Box 1. Leading 'Anti-psychiatrists'

Thomas Szasz (1920-2012)	An American psychiatrist who challenged the idea of mental illness, and argued that what is considered as mental illness is better understood as socially deviant behaviour.*
R.D. Laing (1927-1989)	A Scottish psychiatrist, whose work was influenced by existential philosophy. He analysed the meaning of mental illness 'symptoms' in relation to the familial and social environment. Founded Kingsley Hall, a therapeutic community for people with psychosis.*
Michel Foucault (1926-1984)	A French philosopher whose first major work considered varying understandings of madness through different historical epochs and social responses to it.
David Cooper (1931-1986)	A South African psychiatrist, who worked in Britain. He set up a therapeutic community (known as Villa 21) within an existing asylum. He was a Marxist ideologue and he coined the term 'anti-psychiatry'
Erving Goffman (1922-1982)	An American sociologist whose book, *Asylums*, described the impoverishing effects of 'total institutions,' including asylums, on people's behaviour.

*Szasz did not consider himself an 'anti-psychiatrist,' a term he disliked and considered to be associated with the ideas of R.D. Laing. Laing, in his turn, also eschewed the term.

Box 2. The Social Construction of Depression.

Mental illness in Eastern Europe:
The work of anthropologist Vieda Skultans demonstrates how the western concept of depression was contrived to replace prior understandings of distress popular in the Soviet era (often diagnosed as 'neurasthenia') (Skultans 2007). The growth of pharmaceutical marketing influenced doctors' behaviour and helped to effect this change. Her analysis of medical consultations in Latvia reveals how the transition to the concept of depression involved doctors imposing an increasingly objectified view of suffering onto their patients' complaints, ignoring personal explanations and context. Skultans' analysis illustrates how the diagnosis and treatment of psychiatric complaints reflect their social context; in this case, the effects of an emerging market economy.

Mental illness in Japan:
The introduction of the western concept of 'depression' into Japan has been carefully documented by anthropologists Lawrence Kirmayer and Junko Kitanaka. They describe how prior understandings emphasised somatic symptoms and anxiety with high use of benzodiazepines. Moreover, sadness and suicide were not regarded entirely negatively as in the west, and were valued for indicating sensitivity, bravery and honour. Ihara (Ihara-H, 2012) has documented how pharmaceutical marketing and public health campaigns introduced the western concept of depression as an illness, using the slogan the 'cold of the soul'. This has been accompanied by soaring rates of antidepressant use.

Box 3 Psychoactive Effects of Psychiatric Drugs.

Type of drug	**Psychoactive effects***
Antipsychotics	Sedation, subjective and objective cognitive slowing or impairment, emotional blunting/ indifference, reduced libido, demotivation, dysphoria.
Tricyclic antidepressants	Sedation, cognitive impairment, dysphoria.
SSRIs and related antidepressants	Drowsiness, lethargy, emotional blunting, loss of libido, 'activation' (agitation, irritability).
Lithium	Sedation, cognitive impairment, lethargy, emotional blunting, dysphoria.
Benzodiazepines	Sedation, cognitive impairment, physical and mental relaxation, euphoria.
Stimulants	Increased arousal, vigilance and attention, euphoria.

*The effects of different drugs within each class vary, particularly drugs classified as antipsychotics. The data provided is necessarily a summary which glosses over distinctions between individual agents. For more detail and references see Yeomans et al 2015.

Box 4. An Example of Collaborative Prescribing.

Discussing antidepressant medication:

The psychiatrist should explain that there is no evidence that antidepressants work by correcting a chemical imbalance or other identifiable abnormality. They should inform the patient of the mental and physical alterations produced by common antidepressants (Box 3), acknowledging the paucity of research data about these effects. They might highlight the reduction in intensity of emotions - both desired and undesired - that appears to be produced by some antidepressants and how this effect may be linked with sexual impairment. As with any consultation they should discuss known adverse effects, including withdrawal effects. The psychiatrist should attempt to understand what the patient expects to gain from drug treatment, and whether their expectations match the evidence of what antidepressants can achieve. They should discuss alternative options and help the patient to weigh up the pros and cons of taking an antidepressant in the light of all these considerations.