Brain-Disabling Treatments in Psychiatry
Drugs, Electroshock, and the Psychopharmaceutical Complex
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Chapter 16
Failed Promises, Last Resorts, and Psychotherapy

16.1 Actually Talk to Them?
16.2 An Extensive Literature
16.3 Psychiatric Drugs As A Last Resort
16.4 The Surgeon, The Computer Specialist, and The Psychiatrist
16.5 The Moral Foundation of Genuine Psychotherapy
16.5.1 My Clinical Practice of Psychiatry and Psychotherapy
16.6 The Function of Suffering
16.7 Drug-Free Therapy
16.8 20 Guidelines for Treating Deeply Disturbed Persons
16.8.1 Welcome the person as you would a new friend
16.8.2 Dare to be caring
16.8.3 Create and maintain a safe and comfortable relationship
16.8.4 Create an ideal of the highest ethical and personal standards
16.8.5 Do not ignore or enable obnoxious or threatening behavior
16.8.6 Notice odd behavior and ask what it is about
16.8.7 Get to know the person as a fully developed human being
16.8.8 Help your patients learn their own life story
16.8.9 Be optimistic
16.8.10 Be confident
16.8.11 Be willing to improve your own attitudes
16.8.12 Avoid using artificial therapeutic techniques
16.8.13 Refuse to start patients on medication
16.8.14 Refuse to take any kind of threatening, bullying, or coercive actions
16.8.15 Welcome your patients' most painful feelings
16.8.16 Share your most important values with your patients
16.8.17 Make clear your last resort
16.8.18 Address psychological or learned helplessness early in the therapy
16.8.19 Be willing to offer practical advice and guidance
16.8.20 Graciously recognize that you have no
monopoly on helping people
16.9 Conclusion

Although the focus of this book is on the brain-disabling, spellbinding effects of biological treatments in psychiatry, it is important to conclude with a reminder that there are better alternatives in the form of psychological, social, and educational interventions.

Adults who are negotiating life relatively well can often nonetheless benefit from individual counseling or therapy. Couples therapy can often help people lead happier, more fulfilled lives. Emotionally disabled adults, including those diagnosed as schizophrenic, usually need comprehensive help that involves responsible members of the family and community resources.
16.1 Actually Talk to Them?

16.1.1 Meanwhile, organized psychiatry has begun to realize that professionals have stopped talking to patients diagnosed with schizophrenia, hence an editorial in the American Journal of Psychiatry by Keith (2006) title, “Are We Still Talking to Our Patients With Schizophrenia?” It goes without saying that the journal is not going to recommend treating these people without drugs, but it does recognize that the profession has gone overboard, noting that the 30-year war between biological and psychoanalytic psychiatrists has left American physicians reluctant to carry on psychotherapy with patients diagnosed with schizophrenia. I would add that they lack not only the will but also the competence to relate in a caring and insightful manner to deeply disturbed human beings.

16.1.2 Similarly, in his March 3, 2006, column in Psychiatric News, American Psychiatric Association president Steven Sharffstein wrote a feature headlined “Psychosocial Treatment: We Owe It to Our Patients”. He described how at last year’s annual meeting, he had “declared the fact that for psychiatry the biopsychosocial model has become the ‘bio-bio-bio model.’” Echoing what I wrote in Psychiatric Drugs in 1983 and in more detail in Toxic Psychiatry in 1991, he observed with unusual candor, “Psychiatry has, for what I would argue more for economic reasons than anything else, focused on the psychopharmacological model to the detriment of the psychosocial aspects of care.” Addressing the treatment of “schizophrenia,” he concluded, “Bio-bio-bio is not enough. We owe our patients no less than the competence to relate in a caring, therapeutic manner to people whom we diagnose as schizophrenic. Even worse, in a psychiatric setting, one of the main goals of cognitive therapy is compliance: getting patients to accept the idea of taking psychiatric medication. It is a case of using therapy to manipulate patients into submissively accepting highly toxic chemicals.

16.2 An Extensive Literature

16.2.1 There is an extensive literature on nondrug alternatives for every severity of psychiatric problem, including those patients labeled schizophrenic (e.g., Bratter et al., 2006; Breggin, 1991b; Colbert, 2001; Fergusson, 2000; Irwin, 2004a; Karon, 2003; Karon et al., 1981; Karon et al., 1999; McCreary, 1995; Mosher, 1996; Mosher et al., 2004a; Mosher et al., 1989; Mosher et al., 2004b; Read et al., 2003; Stanton, 1999). Most of these reports describe working with children and adults within institutions. All of them emphasize a noncoercive, nondrug, caring approach, even for the most difficult patients.

16.2.2 Mosher's, McCreary's, Fergusson's, Stanton's, and Karon's publications focus on helping the most disturbed children and adults, including those who would often be incarcerated and diagnosed as schizophrenic. Mosher (1996; Mosher et al., 2004a; Mosher et al., 1989; Mosher et al., 2004b) developed Soteria, a residential homelike treatment model for patients with severe, acute emotional breakdowns (“schizophrenia”). He used nonprofessional therapeutic aides selected for their empathic qualities who were supervised by a social worker who emphasized patient autonomy and healing relationships. In controlled trials comparing this nondrug residential treatment with admission to a mental hospital, Soteria patients did better, and of course, they did not suffer from multiple, dangerous neuroleptic adverse effects.

16.2.3 I have described Soteria and other alternatives, including a state hospital volunteer program that I led in the 1950s, in Toxic Psychiatry (Breggin, 1991c). I have also coedited a compendium of articles by therapists who offer a variety of approaches to helping deeply disturbed patients, including psychotherapy, family therapy, residential milieu therapy, and peer counseling (Breggin and Stern, 1996) and another compendium that focuses on empathy as the central aspect of healing for all human beings (Breggin et al., 2002). In The Heart of Being Helpful (1997), I look most closely at my own approach to therapy.

16.2.4 A Finnish study demonstrated the effectiveness of using a therapeutic, family-oriented approach to treat persons diagnosed with their first schizophrenic episodes (Seikula et al., 2003). A meta-analysis of existing therapy studies confirms the efficacy of psychosocial approaches to people labeled schizophrenic (Gottdiener et al., 2002; Irwin's (2004b) review of controlled trials
Studies by the World Health Organization have shown that patients diagnosed with schizophrenia, "Neuroleptics interfere with long-term recovery and, if appropriate psychosocial interventions are available, are not even necessary for short-term behavior control" (p. 99).

Antonuccio et al. (2002) reviewed the literature confirming the ineffectiveness of antidepressants and the literature on the effectiveness of psychotherapy in treating depression and concluded that psychotherapy is safer and more effective. Most of the individuals were treated in outpatient settings.

Not surprising, lifestyle changes can help more than psychiatric drugs, with no adverse effects on the brain and mind. A number of studies have also described the antidepressant effects of exercise (Babyak et al., 2000; Blumenthal et al., 1999).

16.3 Psychiatric Drugs As A Last Resort

A young man named Maurice came to see me about his episodes of severe anxiety. He would become abruptly frightened; adrenaline flooding his body would make his heart beat faster and his palms sweat; and he would feel doomed, as if he were going to die. Maurice knew he was not going to die, but at the moment of these attacks, he felt in acute danger. To abort these episodes, he carried a plastic pill container with a few tranquilizer tablets. He had not used one in months, but their presence in his pocket gave him a sense of security. He felt sure he would have an anxiety attack if he did not carry the pills along with him.

Our whole society has become like this young man. Pills have become our source of security and our last resort. Most of us can imagine life without electroshock or lobotomy, but few of us seem able to imagine it without having psychiatric drugs as a source of security and a last resort, if not for ourselves, than at least for other people. Our society now tolerates the psychiatric drugging of 2-year-old children, although even some leaders within the medical profession show alarm over this (Coyle, 2000).

