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CHALLENGING THE MYTH OF MEDICATION IN MILD AND MODERATE DEPRESSION AND ANXIETY, A PSYCHOLOGICAL AND PHILOSOPHICAL PERSPECTIVE

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Challenging the Myth of Medication in Mild and Moderate Depression and Anxiety, a Psychological and Philosophical Perspective

Beatrice POPESCU[1]

Abstract

The integrated model of mental health recommends nowadays the collaboration between psychiatrists, psychotherapists and clinical psychologists. It is currently the agreed model in the managed health care system in the West and research has shown that mixing the medical model with the psychological model both in theory and practice elicits the best outcomes and guides the client towards recovery. In this paper I will challenge this view on a particular area of psychopathology, mild and moderate depression and anxiety, showing that in these particular situations, 15-20 sessions of psychotherapy are sufficient and efficient for recovery and there is no further need for medicating the client, unless the client himself desires this particular type of psychiatric approach. I will also focus on a target group, pregnant women who fear toxic reactions for the fetus and don't consider taking antidepressant and anxiolytic medication out of fear of adverse reactions. I will also explore the ethical implications of prescribing these target groups medication against their will. CBT, REBT and Existential Psychotherapy are effective options to treat both the symptoms and causes of mild and moderate anxiety and depression, whilst exercise, nutrition and mindfulness meditation can also be effective treatments (Lake, 2008). Since medications such as antidepressants have recently become the treatment of choice in United States with a 147.5% increase in antidepressant prescription rates between 1990 and 1998 (Clarke & Gawley, 2009) and with a 10.9% decrease in the utilization of psychotherapy, my paper aims to balance this approach in the favour of psychotherapy as a first choice option.

Keywords: *Psychotherapy, ethical issues, medicalization; moderate depression and anxiety.*

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Introduction

This paper has two objectives. The first objective is to challenge the myth of psychiatric medication in two frequent areas of psychopathology: mild and moderate depression and anxiety. The second is to discuss the ethical implications of prescribing medication to pregnant women who fear the side effects of psychiatric medication and the effect of psychiatric medication on the fetus. Starting from the integrated model of mental health, the rationale of the study is based on two assumptions largely accepted by the psychotherapist's community (APA), but still not accepted by the whole medical community: 1. Bona-fide psychotherapy (CBT, REBT, existential psychotherapy etc) is an effective option to treat both symptoms and causes of mild and moderate anxiety and depression. "Bona fide psychotherapy appears as effective as SGAs in the short term treatment of depression and likely more effective than SGAs (second generation antidepressants) in the longer-term management of depressive symptoms." (Spielmans, Berman, & Usitalo, 2011). 2. Since medication and psychotherapy are equally effective in treating mild and moderate depression and anxiety, psychotherapy but not medication should be the first choice treatment option in these particular situations.

1. The integrated model of mental health in depression and anxiety research – a critical analysis

The integrated model of mental health (Farrar et al., 2001) recommends nowadays the collaboration between psychiatrists, psychotherapists and clinical psychologists. It is currently the agreed model in the managed care system in the West and research has shown that mixing the medical model with the psychological model both in theory and practice elicits the best outcomes and guides the client towards recovery.

The medical model (Shah et al., 2007) considers that all psychological problems/disorders have a physical symptom profile, therefore the condition is a physical (medical) problem, eg. blood chemistry changes in depression, physiological changes in anxiety disorders. The assumption is that abnormal behaviour is the result of physical problems and it should be treated medically. This approach posits that disorders have an organic or physical cause and the focus of this approach is on genetics, neurotransmitters and neurophysiology.

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Latest paradigm shift in treatment of depression is from 'chemical imbalance to neuroinflamation' (Köhler, Benros, Nordentoft, et al., 2014), from 'neurotransmitters to neuroplasticity' (Serafini, Hayley, Pompili et al., 2014).

The psychological model posits that the separation between physical and psychological problems is artificial, because these two components are present in almost all human experiences. Psychological problems can be caused by environmental, physical or psychological factors which the client encounters in the daily life. eg. stress and depression play a role in recovery from surgery, psychotherapy improves cancer recovery. The subjective experience of the patient is considered most important in this model. Eg. in the medical model hypochondriac complains don't make sense, while in the psychological model they do.

