovery however, is much more than just the controlling of symptoms associated with biochemical imbalances. Medication may reduce symptoms, but it cannot alter the behaviour patterns that maintain a psychologically disordered lifestyle nor provide meaningful explanations for the hallucinatory content unique to each person with the diagnosis, it cannot remove traumatic memories associated with psychotic episodes and it cannot take personal responsibility. Considering the long-term risks associated with anti-psychotics, their widespread use can only really be recommended as a short-term measure to treat acute episodes. Recovery is a process that takes into account a wide variety of environmental factors that have a deleterious effect on functioning and it is a process that accepts that whilst symptoms may well have a physiological origin, it is the content of these that must be managed. In this regard psychological measures that do not cause harmful physiological changes may offer better long-term outcomes when utilised appropriately.

Therapeutic Recovery

There are a variety of psychological interventions that have been demonstrated to have a beneficial effect on the functional management of schizophrenia. Each of these interventions either focuses on areas of deficit that represent a particular challenge or provide a framework for coping with florid symptoms. The most commonly utilised or recommended of these are Cognitive Behavioural Therapy (CBT) or the more recently formulated Mindfulness-based CBT, Social Skills Training, Family Therapy and Individual Therapy.

Family Therapy is based on the behaviourist approach and seeks to modify behavioural patterns within the family that may cause a relapse. High levels of ‘expressed emotion’ (EE) within the family are, considered to be a

significant environmental risk factor that can result in a cycle of relapse/ rehabilitation[17]. Criticism, hostility and emotional over-involvement are all referred to as EE, even though they may have numerous different causes and manifestations. The aim of the therapy is to teach family members more effective ways to manage the stress of caring for someone, who may have become markedly different from the person they were before becoming unwell. By reassuring them and helping them to understand that they are not to blame for the illness, feelings of guilt are no longer being reinforced and over-protectiveness is much reduced. In order to encourage less critical communication, relatives are taught about the negative impact that stress can have and it's role in triggering episodes. Also, by providing family members with information about schizophrenia and the medication, this can help them to understand why their relative behaves the way they do (which reduces hostility) and helps them feel more in control of a difficult situation. The therapy is geared towards promoting a sense of hope, active engagement with the possibility of recovery and the important role that family can play.

The effectiveness of family therapy has been investigated extensively and in conjunction with medication has been shown to significantly reduce the incidence of relapse, especially when the therapy has lasted for 9 months[18]or more. Considering that the optimum length of this course of therapy is as long as it is, it remains very cost-effective as the cost of its provision is offset by the reduction in hospitalizations[19]. Family therapy for schizophrenia is not however as accessible as it could be, because the training is often provided to already stretched professionals within the NHS who cannot effectively schedule sessions into their workload[20]. Also, even if structural changes were made to accommodate its provision within frontline mental health services, many schizophrenics live alone or with carers who are unable to make a commitment to a very time-consuming therapy, which limits the potential

benefit that it could provide and in such cases it might be more appropriate to incorporate social skills training into a recovery regime.

Many people with schizophrenia have limited social skills, either because the condition has affected them or because they never developed them. The earlier the age of onset the more likely that certain key social skills may either not develop or be significantly impaired[21], the result of both florid positive symptoms (such as hallucinations) directly interfering with social cognition and negative symptoms (such as lack of motivation) reducing the willingness to interact. Those whose condition develops later may have acquired social skills, but then as a result of these positive and negative symptoms, experienced deterioration. Social skills training, like family therapy, is a behaviourist treatment programme that is used to improve the social outcomes for those who may be at serious risk of isolation, withdrawal or being taken advantage of.

Social skills training applies behaviourist techniques of reinforcement to the development of key interpersonal skills[22]. It offers an effective training regimen for expressive, receptive and interactive behaviours[23], as well as guidance for negotiating more socially specific situations (such as development and maintenance of romantic relationships[24]). The programme takes into account the various factors that may impede the process of developing these skills, such as hallucinations, neurocognitive deficits, past experiences of social defeat, sensitivity to criticism and lack of resources[25], tailoring the training towards those areas that most need development for each client. Social skills training usually takes place in a group environment, to allow clients to develop their skills in a social setting and learn vicariously from one another, with an emphasis placed on those skills that are most important for staying safe from harm and remaining healthy.