Even for people who do not necessarily turn to them, psychiatric drugs linger in the backs of their minds as the last resort. They have heard that so-called mental disorders are caused by genetic and biochemical effects in the brain and that psychiatric drugs can correct these defects. These people do not consciously think to themselves, "I have faith in biochemical imbalances and drugs," but in fact, that is how their minds are working.

Even if we do not want to take these drugs for ourselves, we imagine that they must be necessary for other people who become so depressed that they cannot get out of bed or so violent that they are a menace to society. People may not know how to define "schizophrenia" or "bipolar disorder," but they know that these conditions are psychiatric disorders that can only be treated with drugs. They may have little idea what goes into making the diagnosis of attention-deficit/hyperactivity disorder, but they know that some children need drugs to control their behavior so that they can go to school and learn. Many people would fear for society if psychiatric drugs were not readily available and widely used.

In Maurice's case, he had ample reason to feel anxious. He had grown up in an alcoholic family, and his father had sometimes beaten his mother in front of him. As a child, Maurice suffered from spells of terror in anticipation of his father losing control. When his father hit his mother, little Maurice would cower in fear, guilt, and shame. As a young adult, Maurice's anxiety attacks erupted as he tried to come to grips with becoming an independent man who could take command of his life. The deepest roots of his anxiety were buried in the feelings of fear and helplessness that were emblazoned on his mind in childhood. Now the fear and helplessness resurfaced, making it hard for him to take charge of his adult life in a brave, loving, and creative manner. During the attacks of anxiety he reverted to feeling like the child who had no hope and no options for taking control of his life. In therapy he learned to identify the childhood origin of these disabling attacks of anxiety and to use his adult powers to control them in the interest of making rational choices.

In regard to the most commonly relied on drugs, antidepressants and stimulants, there is so little evidence for their effectiveness, and so much evidence for their dangerousness, that it is a wonder that anyone wants to resort to their use. Yet millions of children and adults are taking these medications. Drug companies, federal agencies, insurance companies, and organized medicine and psychiatry have combined to push psychiatric drugs on the consumer as the first and the last resort - indeed, the only resort - in times of emotional distress and suffering. The way we see ourselves, each other, and the solutions to both psychological and cultural problems have been taught to us through a multi-billion-dollar marketing campaign that began as the congressionally mandated "Decade of the Brain" in the 1990s. More recently, the FDA has allowed the drug companies to advertise medications directly to the public, encouraging millions of people to fear that they have "mental disorders" requiring drug treatment, thereby leading them to pressure their physicians to write prescriptions for them.

But even this barrage of prodrug propaganda cannot account for the willingness of so many individuals to succumb to these advertising and public relations campaigns. The brain-disabling, spellbinding effects of all psychoactive drugs reinforce both the propaganda produced by the Psychopharmaceutical Complex and the personal desires of many individuals to find a shortcut to solving their emotional problems.

Once under the influence of psychoactive agents, individuals are no longer able to make a clear assessment of their condition. The drugs blunt inner resources that they might otherwise draw on. Adverse effects, such as emotional rollercoastering, anger, and anxiety, are accepted apathetically. Often, the spellbound victims blame the drug-induced symptoms on themselves and their mental illness or on the provocations of other people in their environment. Sometimes patients think that they feel better than ever when they are in reality suffering from adverse psychiatric reactions to their drugs. And in the extreme, they become profoundly disturbed, violent, or suicidal.
16.3.9 Meanwhile, health care professionals working with these patients tend to ignore the adverse drug effects until they have devastating results, and even then, they often tend to increase the dose or add another drug on the grounds that the patient has been undertreated. When the patient develops a serious drug-induced reaction that cannot be ignored, such as psychosis or mania, then the health care provider blames the patient's supposed underlying disorder, rather than the offending drug, and prescribes yet more of these toxic agents.

16.3.10 Even Sigmund Freud began as an advocate for drugs, in his case, a newly isolated chemical derived from a natural source, the leaf of a plant. It was called cocaine. Freud saw it not only as a last resort but also as a healthy solution to the ordinary stresses and disappointments of life (Byck, 1974 [245]). The future founder of psychoanalysis was positively rhapsodic in promoting cocaine in the medical literature and mailed samples for his fiancée to use. As a result, Freud and many others who listened to him became addicted to cocaine. Freud's disastrous love affair with cocaine was a classic example of medication spellbinding, or intoxication anosognosia.

Drugs - even when advocated by famous doctors - do not make a good first or last resort.

16.3.11 In the 1960s in America many intelligent and educated young people decided that their personal lives, and even society itself, could benefit from their smoking marijuana and indulging in a variety of hallucinogenic substances, from poisonous mushrooms to LSD. When they were indulging their passion for psychoactive drugs, many drug-spellbound individuals felt more creative and happier than ever before, but nearly all of them ended up realizing that they were causing their lives to deteriorate, and few continued indefinitely to inflict these toxins on their brains and bodies. In the last several decades, I have met and treated many of these refugees from the 1960s, many of whom feel that they permanently impaired their mental function during those years of romanticizing drug intoxication.

16.4 The Surgeon, The Computer Specialist, and The Psychiatrist

16.4.1 Nowadays, people are encouraged to believe that going to a psychiatrist is like going for treatment to an internist or a surgeon, but the comparison is flawed. An internist or surgeon deals with your body and not your soul; with physical ailments, rather than spiritual struggles and longings; with the workings of physiology, rather than mental processes; with mechanics, rather than with ideas, feelings, values, beliefs, and aspirations. The internist or surgeon tries to find out what is wrong with your body, rather than with your life. Of course, a more holistic physician may indeed deal with your lifestyle - issues of exercise, good eating, and even psychology - but he or she does so in response to a physical problem in your body.

16.4.2 Patients tend to trust their doctor to do a good job and to trust that medicine as practiced in America today has some rational and scientific basis. In this regard, going to the physician is similar to going to an auto mechanic or computer specialist. The consumer trusts the person and the engineering principles that are being utilized.

16.4.3 Unfortunately, going to the psychiatrist is an entirely different affair from seeking help for the repair of mechanical devices or the treatment of a physical disorder. When an engine stalls, the consumer puts his Ford sedan in the mechanic's hands. When abone is broken or a heart malfunctions, the patient puts his physical body into the doctor's hands. But when a person suffers emotionally, the patient puts not only his body but also his mind and his journey through life in the doctor's hands.

16.4.4 The auto mechanic or the computer specialist is not going to change the Ford or the PC in some fundamental way. It will still be the same Ford or the same PC after the repairs. The car's engine may be retuned and the computer's hardware may be upgraded, but the odds are great that these modifications will improve overall performance without changing anything essential or fundamental and without causing any adverse effects in the functioning of the machines.

16.4.5 When a patient goes to the psychiatrist and receives a drug or electroshock, his or her brain will be fundamentally changed. Its processes will be disrupted. It will not operate on the same physical principles that it operated on before the treatment. The actual function of the brain, the way the neurons communicate with each other, will have been distorted, and in some cases, brain cells will have been killed or caused to grow abnormally. Instead of having new spark plugs or upgraded memory, the brain will be injured and partially disabled by the treatment. If anything, the treatment will be akin to dirtying the spark plugs of your car or degrading some of the memory capacity of your computer.

16.5 The Moral Foundation of Genuine Psychotherapy

16.5.1 Psychotherapy, unlike psychiatry, does not - or at least, should not - pretend to be analogous to medical treatment. The best hospitals in the history of psychiatry thrived during the era of so-called moral psychiatry in the 18th and 19th centuries. Moral hospitals were run by Quakers and other religious denominations, often in outright opposition to medical authorities and approaches (Bockoven, 1963 [153], described the moral era in detail; see also Breggin, 1991 [180]). They were successful in dealing with the most difficult patients of the era, including so-called violence maniacs and those forsaken by medicine and psychiatry.