The medical model highlights the biological bases of behavior and pharmacological treatment of these biological bases in order to achieve behavior change (Schatzberg, Cole & Debattista, 1997), while "psychotherapy is rooted in and enhanced by a therapeutic alliance between therapist and client/patient that involves a bond between the psychologist and the client/patient, as well as agreement about the goals and tasks of the treatment"
(Cuijpers et al., 2012; Lambert, 2004; Karver et al., 2006; Norcross, 2011; Shirk & Karver, 2003; Wampold, 2007).

There is a large body of research showing "that both antidepressants and psychotherapy offer similar efficacy in the short-term, but that after treatment discontinuation, results are better with psychotherapy" (Spielman, 2011). In a meta-analysis conducted by Cuijpers, Sijbrandij, Koole et al. (2013), they found "clear evidence that combined treatment with psychotherapy and antidepressant medication is more effective than treatment with antidepressant medication alone" and that the superior effects of combined treatment remained significant at one to two-year follow-up. Another "meta-analysis found that psychotherapy patients were half as likely to suffer depressive relapse in the long-term, at least one year after acute treatment was discontinued" (DeMaat et al., 2006). Another meta-analysis found that "patients receiving psychotherapy had lower depression scores than patients on antidepressants in the long-term, with this difference increasing with the length of follow-up". (Imel et al., 2008) In another meta-analysis by Farach et al., (2012), the authors question "about how much, and in

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whom, the placebo effect contributes to antidepressant response". In a recent meta-analysis, Fournier et al. (2010) found that for patients with mild or moderate depression symptoms, drug response (compared with placebo), may be minimal or nonexistent. However, for patients with very severe depression, the benefit of antidepressants over placebo is substantial. A recent study (Gibbons, Hur, Brown, Davis, & Mann, 2012) suggests that initial severity of depression is unrelated to antidepressant response. The relationship of response to initial severity "should be systematically examined in the anxiety disorders as well". (Farach et al., 2012). Summarizing, majority of meta-analyses found that medication an therapy and medication work equally for depression, though therapy might be better for long-term protection from future symptoms. My clinical observations also support the key findings of these meta-analyses, insisting on the idea that psychotherapy should be the treatment choice, not the medication. This is why I consider that the client should always be presented both options as valid: an evidence-based method of brief psychotherapy as a first choice and medication as a second choice, in case therapy does not work.

2. On medicalization of mental health

Different authors have different answers to the question: what is *medicalization*?

Based on critical articles of psychiatry, the term "medicalizing" denotes:

- the inappropriate labeling of a "normal" condition or "problem of living" as a disease, disorder, or illness;
- the assertion that a condition or state of affairs requires the services of a nurse or physician;
- the assertion that a condition is due to disturbed physiology, a "chemical imbalance", or some other bodily defect; or
- the assertion that a condition requires a somatic treatment, such as a medication, ECT, etc. (Pies, 2013)

The famous critic of psychiatry, Dr. Thomas Szasz, highlights the fundamental philosophical problem raised by medicalization:

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> *The concept of medicalization rests on the assumption that some phenomena belong in the domain of medicine and some do not. Accordingly, unless we agree on clearly defined criteria that define membership in the class called "disease" or "medical problem" it is fruitless to debate whether any particular act of medicalization is "valid" or not."(Szasz, 2007)*

Modern psychiatry tends to "treat human problems as medical problems" (Parens, 2011: 2) and in this concern, makes an error about the nature of the world. However, the critical thinking requires us to avoid such errors. More specifically, seeing clearly and living well compels us to learn to live with our problems, not to conceal them. "It requires that we learn to affirm, rather than try to erase, variations in our moods, behaviors, and appearances." (Parens, 2011: 2). The same author also proposes the view that there are few problematic "assumptions built into the notion of medicalization": too broad conceptions of the goal of medicine, Conrad's assumption "that he knows the difference between valid (or real) medical diagnoses and invalid (or fake) ones, the medicalization critique's narrow conception of the goals of medicine" (Parens, 2011: 3) and the tendency to embrace "an *individual-differences* model, which seeks to understand why it is that, within populations, there is almost always *continuous variation* with respect to any trait or cluster of traits" (Parens, 2011: 4).