Social skills training, like family therapy has been the subject of considerable research into its effectiveness and has been shown to reduce relapse rates and improve the social outcomes for those it has been provided for[26]. It is considered to be most suitable for those in outpatient rather than inpatient settings[27] and is considered to be particularly effective when combined with family therapy[28]. The long-term benefits of this intervention could possibly be more profound in real terms than the provision of medication to control the acute symptoms. Having access to the necessary skills to request help in a manner that will more likely be responded to, form solid friendships or relationships in the wider community and be assertive in situations that may involve interpersonal conflict, are an invaluable aid to remaining well and avoiding stressful social defeats that could result in a relapse and increased medical intervention. However, social skills training is not and cannot be an aid to dealing with the positive symptoms that may continue to play a significant role in shaping behaviour and there are some ethical considerations in applying behaviour modification upon an individual rather than working with them.

Cognitive Behavioural Therapy (CBT) was not always considered as a possible treatment for the delusional symptoms of schizophrenia, but evidence suggests that these hallucinations and abnormal beliefs (which represent significant cognitive distortions) are as amenable to reality-testing as the negative self-talk of depression[29]. One reason CBT was not always considered applicable may have been the considerable degree of cognitive impairment that schizophrenics experience[30], although it is also possible that the relative safety of engaging with deeply-held psychotic delusions was also a matter of concern[31]. However, after much research, it has been demonstrated that when the process is seen as a collaborative exploration conducted by a therapist and client[32], challenging these delusional beliefs can result in marked improvements. During sessions it is important that the

therapist keeps an open mind, because even the most delusional belief system can have its roots in a ‘real’ experience[33] (albeit distorted). In addition, by challenging a client’s low expectations for success, pleasure or social acceptance, it has also been demonstrated to be an effective treatment for reducing negative symptoms[34].

The addition of ‘mindfulness’ practices to conventional CBT, is perhaps one of the more intriguing developments in psychology. Mindfulness is a concept taken from Buddhist philosophy that encourages adherents to be present within the ‘moment’, observing the various physical, emotional and psychological processes from an objective distance. The inclusion of these concepts to CBT allows distortions to be observed and altered in real-time, utilising meditative techniques that provide a calming effect to rational problem-solving. Reactive patterns tend to occur when on automatic pilot, so being mindful allows an opportunity to observe rather than to react and consider the rational alternatives to thoughts which are not facts[35]. This practice of observation rather than reaction may hold potential for a client gaining a sense of control over hallucinations, as the observation that ‘thoughts are not facts’ can be substituted with ‘voices are not facts’ (thus removing some authoritative power from the hallucination).

Social skills training and CBT are dependent on the client being in the appropriate state of mind to receive treatment and as such are often combined with medication which can reduce the symptoms sufficiently for psychological treatment to be engaged. However, these interventions are still not always applicable for each client and so the concept of ‘personal therapy’ has been gaining some ground in recent years[36]. Personal therapy has been clinically trialled with positive results and constitutes a series of therapeutic stages that are tailored to the client’s requirements and progress at a speed that is appropriate to their needs. The benefit of such personalised therapy is

that it may incorporate any of the techniques that more specific clinical interventions utilise, but also can include more unconventional methods that may be more suitable for a particular client. This client-centred approach is based somewhat on the approach of Carl Rogers[37], yet has been expanded to incorporate an 'eclectic'[38] milieu of therapies. However unless properly organised with a systematic approach, providing personalised therapy is possibly the least cost-effective method. It is a lengthy process that depends on the amount of time each individual takes to progress and would only be cost-effective if the therapies were provided by a team of psychologists (an inconsistency which may cause distress to a client).

