Introduction: Spearheading a Transformation

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In recent years, pharmacology and psychiatric hospitalization have become the standard for most professionals when "treating schizophrenia." Meanwhile, a body of research and practical experience has been evolving that supports innovative psychosocial interventions as less hazardous and more effective. As psychiatry goes through still another historical cycle in the conflict between psychosocial and biological approaches, we may be on the verge of a renewed emphasis on human service interventions. This book hopes to spearhead such a transformation by reviewing current research, theory and practice based on the psychosocial model.

PERSONS AS AGENTS AND BEINGS

How we view human beings in general is fundamental to the controversy over how to conceptualize and approach deeply disturbed, seem-

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Author Note: The title of the book, *Psychosocial Approaches to Deeply Disturbed Persons,* reflects its orientation. Because the term *treatment* tends to encourage a biopsychiatric or medical model, I have chosen the term *approach* as an alternative. How to approach or "come near to" the labeled patient is often critical. Similarly, the term *schizophrenic* narrows the scope of professional roles and viewpoints. Therefore the book title addresses *deeply disturbed people*–those who are profoundly troubled and anguished, and who often receive severe psychiatric labels, such as schizophrenia. Because of the wide variety of viewpoints represented by the contributors and because of the need to communicate in a commonly accepted language, the terms *treatment* and *schizophrenia* will nonetheless recur throughout the chapters.

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ingly irrational people. I believe that all individuals should be viewed as agents and beings (Breggin, 1991, 1992, 1997).

People as *agents* are active forces in their own lives. In philosophical terms, they have autonomy and are capable of self-determination. Free will may have its limitations, including those imposed by genetics and biology, but the effective exercise of free will is critical to recovery and to successful living. Because human beings must exercise free will in order to survive and to prosper, they need a maximum of personal freedom. Thus the principle of liberty becomes crucial to human progress on both the personal and political level (Breggin, 1992). Approaches to deeply disturbed human beings should as much as possible respect their autonomy, independence, and freedom. They should seek to *increase* rather than to limit their liberty.

People as *beings* not only have agency or the ability to take actions, more specifically they are capable of generating values, including love. They can offer love and they can accept it. Love is an active, positive attitude toward others, a treasuring of others that is reverent, caring, and empathic. The capacity to share love is central to recovery and to continued personal growth (Breggin, 1997).

The principles of liberty and love–and relationships based on them–empower individuals, enabling them to overcome trauma stress, and to live their fullest potential. On the one hand, empowerment is healing. It soothes pain and anguish. On the other, it is strengthening–it supports the individual's pursuit of his or her own chosen values and ideals.

Persons are influenced and constrained by their bodies, and they require their bodies in order to function; but they exist as well on a level that is variously called psychological, psychosocial, existential, or psychospiritual. They *generate* thoughts and feelings, they *create* values and meanings, they *choose* courses of actions, and they *relate* to other beings–influencing them and in turn being influenced by them. That is, they are both agents and beings.

Anguished, self-defeating responses to life, from anxiety and despair to madness, are learned through hurtful interactions with ourselves, other people, and life. Often these responses can be understood as "psychospiritual overwhelm" (Breggin, 1991). In a somewhat simplified manner, I have described the origin of this helplessness in the basic stress paradigm of hurt, fear and helplessness (Breggin, 1992, pp. 103-104; 1997). The individual becomes helpless in the face of seeming personal devastation from internal and external threats. Healing requires overcoming helplessness through self-understanding, rational thought processes, loving attitudes, positive values and ideals, effective choices and actions, and loving relationships.