What modern psychiatry seems to forget is that people's life situations and existential crises do not have to be medicalized, but rather resolved in therapy. Not only sociologists like Peter Conrad, but also psychiatrist like Peter Breggin, think that medicalization leaves us incapable to distinguish between emotions, behaviors, and also incapable to acknowledge limitations that are a normal part of human living and those that are abnormal. By seeking instant cures for sadness, exhaustion, uncomfortable situations and unhappy memories, medicalization tries, but not always succeeds, to turn us into perfectly functional creatures, incapable of assuming our human condition. Also, the ethical aspects of mood-altering medication are exposed frequently in his books. (Breggin, 2008).

In my own view, the medicalization in mental health is not good or bad. Trying to have a balanced stance, I think it is each medical practitioner's responsibility to make a sound judgment when prescribing

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medication to a patient. There are some serious 'disorders' in psychiatry, such as psychosis: schizophrenia or delusional disorders which involve losing touch with reality or experiencing delusions and which may require hospital treatment. There are also organic depressions with chronic evolution that also may require medication. But for all the other types of "mental issues" such as mild or moderate episodes of depression or anxiety experienced for the first time in life, the evidence-based psychotherapy should be the first choice treatment.

3. Clinical observations and empirical findings in my psychotherapeutic practice

In this paper I am challenging the mainstream view that both psychotherapy and medication are efficient in this particular area of psychopathology, mild and moderate depression and anxiety, showing that 15-20 sessions of psychotherapy are sufficient and efficient for recovery and there is no need for medicating the client.

3.1. Depression measured with BDI (Beck Depression Inventory), key findings.

BDI scores and the anamnestic interview findings are key to understanding the severity of depression. In practice, the severity of depression does not always correlate with suicidal thoughts or ideation.

Suicidal thoughts and intentions as mentioned in the BDI – II (item 9)

a. I don't think to commit suicide

b. I think of committing suicide but I would never do this

c. I intend to commit suicide

d. I would take my own life if I was offered the occasion

In a sample of 75 clients diagnosed with severe depression and having a BDI – II score > 35, only one client actually expressed the intention of committing suicide (c. *I intend to commit suicide*), from which we may make the inference that clients with a lower depression score (mild or moderate, between 14 and 28) are not in the danger of taking their own life. Even for severe depression (scores higher than 35), the regular answer to this item (9) is: *I think of committing suicide but I would never do this*. Another hint in assessing the severity of depression and the power of suicidal thoughts and intentions would be the idea that a person already seeking help from the moment he or she is offered the

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help, there is no point in committing suicide, provided he or she doesn't also have a personality disorders on Axis 2 (eg. borderline).

3.2. Anxiety measured with BAI (Beck Anxiety Inventory), key findings.

In another sample of 60 clients diagnosed with panic attacks and/ or high anxiety and a BAI score > 36, none of the clients actually expressed the intention of committing suicide, that means clients with a lower anxiety score (mild or moderate, between 0 and 35) are even less in the danger of taking their own life. Considering the fact that even in severe depression, the probability of the client taking his/hers own life is low, we make the assumption that in mild and moderate depression and anxiety the need of medication is minimal, even non-existent, and *psychotherapy should be the first-choice treatment*.

Disclaimer: we consider the client or patient as an individual that has had a formal diagnosis of depression and/or anxiety on Axis I, but he or she does not have an Axis II severe personality disorder diagnosis that imply suicidal behaviours (van Luyn, et. all., 2007).

Psychotherapy not only for fast symptom relief but also for long-term benefits may be the treatment choice often overlooked by medical professionals. Ideally, the patient or client with mild or moderate depression and anxiety symptoms should be referred first to a psychotherapist and only in the case psychotherapy is not effective they would be in the position to prescribe them medication, having in mind the medical model of mental health.