These psychological treatments form part of a psychosocial 'toolkit' that present an array of specific interventions that can work harmoniously with the medications that are routinely prescribed to those diagnosed with schizophrenia. However, recovery that is imposed by a professional is often seen as a disempowerment that removes responsibility for the process from the client. Someone with schizophrenia who chooses to be treated is quite different from someone with schizophrenia who takes responsibility for their own recovery. As a consequence there have been a number of client-led (rather than client-centred) innovations in recovery that have developed.

Peer Support & the Survivor Movement

The survivor movement consists of mental health service-users and former service-users who have endeavoured to take charge of their own recovery, rather than being passive recipients of treatments and interventions. It is a movement where non-compliance or partial compliance with treatment does not necessarily equate to non-engagement with recovery. It is a movement where the person seeks to separate from the label, yet will also remain constantly aware of the challenges that their experiences present. Many

adherents continue to take medication and/or receive additional services provided by the state, but schizophrenia and other psychological disorders have often become political battlegrounds as much as personal ones[39].

The Hearing Voices Movement advocates a view of hallucinatory experiences that removes its association with illness per se, but rather as an acceptable variation of normal human experience that can be problematic if triggered by traumatic events or if unhelpful coping strategies are adopted. Much of the evidence for this disease-free model derives from the research of Romme & Escher (1989, 1993, 2000, 2001, 2006[40]) which indicated that 2-4% of the population hear voices with only 1% being diagnosed schizophrenia and that 77% of those with voices that cause them significant problems have experienced a major trauma. Romme & Escher suggest that even those who do not have problematic voices seek to find meaning from the experience and that this pursuit of meaning is even more important for those who do. They therefore suggest a three-phase process of adaptation to voice-hearing that can lead to recovery:

1. Startling: A period of confusion, helplessness and emotional turmoil
2. Organization: The pursuit of meaning and ways to cope with the experience
3. Stabilisation: A state of equilibrium where the voices have become accommodated into everyday routines[41]

The structure of the movement is primarily a network of support groups where voice-hearers can freely discuss in mutual confidence their experience and methods of coping[42]. Those who have yet to learn adaptive strategies can receive support from those who are coping more effectively and by supporting each other this way, voice-hearers are able to explore the often ignored

qualitative content of their experiences in an environment free of pejorative labels.

Though the Hearing Voices Movement provides an alternative explanation of the voice-hearing experience that avoids diagnostic labels, many of those who attend the groups have been diagnosed with a variety of psychological disorders and indeed some groups are held in hospitals. This suggests the formation of a sub-culture within a conventional clinical framework that, whilst beneficial, has yet to distance itself (at least physically) from the disease model[43]. Additionally, the presence of non voice-hearing professionals within the movement presents significant questions regarding representative affiliation and future direction.

One of the most significant developments in self-determination has been the development of the Wellness Recovery Action Plan (WRAP)[44]. This functions as an advance directive that, whilst not legally binding, must at least be taken into consideration by clinicians when providing treatment. It was devised by Mary Ellen Copeland when it became physically impossible for her body to accept psychiatric medication[45]. She therefore devised a daily maintenance plan, a comprehensive list of triggers and early warning signs, crisis plan and post-crisis plan that could be used as an alternative to conventional treatment. The crisis and post-crisis[46] portion of the WRAP she devised have become widely utilised as a means to prevent non-consensual treatment, during periods when it is impossible to actively provide or deny consent. The daily maintenance plan and list of triggers and early warning signs[47], whilst primarily for the owner of the WRAP, are also provided to carers and chosen professionals, as a means to avert relapses.
The WRAP has provided a much needed sense of self-determination and ownership over recovery, that would otherwise be severely limited for those experiencing regular episodes, but there remain a number of serious

concerns over its effectiveness. The most important of these is the need for the owner of the WRAP to be completely honest when filling in the details, as dishonesty could quite easily negate the effectiveness of its implementation and even then may still have to be adjusted if its practical application is seen to be either ineffective or too burdensome. The second concern is that many owners of a WRAP may not provide copies for those that are directly involved in their care and the important information it contains is thus unavailable to those who need it. The third and final concern is the fact that regardless of how accurate it is, or how many key carers have copies of it, because the document is not legally binding it is still possible for clinicians to ignore its contents. However, despite these concerns the WRAP represents at the very least, a document of empowerment.

