Psychopharmacology And Human Values

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PSYCHOPHARMACOLOGY AND HUMAN VALUES

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Summary

Psychopharmacology and biological psychiatry now dominate the mental health field. Even humanistic and existential therapists are likely to refer difficult or disturbed clients to physicians, especially psychiatrists, for possible medication. The prevailing professional tendency is to conceptualize the conflict between psychotherapy and drug treatment as a scientific one; but it is at root a conflict between two different views of human nature. We need to renew our faith in the psychiatric drug-free human being in both our personal and professional lives.

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Throughout the mental health professions, and medicine in general, there is an increasing reliance on psychiatric drugs for a broadening array of human suffering from conflict between parents and children to anxiety and despair among adults. This professional reliance on drugs takes many forms, including (a) failing to recognize the existence of safer and more effective psychotherapeutic approaches, (b) distrusting their own professional skills at critical moments in therapy, (c) overestimating the value of medication to relieve suffering and, in particular, to prevent suicide, and (d) falsely communicating to patients that they cannot succeed in therapy without the addition of a medication.

Few therapists realize that no antidepressant medication has ever been shown to reduce the likelihood of suicide and that instead many, such as fluoxetine (Prozac), have been implicated in raising the suicide rate (Breggin, 1997a, 2000, 2001a, 2001b). Too often medication is prescribed at exactly the moment that renewed devotion to the therapeutic process is required to save a life and to help the individual to triumph over suffering and conflict (for a discussion of how to help people in crises without resort to drugs, see Breggin, 1997b, 1998, 2000).

In relying on medication, therapists often undermine the humanistic, existential view of human nature—the belief that each human being has the task of learning to live by principles and by higher values, such as liberty, personal responsibility, and love—and that this effort is an essential part of the psychotherapeutic processes and life itself. Not only does the resort to medication tend to subvert these higher values, but the physical impact of all psychoactive medication on the brain also ultimately blunts or distorts the individual's higher faculties (Breggin, 1997a, 2001a, 2001b, 2002).

Nowadays, even the humanistic or existential psychotherapist is likely to recommend medication, or at least a psychiatric consultation, when a client is especially distressed or failing to make progress in therapy. Although this growing resort to drugs is usually couched in the language of science and research, it has more to do with the modern tendency to place faith in experts, in quick and easy solutions, in medical doctors, and in anything that calls itself science or research.

I have criticized the growing trend to use medicalized diagnoses and treatment with drugs and electroshock and have proposed better human services based on empathy (Breggin, 1991, 1992,

1997a, 1997b, 1998, 2001a, 2001b, 2002; Breggin & Breggin, 1994, 1998; Breggin, Breggin, & Bemak, 2002; Breggin & Cohen, 1999; Breggin & Stern, 1996)). My views have drawn on traditions established by psychosocially oriented psychologists and psychiatrists, (e.g. Adler, 1969; Allport, 1955; Ansbacher & Ansbacher, 1956; Fromm, 1956; Laing, 1967; Laing & Esterson, 1970; Rogers, 1961, 1995; Sullivan, 1953; Szasz, 1987). Many other contemporary voices have also been criticizing the fundamental principles of biological psychiatry from scientific, humanistic psychology, and philosophical perspectives (Armstrong, 1993; Caplan, 1995; Cohen & Cohen, 1983; Colbert, 1996; Fisher & Greenberg, 1989, 1997; Jacobs, 1995; Modrow, 1992; Mosher & Burti, 1989; Romme & Escher, 1993; Ross & Pam, 1995).

Psychopharmacology is closely tied to diagnosis. The use of psychoactive drugs is justified by labels that acquire their authority through their resemblance, however fabricated, to more legitimate medical diagnoses. Drawing in part on Laing (1967; Laing & Esterson, 1970) and Szasz (1987), Kramer and Buck (1997) wrote,

> People categorize other people and are skilled at doing so. Although this talent has creative uses, one of its most destructive outcomes follows from the medical model when apparent mental illness is diagnosed and the person is dealt with on that basis. (p. 12)

Many critics of biological psychiatry and advocates of psychosocial services have focused on underlying philosophy as well as science. Pam (1995) has warned, "Unless challenged, contemporary culture will progressively regard Homo sapiens as *homo biologicus*—something on the order of a highly evolved, intricately wired, and socially verbose fruit fly" (p. 2).

FAITH IN "MY BIOCHEMICAL IMBALANCE"

When people consider starting or stopping psychiatric drugs, they often feel as if they are facing a void or stepping off a cliff. These patients and their doctors believe that they must rely on psychiatric drugs. That is, they don't believe there are safer and potentially more effective alternatives to drugs. If they don't take the drugs, what else can they do? If they stop relying on psychiatric drugs, what will they rely on? What will they do about their suffering without their psychiatric drugs? In today's society, people who

seek help from doctors seldom realize that reliance on psychiatric drugs is, at root, based on faith rather than on scientific conclusions. In particular, they don't know how flimsy the data is for supporting the most commonly used psychiatric medications, such as the newer generation of antidepressants called selective serotonin reuptake inhibitor (SSRI), such as fluvoxamine (Prozac), paroxetine (Paxil), sertraline (Zoloft), and citalopram (Celexa) (see Breggin, 2001a, 2001b; Breggin & Breggin, 1994; Fisher & Greenberg, 1989, 1997).