One of the key findings of this empirical study is that 15-20 sessions of brief psychotherapy (CBT, REBT etc) may be more efficient than medication for fast symptom relief, while for the other problems related to goals, meaning, fear of death (existential issues) existential psychotherapy could be the choice. Also schema therapy (Young) can be very efficient when dealing with dysfunctional patterns from the childhood (especially phobias and hypochondriac complains) which if modified, can lead to the improvement of mental health.

In the first 3-4 psychotherapy sessions, especially scheduled more frequently than once a week, most of the client's invalidating symptoms are fading, supposingly due to the cognitive restructuring work being done correctly (15%), also due to the effect of the therapeutic alliance (30%) and to the placebo effect (15%), following the common factors

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model in psychotherapy (Wampold et al., 2015; Duncan, 2002). The next sessions (5-13) are to reinforce the coping skills learned in the first sessions and the client learns how to handle difficult life situation or how to deal with difficult persons. The last sessions (14-20) are meant to pursue further investigation into the meaning of life or into other topics only if the client desires to do this type of exploration. The last sessions are always optional, the client having also the possibility to stop the therapy when the symptoms have completely disappeared.

I would conclude that in maximum two weeks, approximately the timeline in which the antidepressants are supposed to start working, a balanced amount of psychotherapy could be equally beneficial vs. medication, without the side effects and the ethical issues involved. Regarding the use of anxiolythic medication, if the cognitive model of anxiety or panic attack (Clark, 1986; Wells, 1999) is correctly explained to the client (the correlated physiological symptoms and the vicious circle are also explained), this could also be the route of teaching the client how to manage the symptoms till the complete disappearance rather than avoid or burry them via medication every time an anxiogenic stimulus arises in his or her life.

4. Ethical implications of prescribing pregnant women antidepressant and anxiolythic medication

Researchers are continually making efforts to learn more about the risks of exposure during pregnancy to psychiatric medications. In general, the outcomes studied fall into three categories:

1. The risk of birth defects or malformations, or the risk of affecting fetal growth

2. The risk to a newborn of "withdrawal" or perinatal syndromes

3. Longer-term effects on a child's development or behaviour (Dupuy, 2012)

There are few principles that guide a clinician in prescribing psychiatric medication (SSRIs or anxiolithics) to a pregnant woman, as stated in the "ACOG Guidelines on Psychiatric Medication Use During Pregnancy and Lactation" (2012):

All medications cross the placenta, and a developing fetus will be exposed to any medication the mother takes. As a result, the safest situation is to use the fewest number of medications possible at the

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lowest effective dose. To try to use the medications they know the most about, as there are more accumulated data to guide treatment decisions.

Four commonly accepted principles of health care ethics, excerpted from *Beauchamp and Childress (2008),* include the:

- Principle of respect for autonomy – respect for autonomy of the patient;
- Principle of non-maleficence – health care providers do not intentionally create a harm or injury to the patient, either through acts of commission or omission. *Primum non nocere*;
- Principle of beneficence - health care providers have a duty to be of a benefit to the patient, as well as to take positive steps to prevent and to remove harm from the patient;
- Principle of justice - One of the most controversial issues in modern health care is the question pertaining to "who has the right to health care?"

There is still a lot of confusing data and very few clinical studies on the safety of SSRIs prescribed to pregnant women. Exposure to serotonin reuptake inhibitors (SSRIs) late in pregnancy has been associated with transient neonatal complications (Armstrong, 2008). However, the potential risks associated with SSRI use must be weighed against the risk of relapse if treatment is discontinued. In another review, use of antidepressants has been associated with increased risks of hypertension, preeclampsia, and bleeding and evidence is presented for maternal risks in an attempt to develop a risk-benefit ratio (Gadot, Koren, 2015; Palmsten, Huybrechts et al., 2013). In another study, gestational exposure to paroxetine is associated with major congenital malformations and major cardiac malformations for only first trimester exposure above 25 mg/day (Berard et al., 2007).