Different Cultures

Whether a concept of recovery is being espoused by a psychiatrist adhering to the biological model, a psychologist adhering to a therapeutic model or indeed ‘survivors’ of inadequate treatment, they are all developments that have emerged from a Western culture and perspective. The World Health Organization’s (WHO) International Pilot Study of Schizophrenia (IPSS) in the late 1960s identified the presence of schizophrenia in all the countries they studied, but a 5 year follow-up of their findings showed that those in developing countries had a 27% recovery rate in comparison to 7% in the industrial world. A later study, the WHO’s Determinants of Outcome of Severe Mental Disorders identified 37% of patients in developing countries recovered fully as opposed to 16% in developed countries[48]. These statistics quite clearly indicate that despite the medical expertise of the industrialised world, the traditional practices of less advanced countries still offer a better outcome and the only rational reason for this discrepancy is cultural.

Anthropologist and psychologist Holger Kalweit (1984) extensively studied a number of different cultures and discovered that there were marked similarities in the experiences of practising shamans. Whilst these experiences would be interpreted differently, there were commonalities regarding travelling to the world of the dead in spirit form, communion with spirits and more intriguingly a shamanic 'sickness'[49]. The symptoms of this 'sickness' often bear a striking similarity to those of schizophrenia in the developed world and could last many years, but rather than being treated they were regarded as an important transition from one state of being to another[50] (becoming a shaman).

These practices, whilst by no means universal in the developing world, offer a degree of insight into the cultural relationship the Western world has with abnormal psychological symptoms. In a secular, scientifically advanced culture, psychological abnormality appears as a threatening disease that must be treated, whereas in cultures where shamanic practices are accepted and acceptable, those who have been through this 'sickness', become tribal healers. This aspect of Kalweit's research suggests is that the cultural values that identify schizophrenia as a disease to be treated may actually be themselves dysfunctional and that it is preferable to normalize and accept the experience as one that is amenable to development and training.
There are other possible reasons why those in developing countries have higher rates of recovery though and one of these may be that such cultures are less isolated, with more co-operative values than those in industrial countries. A more co-operative value system would naturally increase a sense of group culpability in those that become schizophrenic and thus provide a stronger drive to resolve the related issues from a group perspective (limiting the social withdrawal that is a common negative symptom). Strong co-operative group dynamics may also help mitigate some of the delusional aspects, as a system of group reinforcement of cultural

norms and values may have a more significant effect on an individual in a co-operative society. In societies where voice-hearing is normalized and even respected as a valid cultural experience, stigma is reduced and so these other factors may be more effective at reconnecting an individual to a group identity. If this is the case then these cultures are in effect applying the behavioural family therapy and social skills training models, without recourse to the theoretical paradigms that inspired their development in the West.

Whether developing countries have greater rates of recovery because they are naturally applying behavioural interventions as part of their culture, or because their cultural paradigms do not perceive schizophrenic symptoms as a disease, the results of the WHO's research are a telling indictment of the developed world's relatively ineffective treatment regimes. Despite being largely ignored, Kalweit's research is reflected by and most compatible with the approach that has been independently adopted by the Hearing Voices Movement. Romme & Escher's 3 stage recovery model is similar in many regards to that espoused by shamans who have undergone a 'sickness' and their position within their communities is an example of the 'normalization' process that follows an acceptance of voice-hearing as a natural variant of human consciousness. Behavioural family therapy too, can be seen as a long-overdue reassessment of the importance of community that has been heavily impacted by modern technological advancement and the need for actively applying social skills training can only be seen as a belated response to this communal failure in the developed world.