16.5.2 Recently, my friend, British psychiatrist Bob Johnson (http://www.truthtrustconsent.com), gave me a copy of Samuel Tuke's 1813 treatise Description of the Retreat: An Institution Near York for Insane Persons of the Society of Friends (Tuke, 1996 [1268]). Tuke clearly opposed the then commonplace use of restraint, except under direst circumstances:

16.5.3 "Except in the case of violent mania, which is far from being a frequent occurrence at the Retreat, coercion, when requisite, is considered as a necessary evil; that is, it is thought abstractly to have a tendency to retard the cure, by opposing the influence of the moral remedies employed." (p. 166)

16.5.4 Why was violent mania infrequent at the Retreat? According to Tuke, it is partly because the staff were taught not to provoke the inmates into reacting with violence.

16.5.5 Moral treatment appeals to the remaining free will, or moral powers, of the individual:
16.5_6 "Insane persons generally possess a degree of control over their wayward propensities. Their intellectual, active, and moral powers, are usually rather perverted than obliterated; and it happens, not unfrequently, that one faculty only is affected. The disorder is sometimes still more partial and can only be detected by erroneous views, on one particular subject. On all others, the mind appears to retain its wonted correctness."

16.5_7 "We have already observed, that most insane persons, have a considerable degree of self command; and that the employment and cultivation of this remaining power, is found to be attended with the most salutary effects."

16.5_8 In other words, insane individuals retain moral or ethical faculties that make them amenable to psychological, moral, or religious interventions. These faculties can be appealed to with patience, with "kind persuasions" and with "moral and rational inducements". This is exactly what many successful therapists do when treating deeply disturbed patients.

16.5_9 Tuke (1996) described the necessity of approaching disturbed patients in a most ethical and considerate manner, but unfortunately the caregivers were easily provoked into overreacting by the "often half rational, conduct of the patient":

16.5_10 "It is therefore an object of the highest importance, to infuse into the minds of these persons [the caregivers], just sentiments, with regard to the poor objects placed under their care; to impress upon them, that 'coercion is only to be considered as a protecting and salutary restraint'; and to remind them, that the patient is really under the influence of a disease, which deprives him of responsibility; and frequently leads him into expressions and conduct the most opposite to his character and natural dispositions." (p. 175)

16.5_11 After illustrating his point about empathy with a poem, Tuke went on to say:

16.5_12 "But even this view of the subject [as lacking responsibility] is not exempt from danger; if the attendant does not sufficiently consider the degree in which the patient may be influenced by moral and rational inducements." (p. 175)

16.5_13 In my clinical experience, Tuke's observations are as pertinent today as they were in the early 19th century. Psychiatrists, nurses, hospital attendants, and mental health caregivers in general too often use drugs, threats, and restraints to control their "patients" while forsaking any use of kindness and moral persuasion. Too often they try to enforce submission or to encourage compliance rather than to empower their patients by respecting and encouraging their autonomy and decision making. Yet in my experience, beginning as a college volunteer on the back wards of state mental hospitals in the 1950s (Breggin, 1991c; Umbarger et al., 1962), I have found that even desperately disturbed human beings will almost always respond to patience, empathy, and respectful guidance grounded in kindness.

16.5_14 Critics may complain that love cannot cure patients; but I make no claim that love or caring by itself is enough. As I describe in The Heart of Being Helpful, (1997), in dealing with very difficult, disturbed, and disturbing people, the clinician needs all of the confidence, moral determination, sound principles of living, and life experience that one individual can bring to helping another. With experience, the clinician learns not to overreact and not to become frightened in the face of disturbed behavior but instead to welcome the expression of feeling and to help with understanding it, while explaining the necessity of mutual restraint and consideration. In The Heart of Being Helpful, I summed up the essence of the clinician's role, especially in dealing with profoundly upset people, as "the creation of healing presence".

16.5_15 Tuke (1996) understood the dilemma of treating people who have lost their sense of self-control and personal responsibility by encouraging them to restore these qualities. It is an empathic challenge:

16.5_16 "To consider them at the same time both as brothers, and as mere automata; to applaud all they do right; and pity, without censuring, whatever they do wrong, requires such a habit of philosophic reflection, and Christian charity, as is certainly difficult to attain." (p. 176)

16.5_17 With Tuke, I believe that this charitable habit of philosophic reflection is central to therapy. This is another way of describing what I call the healing presence and characterize as empathic relating.

16.5_18 Instead of threats and punishments, the patient is offered "rational society," "different kinds of amusing employments," and books to read:

16.5_19 "Since whatever tends to promote the happiness of the patient, is found to increase his desire to restrain himself, by exciting the wish not to forfeit his enjoyments; and lessening the irritation of mind, which too frequently accompanies mental derangement."

16.5_20 "The comfort of the patients is therefore considered of the highest importance, in a curative point of view." (pp. 177-178)

16.5_21 The cure lies in kindness and consideration, not in humiliating, punitive measures and deprivations typical of institutional psychiatric treatment, then and now.

16.5_22 Patience in the encouragement and promotion of the patient's rationality and reason is another key to cure:

16.5_23 "Those who have had the opportunity of observing the restoration of reason, will be aware, that she does not, in general, at once, resume her lost empire over the mind. Her approach resembles rather the gradual influx of the tide; she seems to struggle to advance, but again and again is compelled to recede. During this contest, the judicious attendant, may prove the most valuable ally of reason; and render to her the most essential assistance, in the recovery of her lawful throne."
In anxiety and depression, and even in mania, our soul, psyche, or self is crying out for attention and desperately seeking solutions or relief. Most of the great religions view suffering as an avenue to understanding life and God. In psychological terms, suffering is a signal to radiation. Emotional or psychological suffering should not be viewed as something alien to human nature or as something to be gotten rid of. They are apt to go to the utmost limits (p. 187).

I have taken time to quote the lessons of moral treatment because these ethically based approaches remain alien to modern psychiatry. Yet these principles were proven effective nearly 200 years ago, when institutions treated people without the so-called advantage of mindnumbing drugs, electroshock, and lobotomy.

According to J. Sanbourne Bockoven (1963), himself a former state hospital superintendent, the moral era produced at least as good results reclaiming the mentally disturbed as today's best hospitals, and of course, it was accomplished without damaging the brains of the patients. All of Tuke's (1996) basic principles, expressed in the moral era of psychiatry, are embodied in my guidelines for therapists (see subsequent discussion).

Some therapists start out with sound ethics; some do not. Some know a great deal about life—that is, they have wisdom—and some do not. I am not trying to discourage people from practicing or from seeking psychotherapy or counseling. I am trying to be realistic. There is nothing standardized about therapy. Every therapy will vary depending on the therapist's theoretical and practical approaches, ethics, experience, and personality. As no two people are alike, no two therapies are alike.

Indeed, the term therapy itself is misleading, lending itself too easily to a medical model with artificial diagnoses, manipulation, and medication. The term counseling is in many ways preferable and arises out of a tradition that is more respectful of the autonomy and human needs of the individual. Similarly, the word patient is also potentially misleading and might better be replaced with client. But and medication. The term counseling is in many ways preferable and arises out of a tradition that is more respectful of the autonomy and human needs of the individual. Similarly, the word patient is also potentially misleading and might better be replaced with client. But since I am a physician and psychiatrist and do not wish to add undue confusion to this book, with these caveats I will continue to use the terms therapist and patient.

At best, therapy and counseling should be one approach to helping an individual with personal or life problems, but not as another kind of last resort. As a psychiatrist and therapist, I discourage clients from thinking of me as their last resort. It is not good for my patient to think that any one human being is his or her last resort. And it is certainly not good for me to think about myself in such unrealistic, grandiose terms.