Considering that mild and moderate depression or anxiety scores do not translate into suicidal risks, we assume that psychotherapy, not medication should be the first-choice treatment also for the pregnant women or women lactating. Non-maleficence principle implies that a physician should not cause harm to a woman patient or to her fetus prescribing her antidepressants, but rather refer her to a psychotherapist who practice an evidence-based type of therapy for fast symptom relief, providing she has not been given a diagnosis of severe depression or major depression. In the case of major depression or post-partum psychosis with suicidal ideation, the patient's life being at risk without

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medication, the physician should correctly balance the risks and save both the mother and the child.

Conclusions

Bona-fide and evidence-based psychotherapy is effective in treating both symptoms and causes of mild and moderate depression and anxiety. Psychotherapy should become the first choice treatment of mild and moderate psychological problems. The medical model should be challenged in the case of emotional disturbances and life issues, mild and moderate symptomatology. Understanding the subjective experience of the patient is key to the fast recovery. In the long-run, psychotherapy by teaching coping skills is more effective than medication only and 15-20 psychotherapy sessions, even though not cost effective short-term, are cost-effective in the long-run by preventing relapses. Side-effects and ethical issues are to be considered when recommending a treatment choice to a new patient: medication, psychotherapy or both. For pregnant women, psychotherapy should be also the first-choice treatment, regardless of very few studies that deny the teratogenic and mutagenic effect of SSRIs on the fetus and considering a lot of reviews that support the exposure to paroxetine in the first semester of pregnancy associated with major congenital birth defects. Principles of beneficence and non-maleficence are two sides of the same coin (David Thomasma) and they should be considered when prescribing medication to the above target group. In more severe depression episodes, the above principles are crucial to help balancing the risks and the benefits, since preserving mother's life is more important than the unborn child's health in the long run. Further research and clinical investigations are needed in order to balance the costs and the benefits of a particular approach, either psychotherapeutic or psychiatric.

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References

http://www.apa.org/about/policy/resolution-psychotherapy.aspx

Armstrong, C. (2008). ACOG Guidelines on Psychiatric Medication Use During Pregnancy and Lactation. *Am Fam Physician.* 2008 Sep 15; *78*(6): 772-778.

Beauchamp, T., Childress, J. (2013). Principles of Biomedical Ethics, 7th Edition. New York: Oxford University Press.

Berard, A., Ramos, E., Rey, E., Blais, L., St-Andre, M., Oraichi, D. (2007). First trimester exposure to paroxetine and risk of cardiac malformations in infants: the importance of dosage. *Birth Defects Res B Dev Reprod Toxicol*, *80*(1), 18-27.

Breggin, P. R. (2008). *Medication Madness: A Psychiatrist Exposes the Dangers of Mood-Altering Medications*. New York: St. Martin's Press.

Clarke, J., & Gawley, A. (2009). The Triumph of Pharmaceuticals: The Portrayal of Depression from 1980 to 2005. *Administration and Policy in Mental Health, 36*, 01-101.

Cuijpers, P., Reynolds, C. F., Donker, T., Li, J., Andersson, G., & Beekman, A. (2012). Personalized treatment of adult depression: Medication, psychotherapy or both? A systematic review. *Depression and Anxiety*, *29*, 855-864.

Cuijpers, P., Sijbrandij, M., Koole, S. L., et al. (2013). The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons. *World Psychiatry*, *12*, 137–148.

De Maat, S., Dekker, J., Schoevers, R., De Jonghe, F. (2006). Relative efficacy of psychotherapy and pharmacotherapy in the treatment of depression: a meta-analysis. *Psychother Res., 16*(5), 562–572.

Duncan, B. L. (2002). The founder of common factors: a conversation with Saul Rosenzweig. *Journal of Psychotherapy Integration, 12*(1), 10-31.

Dupuy, J. (2012). Are psychiatric medications safe in pregnancy? *Harvard Vanguard Medical Associates*. May 2012.

Farach, F. J., Pruitt, L. D., Jun, J. J, Jerud, A. B., Zoellner, L. A., Roy-Byrne, P. P. (2012). Pharmacological treatment of anxiety disorders: Current treatments and future directions. *J Anxiety Disord.*, *26*(8), 833–843.

Popescu, B. (2015). Challenging the Myth of Medication in Mild and Moderate Depression and Anxiety, a Psychological and Philosophical Perspective. Postmodern Openings, 6(1), 175-188.