PERSONS AS OBJECTS OR BIOCHEMICAL DEVICES

The "scientific" or scientistic approach takes a starkly contrasting attitude toward those who suffer mental disturbances and anguish, especially those who end up with psychotic labels (e.g., schizophrenia, major depression and manic-depressive disorder).[1] In the extreme, the person is seen as a reactive object or biological mechanism. He or she becomes an "it" devoid of the capacity to generate thoughts or feelings, to create values or meanings, to choose courses of action, or to influence and be influenced by others. Or if the person is granted these human capacities, the capacities are seen as irrelevant to the processes involved in "mental illness" and "treatment" (Breggin and Breggin, 1994a & b).

In previous decades, the scientistic approach in psychiatry included both a biological and an environmental wing. The individual's behavior was seen as determined by either biological variables or environmental ones; but either way, the principles of cause and effect applied. In more recent times, environmental determinism has lost its verge and been largely replaced by genetic and biochemical determinism. Environment has come to play almost no role in the thinking of many modern psychiatrists, especially in regard to the "causation" of severe "mental illnesses," such as major depression, manic-depressive disorder, and schizophrenia (reviewed in Breggin, 1991).

More "balanced" or "eclectic" psychiatric perspectives tend to include both genetic predispositions and environmental influences. These are usually found in textbooks of psychiatry. In actual practice, however, most current theories and textbooks tend to emphasize genetic and biochemical factors and to encourage physical treatments. Even while giving passing mention to psychosocial theories and practices, these theories and textbooks display skepticism toward them. They devote no attention to psychospiritual issues, such as love.

CONTRASTING THERAPEUTIC APPROACHES

If we approach the human as a being, then our task is to understand and to empower. Understanding involves intuition, empathy and love. Empowerment involves self-understanding, moral encouragement through a caring relationship, and guidance toward more effective, autonomous and loving principles of living. It may also involve direct assistance in negotiating life's stresses, for example, by helping the individual become more effective in utilizing community resources or by including his or her family in the therapy.

If we approach the human "scientifically" or "objectively," then the tendency is to diagnose and to control, to impose our own abstract and potentially oppressive category upon the person, and to manipulate the outcome. Physical interventions, such as drugs and enforced confinement in a mental hospital, become the preferred tools (Breggin and Breggin, 1994a & b).

Often the patient feels *mis*understood, rather than understood; *dis*empowered rather than empowered. These approaches seem to empower the doctor far more than the patient.

The biopsychiatric approach can easily reinforce the patient's worst feelings and attitudes. The patient already feels helpless–at the mercy of forces beyond his or her control. The patient often feels like an object or thing that can do nothing more than react helplessly to internal and external threats. In the extreme, the individual suffers from delusions and hallucinations about being influenced and manipulated by imaginary others and outside unknown forces. Often the patient feels "mentally defective."

Unfortunately, the biopsychiatrist's approach will encourage the patient's self-destructive attitudes by further encouraging the patient to think and act like a helpless victim of overwhelming forces, namely, genetic and biochemical abnormalities. The doctor then "takes over" and prescribes physical agents that are supposed to counteract the genetic and biochemical influences. This further reinforces the patient's self-destructive helplessness.

The patient can easily become a passive battlefield between two warring parties–the forces of his or her own alleged biological abnormalities, and the forces of biopsychiatry in the form of drugs and electroshock. Whatever the seeming outcome, the patient's worst view of life is reconfirmed–that he or she is a passive victim of forces beyond personal understanding and control.

In an especially tragic irony, the biopsychiatrist frequently renders the patient *more helpless* by means of brain-disabling treatments and involuntary hospitalization (Breggin, 1991; Breggin & Breggin, 1994a & b). The patient–whose problems are driven by overwhelming feelings of helplessness–is further overwhelmed by coercive therapy and brain dysfunction.

PHILOSOPHY AND SCIENCE

There are, of course, not only philosophical considerations but scientific ones. To a great extent both the public and mental health profession has accepted the claim that so-called schizophrenia is a genetic and biochemical disease, and that drugs, electroshock, and mental hospitals are effective, humane approaches to severe human suffering. The public, the media

and much of the profession mistakenly believe that the biopsychiatrists have a corner on the scientific market.