Conclusion

Schizophrenia is an incredibly complex disorder that affects day-to-day functioning in a number of different ways. Some of these effects may be relatively subtle, yet just as devastating as those that are more generally

recognised. It's aetiology remains a matter of dispute despite a wealth of scientific evidence, largely because this evidence is open to questions of cultural relativity and whether the evidence can be reliably considered to represent a physiological cause and effect. There are a number of treatments and therapies that are available, yet the one most frequently applied is the one which is known to cause sometimes irreversible side-effects. Of perhaps greatest concern is that it is also a condition which the most technologically advanced societies are less able to effectively treat than those in the developing world. So the question remains twofold: What exactly is recovery and how is it best achieved?

If recovery remains primarily couched in terms of remission from symptoms, then that remains the only result that is considered feasible and yet these are not the terms of recovery. It is only when the content of the experience is explored that the possibility of adaptation becomes open and at present this seems best achieved through the collaborative reality-testing of CBT, the integration and acceptance of trauma that is commonly espoused by the survivors movement and the principles of insightful self-management that a peer supported WRAP encourages. When these perspectives are applied it becomes both possible and feasible to recover despite the continued presence of symptoms, as these can become an integrated part of the holistic entity, rather than an externally superimposed schizophrenic identity that must be extinguished. For this reason, recovery is best described as a self-managed, multidimensional process of personal integration, adaptation and transformation, within a unique experience that commonly results in behavioural and perceptual symptoms that are referred to as schizophrenia and this is best achieved when there is a close-knit social framework that is accepting, supportive and non-stigmatizing.

Bibliography

Bellack, A.S., Mueser, K.T., Gingerich, S., Agresta, J. (2004), *Social Skills Training for Schizophrenia: A Step-by-Step Guide,* The Guilford Press

Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd.

Breggin, P. (1993), *Toxic Psychiatry – Drugs and Electroconvulsive Therapy: The Truth and the Better Alternatives,* HarperCollins Publishers

Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc.

Copeland, M.E., Mead, S. (2004), *Wellness Recovery Action Plan & Peer Support,* Peach Press

Crane, R. (2009), *Mindfulness-Based Cognitive Therapy,* Routledge

James, A. (2001), *Raising Our Voices: An Account of the Hearing Voices Movement,* Handsell Publishing

Kalweit, H. (1984), *Dreamtime & Inner Space: The World of the Shaman,* Shambala Publications Inc. (1988 translation)

Kring, Johnson, Davison, Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd.

References

---

[1] Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., p.458

[2] Bleuler, E. (1911) cited in Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., p.458

[3] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., p. 76

[4] Butcher, J.N., Mineka S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., pp. 490-491

[5] A movement disorder that diminishes voluntary movements and increases involuntary movements, usually of the mouth, tongue and jaw

[6] A movement disorder that results in repetitive twisting motions and abnormal posturing

[7] Inner restlessness that causes difficulty with sitting still or remaining motionless

[8] Breggin, P. (1993), *Toxic Psychiatry,* HarperCollins Publishers, p. 100

[9] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., pp. 224-225

[10] Bezchlibnyk-Butler & Jeffries (2003) cited in Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., p. 491

[11] Breggin, P. (1993), *Toxic Psychiatry,* HarperCollins Publishers, pp. 84-112

[12] James, A. (2001), *Raising Our Voices,* Handsell Publishing, pp. 37-39

[13] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., pp. 231-235

[14] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., p. 227-228

[15] Patel et al. (2007), cited in Kring, Johnson, Davison, Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd., p. 334

[16] Goff & Coyle (2001) cited in Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., p. 483

[17] Brown et al. (1966), Weisman et al. (1998), Lopez et al. (1999), cited in Kring, Johnson, Davison, Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd., p. 339

[18] Falloon et al. (1982, 1985), Hogarty et al. (1986, 1991), Kopelowicz & Liberman (1998), McFarlane et al. (1995), Penn & Mueser (1996) cited in Kring, Johnson, Davison & Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd., p. 349

[19] Tarrier et al. (1991) cited in Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education, Inc., p. 492