**My Clinical Practice of Psychiatry and Psychotherapy**

My own career in psychiatry began as a college student when I was chairman of the Harvard-Radcliffe Mental Hospital Volunteer Program (Breggin, 1991c) and coauthored my first book (Umbarger et al., 1962). In the mid-1950s, we changed the environment of the local state mental hospital, moving it in some ways from a custodial to a therapeutic milieu. In addition to these more general effects on the institution, we developed a case aide program, in which individual college volunteers were assigned their own patients.

Working under group supervision by a social worker, in the first year of the case aide program, 11 of our 14 patients were released from the hospital, and only 3 returned during follow-ups that lasted 1 or 2 years. These abandoned people were so-called back-patients, individuals on whom psychiatry and the community had given up. The staff referred to many of them as burned-out schizophrenics. But we were able to place them into much better circumstances in much more advantageous local community homes or with their families. I gained valuable lessons from this experience, from the futility and destructiveness of drugging, shocking, and lobotomizing people to the wonderful power of offering them help and caring guidance.

The volunteer program lasted for many years after I had graduated, until finally, with the domination of biological psychiatry, it withered away. Working in the hospitals in those years just before the so-called miracle drugs became the only treatment, I learned how basic human relationships could revive, and even restore, the lives of the most chronically disturbed patients, even those who had experienced years of abuse in a state mental hospital.

**The Function of Suffering**

Suffering cannot be pulled out of the brain like a splinter from a foot. It cannot be obliterated from the brain like a tumor subjected to radiation. Emotional or psychological suffering should not be viewed as something alien to human nature or as something to be gotten rid of. Most of the great religions view suffering as an avenue to understanding life and God. In psychological terms, suffering is a signal. In anxiety and depression, and even in mania, our soul, psyche, or self is crying out for attention and desperately seeking solutions or relief.

In my therapy practice, I welcome suffering as a sign of life. Instead of trying to dull it or to snuff it out with toxic agents, I
encourage my patient to share it with me - to bring it fully out in the open and to examine it with the aim of understanding what the suffering is saying about the individual's life.

16.6_3 Human suffering is proportional to our sense that life can and should be better. For example, when people feel depressed, they have lost hope and feel paralyzed in regard to achieving their goals, such as love and happiness. They would not feel this frustration and despair unless they had a corresponding vision, however unconscious, of a better life that was going unfulfilled. My patient's suffering tells me that he or she is alive and has a marvelous energy that can be transformed into a creative force: a love for life. Unlike the biological psychiatrists, I have no desire to destroy my patient's suffering and along with it my patient's brain function. Instead, I want to become comfortable with the suffering, to welcome it and see through it with my patient to the message it is giving about my patient's unfulfilled needs and my patient's desire to find a better understanding and approach to life.

16.7 Drug-Free Therapy

16.7_1 Since starting my private practice in 1968, I have treated all of my patients, children and adults, many severely disturbed, without resort to medication. In all my decades in full-time private practice, perhaps half a dozen of my patients have required hospitalization. To my knowledge, none of my patients has committed suicide. Very few have gotten worse during treatment, an unfortunate circumstance that frequently occurs in traditional practices, where patients are medicated, electroshocked, or forcibly hospitalized.

16.7_2 To make it absolutely clear, to this day I never start my patients on psychiatric drugs. I only prescribe drugs to patients who have come to me already taking medication, and then almost always for the purpose of eventually withdrawing them. In a few cases, when withdrawal reactions have proven undeniably painful, I have continued patients on low doses of antidepressants or benzodiazepines because there has been no satisfactory alternative.

16.7_3 In rare cases where patients do not want to try to taper and withdraw from their psychiatric medication but want my help as a therapist, I usually recommend that they obtain their medication from other doctors while seeing me for psychological help. I do not want to enable the use of medications that I feel will harm them in the long run and, of course, they have no trouble finding someone else to prescribe for them. Usually the individual has continued in therapy and eventually stopped taking medication. Despite my rejection of medication treatment in my practice, my clinical experience with medication is extensive. As a doctor who works with patients who come for help in withdrawing from multiple medications, I frequently have to prescribe medications as a part of the process of tapering patients off them. And as a medical expert in many medication cases, where I also work directly with the legal clients, I have also garnered considerable firsthand experience with psychiatric medication over the past 40 and more years. And of course, I have extensively researched, written, and consulted on the subject of medication.

16.7_4 In my psychiatric practice, I find that very disturbed persons respond well to individual and family therapy aimed, first and foremost, at providing them a safe space in which to dare to begin trusting another human being. As I described in Toxic Psychiatry (1991c) and in The Heart of Being Helpful (1997b), psychosis is a loss of connectedness to other human beings. The individual who withdraws into a fearful, self-protective, irrational fantasy world responds best to being treated with kindness, respect, and the gradual building of rapport. The required skill in working with the most emotionally disabled persons, especially during the initial period of emotional crisis, has more to do with empathic relating and sound guidance than with deep insights or psychological interpretations. More subtle or insightful therapy can be effective only after the individual no longer feels overwhelmed and emotionally helpless.

16.7_5 Often, the more acute or flagrant symptoms will begin to calm down during an initial session in which the vulnerable, overwhelmed person discovers an opportunity to relate to another person in a safe space. The most difficult people to help are those who have already been humiliated by oppressive psychiatric approaches and whose brains have been damaged by electroshock and neuroleptic drugs.

16.7_6 Psychosis is a loosely defined word that reflects in its broadest sense "a loss of touch with reality". At least in the extreme, hallucinations and delusions are the hallmarks. At its worst, perhaps, psychosis becomes a living nightmare, in which the individual's mental processes resemble a solipsistic, terrifying nightmare from which the person cannot be fully awakened. The individual becomes so withdrawn and preoccupied with these highly personal and irrational processes that no one can reach him.

16.7_7 If we look for the common element of all psychotic or profoundly disturbed mental processes, they involve a loss of connection to other human beings. In the extreme, other people become like fragmented objects in the individual's shattered awareness. Other people are imagined to be conspirators with the FBI or CIA who are out to get the victim. Or they are seen as aliens from another planet. Or they are poisoning the victim's food. Most commonly, perhaps, they are whispering humiliating things about the victim.

16.7_8 If the psychosis has a manic, rather than a withdrawn, quality, then other people are seen as menacing, especially if they thwart the ambitions of the person who is living on an emotional "high". Or other people are treated as objects without regard for their feelings as the individual grandiosely tries to manipulate everyone around him. Underneath all the bravado and displays of superconfidence, the manic individual feels as overwhelmed as the withdrawn one but compensates by acting allpowerful.

16.7_9 I am not trying to elaborate a new psychiatric diagnostic system but merely to confirm that all severe psychiatric disturbances are disturbances of interpersonal relationship. The deeply disturbed person is deeply disturbed in his or her relationships with other people. In all these expressions of psychosis, the individual feels overwhelmed by other people and by life and unable to connect to other people and to competently handle life. Psychosis is a breakdown of human relationship, a disturbance in the fabric of the person's social life, accompanied by an inability to cope with everyday stresses. All effective therapies for deeply disturbed persons begin with the concept of building or rebuilding relationship, while providing a certain amount of guidance in dealing with immediate emergencies and crises. As relationship is restored with one other human being - the therapist - and as the immediate crisis no longer seems so catastrophic, the individual can grow less overwhelmed, more trusting, and less disturbed in general. The individual can begin to venture into relationships with others and to make more rational decisions.

16.7_9
and your expressed concern, you want to show that you care about your client. You want to be interested and empathic. Through your attitude, your questions, your recollection of what you have already been told, or even sympathetic attitude. You do not want to be dragged down by your patients' plight, or you will drag them further down with you.

16.8.2 

When the person is so disturbed that he or she cannot function in a private office or clinic setting, a therapeutic setting can be more helpful. The goals, however, remain the same: providing a setting that is safe and relationships that are safe so that the individual can begin to trust other human beings and emerge from his or her deeply disturbed state. Traditional mental hospitals are extremely controlling, authoritarian, humiliating, and physically dangerous places—exactly the opposite of what already overwhelmed people need.