I have critiqued this "science" in *Toxic Psychiatry: Why Therapy, Empathy, and Love Must Replace the Drugs, Electroshock and Biochemical Theories of the 'New Psychiatry'* (1991), as well as in a variety of other professional publications (Breggin, 1979, 1983; Breggin and Breggin, 1994a & b). Karon and Whitaker will continue that analysis in their chapter in this book. I will not try to duplicate or to summarize the arguments and evidence already offered in rebuttal, except to say that biopsychiatric claims are largely without foundation. There is no convincing evidence to support genetic and biochemical theories or the physical interventions so highly touted by contemporary biopsychiatry. Most available scientific evidence instead undermines biopsychiatric theory and practice.

Scientific research does have a place in the helping professions, for example, in testing theories and more practically in the evaluation of "outcomes." But any attempt to evaluate the results of a therapeutic approach will reflect the researchers' underlying values, often expressed in the variables which are selected for evaluation. For example, studies that demonstrate the effectiveness of drugs for depression typically focus on symptom relief, such as weight gain or reduced insomnia. These studies merely reconfirm the well-known fact that many drugs, including tricyclic antidepressants, can physically stimulate appetite and cause sedation. On the other hand, research that demonstrates the efficacy of psychotherapy tends to focus on subjective changes in the patient's feelings and on actual changes in lifestyle or the conduct of life (Fisher and Greenberg, 1989). Psychotherapy is more effective than medication when these criteria are used.

Psychosocial research should place much more emphasis on the patient's personal or subjective response to "treatment." In biopsychiatry, patients who are medicated or shocked are typically labeled "improved" when they conform to hospital demands or receive discharge from the hospital. But the patients themselves often feel badly drugged, befuddled, or coerced. Often they actively resist the supposedly beneficial treatment by secretly spitting out their pills or by pleading for an end to shock treatment. Increased discharge rates often reflect the desire to escape from escalating treatment with drugs or shock (Breggin, 1979, 1983, 1991).

Unfortunately, it is difficult to find research that takes into account the patient or client's personal, subjective response, or that examines beneficial changes in lifestyle. We end up trying to infer benefits from other variables, such as length or frequency of hospitalization, that bear little relationship to overall improvement in mood, attitudes or lifestyle.

A CONFLICT RESOLUTION MODEL

People who come to the attention of mental health professionals are in conflict. Their conflicts may be internal, and characterized by guilt, shame, anxiety, numbing and anger. Or they may be external or "behavioral," involving others in their lives and society. The more severely "ill" they seem, the more they are embroiled in severe conflict–within themselves and with others, often including active strife with mental health professionals who try to treat.

Conflict resolution based on respect for the principles of liberty and love provides an effective contemporary model for the mental health profession. It addresses the basic needs of each individual involved in the conflict and seeks to increase their satisfaction (Breggin, 1992, 1997). It calls for creating a safe space for the individual in which coercive power is replaced by reason, love, and mutual attempts to satisfy the basic needs of those involved in the conflict.

Unfortunately, much of the mental health profession relies on the medical model which seeks to identify one member of the conflict as the "cause of it all" and further seeks to locate the "cause" within the labeled individual's genetic and biochemical vulnerability. In the process it frequently revictimizes one of the victims of the conflict, while it ignores the larger psychological, familial, social and political context of the conflict. Often it utilizes coercive power in the form of brain-disabling treatments and involuntary hospitalization.

Deeply disturbed people should be viewed as persons struggling to survive and to grow–as persons in conflict with themselves and with other people. Healing comes through a combination of self-development and beneficial relationships with others. It is maximized when people are treated as agents and beings, according to the ideals of liberty and love.

NOTE

1. Scientism is the misapplication of the principles of the physical sciences to understanding human mental life and conduct. It emphasizes simple-minded cause and effect reactivity at the expense of volition and subjectively-chosen values.

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