[20] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., pp. 251-252

[21] Bellack, A.S., Mueser, K.T., Gingerich, S., Agresta, J. (2004), *Social Skills Training for Schizophrenia,* Guilford Publications Inc., p. 5

[22] Bellack, A.S., Mueser, K.T., Gingerich, S., Agresta, J. (2004), *Social Skills Training for Schizophrenia,* Guilford Publications Inc., p. 46-47

[23] Bellack, A.S., Mueser, K.T., Gingerich, S., Agresta, J. (2004), *Social Skills Training for Schizophrenia,* Guilford Publications Inc., p.9

[24] Bellack, A.S., Mueser, K.T., Gingerich, S., Agresta, J. (2004), *Social Skills Training for Schizophrenia,* Guilford Publications Inc., p. 15-16

[25] Bellack, A.S., Mueser, K.T., Gingerich, S., Agresta, J. (2004), *Social Skills Training for Schizophrenia,* Guilford Publications Inc., p. 5-8

[26] Kopelowicz et al. (2002) cited in Kring, Johnson, Davison, Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd., p. 348

[27] Corrigan (1992), cited in Bellack, A.S., Mueser, K.T., Gingerich, S., Agresta, J. (2004), *Social Skills Training for Schizophrenia,* Guilford Publications Inc., p. 21

[28] Valencia et al. (2007), cited in Kring, Johnson, Davison, Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd., p. 348

[29] Drury et al. (1996), Haddock et al. (1998), Beck & Rector (2000), Garety, Fowler & Kuipers (2000), Wykes et al. (2008), cited in Kring, Johnson, Davison, Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd., p. 349

[30] Butcher, J.N., Mineka, S., Hooley, J.M. (2010), Pearson Education Inc., p. 493

[31] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., p. 253

[32] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., p. 252

[33] 'Hannah's Story' & 'Living with Mr. Pinkerton' cited in Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., pp. 128-130, 145-147

[34] Beck, Rector & Stolar (2004), Rector, Beck & Stolar (2005), Wykes et al. (2008), cited in Kring, Johnson, Davison, Neale (2010), *Abnormal Psychology,* John Wiley & Sons (Asia) Pte Ltd., p.348

[35] Crane, R. (2009), *Mindfulness-Based Cognitive Therapy,* Routledge, pp.93-96

[36] Hogarty et al. (1997), Kendler (1999), cited in Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., pp. 493-494

[37] Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., pp 581-582

[38] Butcher, J.N., Mineka, S., Hooley, J.M. (2010), *Abnormal Psychology,* Pearson Education Inc., p. 588

[39] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., p. 287

[40] Extracted from http://www.intervoiceonline.org/tags/essential%20facts,, on 03/06/10

[41] Romme, M. & Escher, S. (1987), cited in James, A. (2001), *Raising Our Voices,* Handsell Publishing, pp. 33-37

[42] James, A. (2001), *Raising Our Voices,* Handsell Publishing, p. 53

[43] James, A. (2001), *Raising Our Voices,* Handsell Publishing, p. 53

[44] Copeland, M.E. & Mead, S. (2004), *Wellness Recovery Action Plan & Peer Support,* Peach Press, pp. 65-66

[45] Extracted from http://www.youtube.com/watch?v=G6xMN57K0xU, on 03/06/10

[46] Copeland, M.E. & Mead, S. (2004), *Wellness Recovery Action Plan & Peer Support,* Peach Press, pp. 109-121

[47] Copeland, M.E. & Mead, S. (2004), *Wellness Recovery Action Plan & Peer Support,* Peach Press, pp. 75-82

[48] Bentall, R. (2009), *Doctoring the Mind: Why Psychiatric Treatments Fail,* Penguin Books Ltd., pp. 19-20

[49] Harvey, Y.K. (1980), cited in Kalweit, H. (1984), *Dreamtime & Inner Space: The World of the Shaman,* Shambala Publications Ltd. (1988 translation), p. 84

[50] Kalweit, H. (1984), *Dreamtime & Inner Space: The World of the Shaman,* Shambala Publications Ltd. (1988 translation), p. 89

March 2011