16.8.1

There are a handful of inspired and inspiring humanistic psychotherapy training programs around the country. However, they well are often opposed and even destroyed by the psychopharmaceutical complex (Breggin, 1991c 190). The best source of potential information about residential alternatives can be found on the Web site of the International Center for the Study of Psychiatry and Psychology (www.icspp.org). Another alternative is to meet therapists and to learn about alternatives at the organization’s annual conferences, which usually takes place in October and which can also be located on the Web site.

16.7

Sometimes this restoration of relationship and rational judgment can begin in minutes if the disturbed person quickly senses that he or she can dare to trust the new person, the therapist. On many occasions, I have been able to calm down seemingly crazy persons and to begin a somewhat rational discourse in a matter of minutes. Sometimes the process will take weeks or months.

16.7.11

Sometimes a particular therapist, including me, may not be able to help a particular patient. In response to the failure of the therapeutic relationship, the therapist should not advocate drugs. If therapists fail some of the time, drugs fail all of the time, at best suppressing overall mental function and at worst damaging the brain and ruining the individual's capacity to enjoy life for the remainder of his or her life. When a therapeutic relationship is not working, it is best to help the patient find other psychosocial alternatives, including a different therapist. However, in my experience, the therapist rarely has to direct the patient elsewhere. If the therapist is not coercing, manipulating, or drugging the patient, a disappointed patient will be able to seek help elsewhere on his or her own.

16.7.12

In my own experience, if there are well-intentioned family members, then working with the family is the most effective way of helping a disturbed individual restore his or her relationships with other human beings. It is far better if other family members, rather than the therapist, become the patient’s primary resort and the place where relationship is recovered.

16.7.13

16.8.1_1

Wish I had a range of residential alternatives to offer prospective patients and their families, but few exist, and those that work well are often opposed and even destroyed by the psychopharmaceutical complex (Breggin, 1991c 190). The best source of potential information about residential alternatives can be found on the Web site of the International Center for the Study of Psychiatry and Psychology (www.icspp.org). Another alternative is to meet therapists and to learn about alternatives at the organization’s annual conferences, which usually takes place in October and which can also be located on the Web site.

16.7.15

Being an effective therapist begins with being a person that other people can trust with their most vulnerable feelings. In this regard, by creating an authoritarian and manipulative attitude, most contemporary training programs in psychotherapy do more harm than good. They almost always teach a relativistic, self-protective ethic (doing what works; collaborating with psychiatrists; using drugs along with therapy; making cookie-cutter diagnoses; referring desperate or suicidal patients for drugs, electroshock, or incarceration).

16.7.16

There are a handful of inspired and inspiring humanistic psychotherapy training programs around the country. However, they can be hard to locate, and the quality of individual programs may vary from year to year. As an aspiring professional or teacher, the best way to find these programs is through meeting people at the conferences of the International Center for the Study of Psychiatry and Psychology (ICSP); by looking up the affiliations of the authors in its journal, Ethics/ Human Psychology or Psychiatry; or by reviewing the background and credentials of authors you respect. By searching for “humanistic psychology training programs” on the Internet, I found a number of familiar and useful sources.

16.8

20 Guidelines for Treating Deeply Disturbed Persons

16.8.1

Here are 20 principles for providing therapy to deeply disturbed persons. Many of them are elaborated in The Heart of Being Helpful (1997b 1999), and all of them draw on the “Principles of Life” that I present in Medication Madness (in press). While the focus is on providing help to emotionally disturbed and disabled patients who seek individual therapy in a private practice or clinic, the same principles apply to residential and milieu treatment as well. In a more general way, these 20 guidelines can also be applied to our experiences with other people in our workplace, families, and everyday life.

16.8.1_1

Welcome the person as you would a new friend

16.8.1_2

Every session, welcome the person as you would a new friend, someone you have been eagerly awaiting, someone you feel privileged to meet, someone who would never offend, someone whose feelings you will treat with exquisite tenderness.

16.8.1_3

Yet you must be careful not to come on too strong. To conduct yourself in this well-centered manner, you will have to find a very comfortable place inside yourself that is not threatened by other people’s craziness, and you will have to see the person and not the symptoms.

16.8.1_4

The Quakers speak of relating to “that of God” in each person. Find your own way of conceptualizing your respect and concern for the preciousness of each human being. Build your helping relationships around Martin Buber’s (1968) I - Thou relationship that treasures the other human being.

16.8.1_5

When you feel a tendency to look down on your clients, to diagnose them, or to lack empathy for them, remember how tough their lives have been compared to your relative safety and security. Then repeat to yourself the mantra of good therapists: “There but for the grace of God go I.”

16.8.2

Dare to be caring

16.8.2_1

A caring relationship is the core of healing; everything else is icing and comes in many flavors. By caring, I do not mean a sad or even sympathetic attitude. You do not want to be dragged down by your patients’ plight, or you will drag them further down with you. You want to be interested and empathic. Through your attitude, your questions, your recollection of what you have already been told, and your expressed concern, you want to show that you care about your client.
16.8.3 Create and maintain a safe and comfortable relationship

16.8.3.1 The therapeutic relationship should be as conflict-free as possible. It should feel comfortable and safe for both the client and the therapist. If either the client or therapist feels disrespected or threatened, that issue should be addressed and resolved. It is impossible for people to receive help - or to provide it - when they feel unsafe or uncomfortable. To repeat, the client and the therapist alike need a safe, nurturing environment.

16.8.3.2 In the process of working on the creation of a mutually safe relationship, the disturbed client learns, perhaps for the first time, what it is like to feel close to someone without causing turmoil and without feeling endangered.

16.8.3.3 As a part of creating a safe, comfortable relationship, make your therapy space more like a home than an office, clinic, or hospital. Pleasant pictures, not framed credentials, should create the ambience. When clients are especially frightened, begin by suggesting that they look around your space to see how pleasing and safe it is. Very anxious people often begin relaxing when they realize that they are not in an office as much as in a comfort zone.

16.8.3.4 Ask if there is anything you can do to make your clients feel more comfortable. Do not be afraid of being solicitous; I guarantee that most patients will immediately sense that there is something different going on in this health care provider's office when you show interest in their creature comfort.

16.8.3.5 In the interest of focusing on your patients' comfort and creating a good relationship, avoid taking notes during sessions with very disturbed people. Ordinarily, I take notes during the first session with patients to establish a base of information for future reference, but I always apologize for any interference it may cause. If clients are very disturbed, frightened, or suspicious, I put aside the note tablet. If they have a tenuous grip on reality, seeing me take notes may frighten and distract them. They may become fearful of who will read the notes. If nothing else, they will get stuck wondering why I find one thing or another worth writing down. It is best to be able to relax and converse more casually during therapy.

16.8.4 Create an ideal of the highest ethical and personal standards

16.8.4.1 Create an ideal, even utopian environment in which both you and your client relate to each other according to the highest ethical and personal standards.

16.8.4.2 In keeping with the first three guidelines, therapy should be like a mini-utopia, in which you are absolutely at your best as a person and are therefore able to reach people whom others have found impossible to deal with. This mini-utopia is made possible by the limits placed on it such as restricting the relationship to the office, avoiding any outside entanglements, and establishing rules for courteous and rational relating. Within these limits, the therapist should strive to create an ideal relationship, one that will help the client learn how best to relate to all the people in his or her personal life.

16.8.5 Do not ignore or enable obnoxious or threatening behavior

16.8.5.1 If your client, on the first visit or any other visit, acts in a disrespectful or threatening manner, do not ignore it. As soon as the other person begins making you feel uncomfortable with hostile remarks, gently draw attention to it, express your concern, and ask if you have done something to contribute to the angry reaction. Your vulnerability will actually reassure most people. Tell the truth; explain that it is hard for you to be at your best if you are feeling defensive.