Farrar, S., Kates, N.,. Crustolo, A. M., Nikolaou, L. (2001). Integrated model for mental health care. Are health care providers satisfied with it? *Can Fam Physician., 47*, 2483–2488.

Fournier, J. C., DeRubeis, R. J., Hollon, S. D., et al. (2010). Antidepressant drug effects and depression severity: a patient-level meta-analysis. *JAMA Psychiatry, 303*(1), 47–53.

Gadot, Y., Koren, G. (2015). The use of antidepressants in pregnancy: focus on maternal risks. *J Obstret Gynaecol Can., 37*(1), 56-63.

Gibbons, R. D., Brown, C. H., Hur, K., Davis, J., Mann, J. J. (2012). Suicidal thoughts and behavior with antidepressant treatment: reanalysis of the randomized placebo-controlled studies of fluoxetine and venlafaxine. *Arch Gen Psychiatry., 69*(6), 580-587.

Imel, Z. E., Malterer, M. B., McKay, K. M., Wampold, B. E. (2008). A meta-analysis of psychotherapy and medication in unipolar depression and dysthymia. *J Affect Disord.*, *110*(3), 197–206.

Karver, M. S., Handelsman, J. B., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review, 26*, 50-65.

Köhler, O, Benros, M. E., Nordentoft, M., et al. (2014). Effect of anti-inflammatory treatment on depression, depressive symptoms, and adverse effects: a systematic review and meta-analysis of randomized clinical trials. *JAMA Psychiatry*, *71*(12), 1381-1391.

Lake, J. (2008). Integrative Mental Health Care: From Theory to Practice, Part 2. *Alternative Therapies in Health and Medicine, 14*(1), 36-42.

Lambert, M. J. (Ed.). (2004). Bergin and Garfield's handbook of psychotherapy and behavior change (4th ed.). New York: Wiley.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed). New York, NY: Oxford University Press.

Palmsten, K., Huybrechts, K. F. et all (2013). Antidepressant use and risk for preeclampsia. *Epidemiology, 24*(5), 682-691.

Parens, E. (2013). On good and bad forms of medicalization. *Bioethics*, *27*(1), 28-35.

Pies, R. (2013). What is "Medicalizing"? What is "Normality". *Global Summit of Diagnostic Alternatives.*

Popescu, B. (2015). Challenging the Myth of Medication in Mild and Moderate Depression and Anxiety, a Psychological and Philosophical Perspective. Postmodern Openings, 6(1), 175-188.

Shirk, S. R., & Karver, A. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*, 452-464.

Schatzberg, A. F., Cole, J. O., & DeBattista, C. (1997). *Manual of clinical psychopharmacology* (3rd ed.). Washington, DC: American Psychiatric Press.

Serafini, G., Hayley, S., Pompili, M., et al. (2014). Hippocampal neurogenesis, neurotrophic factors and depression: possible therapeutic targets [published online November 30, 2014]? CNS *Neurol Disord Drug Targets*.

Shah. P., Mountain, D. (2007). The medical model is dead – long live the medical model. *The British Journal of Psychiatry, 191*, 375-377.

Spielmans, G. I., Berman, M. I., & Usitalo, A. N. (2011). Psychotherapy versus second-generation antidepressants in the treatment of depression: A meta-analysis. *Journal of Nervous and Mental Disease*, *199*(3), 142-149.

Spielman, G. (2011). Antidepressant versus psychotherapy for depression. *The Carlat Report Psychiatry*, *9*(10).

Szasz, T. S. (2007). *The Medicalization of Everyday Life: Selected Essays*. Syracuse University Press, p. xiii.

Van Luyn, B., Akhtar, S., Livesley, W. J. (2007). *Severe Personality Disorders. Everyday Issues in Clinical Practice*. UK: Cambridge University Press.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *The American Psychologist*, *62*, 857-873.

Wampold, B. E., Imel, Z. E. (2015). [2001]. *The great psychotherapy debate: the evidence for what makes psychotherapy work* (2nd ed.). New York: Routledge.

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