16.8.5.2 If a patient retorts, "I thought this is where I could say anything I want" or "I thought I was supposed to say what I feel," you can explain that therapy is intended to be a safe place where people learn how to talk in a respectful and even caring manner toward each other. At times, that will mean restraint on your part and on the patient's part. The object is to develop good communication - not to express anything that comes to mind without regard for the consequences. Always work to create a caring, respectful atmosphere and tone.

16.8.5.3 Nothing is more frightening to disturbed or out-of-control people than their own out-of-control anger. People, especially disturbed people, need to learn that they will feel safer when they decide to avoid provoking or escalating conflict. Nearly every client I have known has responded well to my encouragement of a mutually friendly, respectful, and even caring attitude.

16.8.5.4 Through learning how to treat others in a respectful and caring manner, clients also learn how they should be treated. They learn to no longer tolerate or enable bullying, abusive, and controlling behavior on the part of family members and other people in their lives.

16.8.6 Notice odd behavior and ask what it is about

16.8.6.1 Notice odd behavior, gently call attention to it, and ask what it is about.
Be optimistic

The importance of being optimistic may seem so obvious that it need not be stated, but in fact, modern psychiatry is deeply pessimistic, even profoundly negative, in its attitude toward patients. Because psychiatrists nowadays rarely have the knowledge or inclination to build therapeutic relationships with their patients, they have no idea about how to genuinely heal other human beings. In fact, they have been taught that they cannot talk to schizophrenia, and so they pessimistically turn to prescribing drugs and therapies.
electroshock, despite causing innumerable adverse effects and irrevocably damaging many patients. Commonly, they instruct patients to take their medications for the rest of their lives, sending a clearly pessimistic message. Even the often-expressed myth that patients have a biochemical imbalance is profoundly discouraging. On top of that, psychiatrists tell their patients that they have genetic disorders, adding to their sense of hopelessness and engendering fears for their biological offspring. Biopsychiatric pessimism about the capacity of human beings to take charge of their lives reinforces their patients’ worst view of themselves as helpless in the face of their problems. By being pessimistic, health care providers - including most psychiatrists - make their patients dependent on them and end up doing far more harm than good.

16.8.9.2 So it is especially important for therapists to keep in mind that they can help almost all their clients by starting with a warm, welcoming, and caring relationship. Especially for, disturbed patients who have already been overwhelmed by psychiatric pessimism, make clear how optimistic you feel about being able to help them to live better, happier, more productive and loving lives.

16.8.10 Be confident

16.8.10_1 In keeping with being optimistic about a patient’s future success, be confident about your ability to help this very disturbed person and expect that he or she will show signs of being less disturbed, even within a few minutes. You might even remind the patient that success in therapy depends more on the patient than the therapist. A responsible, hardworking client is likely to find help even from a marginal therapist, while a helpless, dependent client is likely to find little help anywhere.

16.8.10_2 Your goal is to create an environment that allows or encourages people to relate to you without pushing or manipulating them. So while expressing confidence that this person will shortly discover how useful therapy can be, also be humble enough to realize that it is ultimately up to the individual to decide how he or she feels about you and your approach. Trying too hard is one of the worst mistakes a therapist can make. It reeks of desperation and disrespects the autonomy of the other. Yet you want to communicate a quiet confidence that the individual in the room with you can work with you in an understandable and productive manner.

16.8.11 Be willing to improve your own attitudes

16.8.11_1 If you are finding it difficult to become caring, empathic, optimistic, or confident about a particular client, then it is your job - your professional obligation - to find those resources within yourself. In The Heart of Being Helpful (1997b) [199], I call this empathic self-transformation - the willingness and ability to find the human-to-human resources necessary for the work of being a psychotherapist with each individual patient. In the job of helping people with their psychological problems, the therapist cannot self-indulge with feelings of helplessness, resentment, or pessimism. These feelings have to be overcome. Knowing that there are no exceptions to this rule will help you to maintain a positive outlook as a therapist and make your hours of therapy relatively stress-free and satisfying to you and, ultimately, to your client.

16.8.12 Avoid using artificial therapeutic techniques

16.8.12_1 Avoid using artificial therapeutic techniques, especially with very disturbed persons.

16.8.12_2 If people have relatively strong egos and feel reasonably secure in themselves, they may be able to tolerate or even benefit from one or another therapeutic technique, whether it is role-playing, dream analysis, free association, cognitive therapy, behavioral therapy, self-hypnosis, relaxation techniques, biofeedback or whatever. But disturbed people will experience anything that is rote, contrived, or repetitive as one more humiliating insult, and even as an assault.

16.8.12_3 Working with disturbed people requires you to offer them a genuine human relationship, even in the face of their craziness. You, in turn, should not introduce anything out of the ordinary into the session. Your goal is to build a genuine relationship.

16.8.12_4 Again, what makes this possible with disturbed patients is the utopian quality of the therapy setting, including its limits, its safety, and the skills of the therapist in maintaining a genuine relationship with people who tend to drive others away.

16.8.13 Refuse to start patients on medication

16.8.13_1 Refuse to start patients on medication or to refer them for medication evaluation, especially if they are very disturbed.

16.8.13_2 The need to keep therapy drug-free is even more imperative with very disturbed or psychotic patients. When people are already feeling emotionally overwhelmed in the extreme, the last thing they need is a big dose of brain dysfunction. Already struggling to control their feelings and to understand them, they do not need the bizarre mixture of apathy and emotional lability that characterizes so many drug effects. They do not need the added burden of trying to figure out from moment to moment and day to day if they are experiencing their own genuine emotions or the emotional effects of adverse drug reactions.

16.8.13_3 For these already disempowered persons, it is further disempowering for them to be told that their salvation, cure, or restoration depends on a physical intervention, rather than learning to take charge of their lives. They have already given up hope in themselves and in other human beings; do not confirm their worst fears. They already feel helpless in the face of their emotions; do not make them feel even more helpless by telling them that they have a biochemical imbalance that is out of their personal control. Do not make them feel even more dependent and helpless by acting as if you can diagnose a mythical biochemical imbalance or cure them with a pill.

16.8.13_4 I explain to my patients that I never use psychiatric medications as therapy, but that I will continue to prescribe for them if they cannot manage to withdraw from their drugs. All of my patients are free to obtain medications from other doctors and to continue to see me for therapy and for additional monitoring of how the drugs are affecting them. On rare occasion, some have done this for a while.
However, they are likely to discover that taking medications tends to make them preoccupied with tampering with their drugs, rather than with learning to take charge of their lives. They will also find that it is hard to know what they really feel, and how they are really responding to life, when toxic agents are jerking around their brains, minds, and emotions.

16.8.13_5 Nowadays, when patients come to health care providers, they know that the moment they mention any kind of painful feelings, a drug will be prescribed, or a new drug will be added, or doses will be upped. The modern patient literally lives in a world where conversation consists of the patient expressing feelings and the doctor responding with drugs. This truly bizarre relationship ultimately devolves into a ritual of mutual manipulation, wherein the patient expresses feelings with an eye to controlling the flow of medication, while the doctor prescribes the medication to suppress the patient's feelings. It is, of course, impossible to conduct genuine therapy of any kind under such circumstances.

16.8.13_6 I believe that my refusal to start patients on drugs is one reason why, since approximately 1970, I have not had any suicide attempts in my practice where I have been the primary therapist, and only one where I have been consulting on medication withdrawal in a criminal case where a man was anticipating going to jail. My patients work with me with unencumbered brains and with the knowledge that they will not be drugged in response to sharing their most desperate feelings with me. On the other hand, our patients have ultimate responsibility for themselves, and any good therapist could experience an occasional suicide attempt or even a completed suicide among his clients.

16.8.13_7 The more disturbed the person, the more the therapy must focus on empowerment. It enormously undermines personal confidence to be diagnosed with a mental illness or biochemical imbalance and to be told that you cannot manage your life without drugs. But it is enormously uplifting to learn that you can learn to manage your feelings, to straighten out your thoughts, and to relate to people and life in an effective, satisfying manner.

16.8.14 _Refuse to take any kind of threatening, bullying, or coercive actions

16.8.14_1 Refuse to take any kind of threatening, bullying, or coercive actions, especially against vulnerable, disturbed people who cannot resist or fight back effectively.

16.8.14_2 Coercion in the mental health system comes in many forms, from authoritative assertions that the person cannot do without drugs to outright involuntary commitment and forced treatment. For patients who have already experienced coercion in the mental health system, I quickly mention that I never commit patients or treat them against their will. Especially if the patient has already had bad experiences, I will explain that since finishing my training in 1966, I have never signed commitment papers or participated in locking up anyone, even people who have had self-destructive thoughts and fears.

16.8.14_3 There is no law that specifically requires a doctor to lock up patients against their will. However, the law in most states does require doctors to take preventive measures of some kind if they have reason to believe that a patient is likely to commit violence against a specific person. It is called "the duty to warn". I can recall exercising this option on only one occasion many years ago and the outcome was most remarkable. I was afraid that a man was going to assault his wife that very night after the session was over, so I discussed my legal duty to warn his wife of the danger. I did not want to do anything behind my patient's back and, somewhat to my surprise, he gladly went along with my calling his wife while he sat in the office with me.

16.8.14_4 When I got my patient's wife on the phone and explained to her that I was afraid her husband was growing dangerously violent toward her, she angrily told me to stop interfering in her life and hung up. The man continued successfully in therapy without perpetrating violence.

16.8.14_5 Most severely disturbed patients will have seen numerous other mental health professionals before finding their way to me. If mental health professionals have already seen them, then they have already experienced coercion (Breggin, 1964 [172], 1991c [190]). All or nearly all patients who display serious mental problems are quickly pressured to take drugs and are threatened, bullied, or locked up if they display too much reluctance.

16.8.14_6 Tragically, people who already feel emotionally overwhelmed are especially sensitive to and demoralized by any kind of authoritarianism or manipulation, let alone outright physical coercion. Therefore it provides enormous relief to disturbed persons when the therapist promises to behave differently and never to threaten or bully them, and never to force them into treatment or a hospital. In addition to feeling safer, they may feel, for the first time in their checkered experience with doctors and therapists, that they have met someone who feels competent and confident about offering help to them, rather than imposing it on them. As they begin to trust your word about not committing them, they will usually become more open and forthright in discussing their feelings with you so that you can deal more openly with suicidal or violent feelings.

16.8.14_7 In addition to not giving drugs, I believe that not coercing patients has also contributed to my relative success as a therapist. If patients become suicidal in my practice, for example, they do not have to hide it from me for fear of my prescribing drugs or locking them up. Instead, they can freely talk with me.

16.8.14_8 From my viewpoint as a psychiatrist and psychotherapist, it has been an enormous help to me to entirely reject the idea of coercing my patients. It means that I must rely on my ability to offer my patients, even my most disturbed patients, quality help that they will voluntarily accept and benefit from. When the going gets rough, it means I sometimes have to worry more, care more, think more, and be more available than doctors who commit their patients, but it has made me a better and happier therapist.

16.8.14_9 Therapy must be voluntary for the patient; otherwise, it becomes something else, such as indoctrination, intimidation, or brainwashing. As mentioned earlier in the chapter, this was obvious to Tuke in 1813, but it continues to elude the modern psychiatrist, who refuses to let go of the power to force patients into "treatment".

16.8.14_10 In reality, there is no such thing as involuntary therapy. Involuntary treatment is not treatment; it is incarceration, forced
drugging, forced electroshocks to the head, and so on.

16.8.14_11 It is commonplace for psychiatrists to claim that a patient’s irrational or self-destructive behavior demonstrates that he or she is asking for someone to take over his or her life. Because I am unequivocally against involuntary treatment, I get to hear what patients really think about it. Most of them resent the humiliation and loss of freedom for the rest of their lives, and many join organizations to oppose it such as MindFreedom (www.Mindfreedom.org). But even if some individuals seek oppressive treatment, psychiatrists should view it as a self-defeating pattern that should not be enabled.

16.8.14_12 If involuntary treatment seems to work, it is because the client has become submissive in response to authority. Involuntary treatment teaches the victim to become docile and to manipulate to avoid and escape punishment, and it motivates the so-called therapist to rationalize abusive acts. As I describe in detail in Beyond Conflict (1992a) [191], victims of coercion hide their true feelings from those who exercise arbitrary power over them.

16.8.14_13 Meanwhile, people who exercise that arbitrary power never want to know what their victims are truly feeling. As a result, involuntary treatment alienates the victim from the oppressor - the patient from the doctor - and substitutes a charade for a genuine relationship.

16.8.14_14 Despite hundreds of years of implementation, there are no studies showing that involuntary treatment helps people, protects them from suicide, or protects the public from violence.

16.8.14_15 If you decide that it is necessary and right in principle to lock up and drug any of your patients, including the disturbed ones, it will handicap you as a therapist. To be successful as a therapist for very disturbed people, you have to be convinced that all human beings can learn to take control of their emotions and their behavior and go on to live useful and happy lives. You will have to welcome emotional suffering as a sign of life and an indicator that the person inside is alive and well, if screaming in pain, and ready to find a better way to live. You also have to respect and treasure each individual’s freedom and responsibility sufficiently to believe that no human being has a right to lock up another for their own good. To me, locking up people or giving them drugs is quitting on them by saying, in effect, "You can't handle your life, and I can't handle you either."

16.8.14_16 Many well-meaning professionals attempt to provide therapy to individuals who are incarcerated against their will in mental hospitals or prisons. In theory, it might be possible to do this on a voluntary basis. But the therapist must remain acutely aware of institutional pressures on how he conducts his therapy and attempt at all times to serve the client, rather than the institution. Unfortunately, as I have learned from many colleagues, aligning oneself with the clients, rather than with the authorities, in an institution inevitably leads to getting fired. For this reason, it is probably impossible to conduct genuinely voluntary therapy within an involuntary institution.

16.8.14_17 Increasingly, it is also impossible to conduct genuine therapy in public outpatient clinics, because nearly all of them are under the control of biological psychiatrists who will not put up with any opinions that deviate from their own. I have seen highly competent professionals fired from mental health clinics for opposing the use of drugs. I always encourage mental health professionals to have at least a part-time private practice where they can conduct therapy more as they wish.

16.8.15 Welcome your patients’ most painful feelings

16.8.15_1 You will not be able to welcome your patients’ most desperate feelings if you plan to drug the feelings into oblivion or to lock them up for their own safety. Even if you say you want to hear all their most desperate feelings, your patients will hesitate to communicate them, unless they want to push you to give drugs or to lock them up.

16.8.15_2 When clients tell me that they are feeling suicidal, I explain to them, in effect, “If you didn’t have a sense that life can and should be better, you wouldn’t be so despairing over how bad it’s gotten. How much you want to die - that’s how much you want to love your life and how much you really want to live. I’d be more worried if you were indifferent about life. Life matters to you, and as long as that’s so, I know you can learn to live an especially wonderful life.”

16.8.15_3 I also give suicidal or desperate patients a phone number where they can reach me and arrange to see me as often as necessary. Since I do not give drugs, I have to give more of myself. If my patients have a caring family, I will work with them as well.

16.8.16 Share your most important values with your patients

16.8.16_1 Share your most important values with your patients because new and better values are key to an improved life.

16.8.16_2 Values matter. In our personal lives - our relationships with family and friends, and in our choice of work and recreation - I believe in individual liberty. People should not accept emotional or physical bullying or coercion in their personal or professional lives. In the political realm, the problem of individual freedom obviously becomes more complicated, but in our personal lives, it can be straightforward. In our personal lives, we should respect each other’s freedom. As therapists, we respect the freedom of our patients, and we encourage them to respect the freedom of others (see my discussions of liberty, love, and oppression from an individual and societal perspective in Breggin 1988 [183], 1988-1989 [184], and 1992a [191]).

16.8.16_3 For many good reasons, adults may choose to take care of less able children or adults. Responsible adults may also decide to tolerate unpleasant or difficult people to help them or to achieve important goals. But in our personal lives, helping people should be a choice rather than the result of being physically or emotionally bullied.

16.8.16_4 I also believe that a life without love is more akin to death than to life and that people thrive to the extent that they love other people, nature, life itself, or God. So my therapy promotes liberty and love.
16.8.16 | I also believe that we must take complete responsibility for our actions, moving beyond viewing ourselves as victims. Ultimately everything I do in therapy takes place in the context of promoting liberty, love, and personal responsibility.

16.8.16 | While there is a great deal of room for disagreement about values, I have tried to get to the rock bottom of those that matter in adult relationships and have summed them up to my own satisfaction with the ideas of personal responsibility, liberty, and love (Breggin, 1988-1989 [184]; 1992a [191]). My clients know or quickly learn my values, and of course, they can read my books. I believe that clients have a right to know their therapists' basic values because those values will inevitably affect them.

16.8.16 | Beyond the right to know what kinds of values are being implemented in the therapy, learning new values is among the most important aspects of insight therapy. My patients tend to perk up from the moment that I tell them that I believe in promoting their right to live life as they choose. They perk up even more when I explain that I believe in love and want to help them lead more love-filled lives.

16.8.16 | Having said that, I must admit that some patients, and even acquaintances outside of therapy, get nervous when I then speak about personal responsibility, fearing that it means something onerous. But often, that fear or resentment of personal responsibility is precisely how and why these people have ruined their lives, and they need eventually to face this reality if they are going to prosper. Therapy can help people overcome the guilt they feel about pursuing their own interests, including the expression of love for others, and it can help them overcome their self-defeating resentment of taking responsibility for their lives, including the pursuit of love in their lives.

16.8.17 **Make clear your last resort**

16.8.17 | Other professionals often beg me to admit that there are some people I would drug. I make no exceptions, but they sometimes seem desperate to make me admit to at least one exception. Why is that? Because drugs have become their last resort, their fallback position, their default position. They cannot believe that a therapist can function without sharing that same faith - without believing in drugs as a last resort. They feel driven to hope that sometimes I will also turn to prescribing psychiatric medications, if only on rare occasions. Otherwise, I am wholly denying their version of God - the Almighty Drug As the Last Resort.

16.8.17 | Other human beings and a personal relationship with God are far better last resorts than drugs. In fact, life itself, with all its varied ways of healing, is the alternative to a medication-impaired brain. Your clients will do much better if they understand that the restoration of their mental balance or sanity can best occur from a combination of their own internal resources and the people in their lives as well as from their most profound values and devotion to community and to a higher power, if they believe in one.

16.8.18 **Address psychological or learned helplessness early in the therapy**

16.8.18 | People become overwhelmed when they give up in the face of enormous stress, conflict, disappointment, or trauma. Psychosis and other deep disturbances are personal surrenders. The failing individuals succumb to feeling helpless and overwhelmed. Their will is broken, and in the extreme, they give up trying to manage their mental lives or their daily activities.

16.8.18 | It is important, in a caring but consistent manner, to address feelings of helplessness because therapy or any other intervention will prove ineffective until individuals believe that they can learn to control their emotions, behavior, and lives. Make clear that feeling helpless is not the same as acting in a helpless fashion. Help them understand that even the most urgent signals of helplessness must not be obeyed and, if they are not obeyed, they will eventually weaken. Explain that reason, personal responsibility, respect for the rights of others, and love must become the final guidelines for action. Explain that some people survive and even triumph over the worst kinds of stresses, from multiple losses, to physical paralysis, to years of incarceration, and that their job is to survive and then to triumph by going on to live an even better life based on sounder principles.

16.8.18 | I am not talking about giving lectures to patients. I have already written more about helplessness in this chapter than I will talk about it in most therapies. Usually, a few words at appropriate moments will get the point across that helplessness cannot be indulged without destroying one's own life. The actual therapy work involves learning where helplessness was engendered in childhood and then choosing and learning to overcome it in adulthood.

16.8.18 | Once the person begins to grasp the importance of rejecting helpless, victimized feelings, the additional work of therapy can begin, including the investigation of how the individual learned to react helplessly to stress and conflict.

16.8.19 **Be willing to offer practical advice and guidance**

16.8.19 | Many clients - including those who are not deeply disturbed - can benefit from guidance in how to go about making decisions and resolving conflicts with loved ones. In couples therapy, for example, I observe how my clients interact with each other and give them direct advice on how to communicate in a more respectful and loving manner. In the process, I emphasize the centrality of love to all personal relationships.

16.8.19 | Obviously, therapists will vary in their ability and interest in providing guidance, but it can be a helpful aspect of the therapeutic relationship. In my older years, people seem to benefit a great deal from my advice, and in retrospect, I am glad that I offered less of it when I was young.
Bibliography


Blumenthal, J., Babyak, M., Moore, K., Craighead, W., Herman, S., Khatri, P., et al. (1999). Effects of exercise training on older patients with major depression. Archives of Internal Medicine, 159, 2349-2356.


Brain-Disabling Treatments in Psychiatry. Drugs, Electroshock, and the Psychopharmaceutical Complex. By Peter Breggin, M.D. Hardback Published by Springer Publishing Co. Second edition, revised and updated. Renowned psychiatrist Peter Breggin documents how psychiatric drugs and electroshock (ECT) disable the brain. He presents the latest scientific information on potential brain dysfunction and dangerous behavioral abnormalities produced by the most widely used drugs including Prozac, Xanax, Halcion, Ritalin, and lithium. while supplies last. Chapter 1: The Brain-Disabling Principles of Psychiatric Treatment. The last decade has seen escalating reliance upon psychiatric drugs, not only within psychiatry, but throughout medicine, mental health, and even education. Nearly every patient who is psychiatrically hospitalized is encouraged or forced to take medications. There is a movement within psychiatry to make it easier to force clinic outpatients to take long-acting injections of drugs. In private practice psychiatry, it is common to give patients a medication on the first visit and then to instruct them that they will need drugs for Praise for Brain-Disabling Treatments in Psychiatry, 1st Edition ?This book proves once again that Peter Breggin truly is the ?conscience of American psychiatry.? Breggin shows that the brain-disabling hypothesis of organic psychiatric treatments is overwhelmingly confirmed by clinical experience and the scientific literature. 2nd edition. — Springer Publishing Company; 2008. — 577 p. In Brain Disabling Treatments in Psychiatry, renowned psychiatrist Peter R. Breggin, M.D., presents startling scientific research on the dangerous behavioral abnormalities and brain dysfunctions produced by the most widely used and newest psychiatric drugs such as Prozac, Paxil, Zoloft, Cymbalta, Effexor, Xanax, Ativan, Ritalin, Adderall, Concerta, Strattera, Risperdal, Zyprexa, Geodon, Abilify, lithium and Depakote. Many of Breggin's earlier findings have improved. Clinical practice, led to legal victories against drug companies, from: Brain-Disabling Treatments in Psychiatry. The benzodiazepines have for several decades been recognized in the literature and clinical practice for their capacity to cause mental and behavioral abnormalities. Xanax (alprazolam), and to an even greater extent, Halcion (triazolam), have a significantly different profile from other benzodiazepines due to their greater capacity to bind to receptors and their shorter half-life. Halcion's very short half-life led to the hope that it would make a particularly good sleeping medication but it has proven especially dangerous. The brain-disa...