In clinical practice, patients commonly present with one or another variation on the following scenario. Ms. Martin was 18 years old when she left an abusive, "dysfunctional" family and attempted to live alone and to work while putting herself through college. Her family actively opposed her efforts, and she eventually began to feel paralyzed with anxiety and hopelessness. After returning home, the family doctor told her that she was suffering from "major depression" caused by a "biochemical imbalance." He placed her on an antidepressant that she continued to take for several years. She then suffered a brief "manic" episode that, in retrospect, was probably induced by the antidepressant.

The family doctor referred Ms. Martin to a psychiatrist who reemphasized to her that she had a "biochemical imbalance" caused by genetic and biological dysfunctions. He changed her diagnosis from major depression to bipolar (manic-depressive) disorder without informing her that the antidepressant probably caused her "mania." He prescribed another antidepressant and added lithium to "stabilize" her "mood swings." For the next 10 years, Ms. Martin's life involved a constant tinkering with antidepressants, often two at a time, and various dosing schedules of lithium and other drugs. She never returned to college and enjoyed only moderate success at work compared to her real abilities.

When Ms. Martin began to realize that she was becoming increasingly apathetic and experiencing memory loss, she sought help to assist her in coming off psychiatric drugs. In the initial discussions, it became apparent that Ms. Martin had been living for many years according to the simplistic faith of biopsychiatry: "I have a genetic and biological disease called bipolar disorder that requires treatment for the rest of my life. The drugs correct my biochemical imbalance."

The biopsychiatric faith had left Ms. Martin dependent on doctors for medication. The drugs had confined her within the physi-

cal constraints of drug-induced emotional numbness and apathy and ultimately impaired her cognitive function. She plodded along in drug-induced stagnation without ever experiencing personal fulfillment in her work or social life.

Although Ms. Martin's initial crisis developed during her teenage attempt to leave an abusive home, none of her doctors suggested to her that she might have psychologically based problems and that psychotherapy or counseling might be helpful. The biomedical bias of her doctors actively discouraged her from learning about and overcoming the original sources of her problems.

Over a period of several months, Ms. Martin was able to withdraw from psychiatric drugs. In the process, she developed a philosophy of life that empowered her to take charge of her thoughts and feelings and to take new steps toward the fulfillment of her psychological, social, and creative needs. She convinced her employer to pay for her college credits, and she began a marked escalation in career achievements. She was also more able to express her feelings and to develop more fulfilling personal relationships.

FAITH IN "MY CHILD'S BIOCHEMICAL IMBALANCE"

Within the last few years, there has been an increasing reliance on psychiatric drugs in the treatment of children (reviewed in Breggin, 1998, 2001a, 2001b, 2002). A recent issue of *Current Psychiatry*, mailed free to psychiatrists around the country, displayed a subheading on its cover, "Pipelines fill with psychotropics for children and adolescents" (for the article itself, see DeVeaugh-Geiss, 2002).

In my office, the following tragic scenario is typical. From an early age, Tony was more demanding and active than many other children. He wanted attention from adults or he wanted to be doing something that enthralled him, like computer games or playing ball with his dad. In school, his kindergarten teacher noticed that he was more energetic than most children and sometimes required extra attention from her, but she reassured Tony's parents that their son was a remarkable and even admirable youngster with an exciting future.

Early in second grade, Tony's parents divorced, and after considerable conflict, his mother gained primary residential custody. But by the end of the second grade, his mother began having serious difficulty getting the rambunctious little boy under control. He would talk back to her, mimic her, and refuse to do almost anything she requested. Getting out of the house for school each morning became a major production.

In the classroom, Tony began to disrupt the routine by talking out of turn or fidgeting in his seat. The teacher rated Tony's behavior on a scale given to her by the school psychologist and found that he fit in the profile of children diagnosed with attention deficit/hyperactivity disorder (ADHD). After a meeting with a team of "specialists" at the school, his mother complied by taking Tony to the pediatrician for an "evaluation." After chatting with her for 5 minutes, the pediatrician reassured her that she was a wonderful mother and that neither parents or teachers were to blame for the behavior of an "ADHD child." She was also reassured that the divorce played no role in her son's "ADHD," which was caused by genetic and biological factors. "In fact," he explained with conviction, "your son has a biochemical imbalance." Tony was then placed on methylphenidate (trade name, Ritalin), and within 2 days the teachers reported the boy was "doing much better in class." He was described as well-behaved, quiet, and cooperative.

Meanwhile, Tony's mother noticed that the "spark" had gone out of his eyes. Dad, who saw him on weekends, thought Tony looked "vacant" at times and seemed listless. However, the teacher reaffirmed her "faith" in Ritalin and urged both parents to keep Tony on the drug. The pediatrician ridiculed anyone who "didn't believe in Ritalin." Nonetheless, Tony's parents decided to set aside their conflicts to seek help from a doctor who "didn't believe in Ritalin."

Tony's parents were asked to bring their son with them to the first session. Within an hour, it was obvious that their conflicts and their opposing styles of discipline were driving Tony into a state of anxiety and confusion. The next several sessions were spent with the parents alone helping them to redevelop rapport between them while also teaching them better approaches to parenting Tony. They were encouraged to revive their faith in themselves as parents and in their son as a normal yet energetic child.

Within weeks Tony was getting along better with each parent and the sparkle was back in his eyes. Although he was becoming somewhat calmer in school without medication, he still did not fit

comfortably into the large, boring, overcontrolled classroom. The parents pooled their resources to send him to a private school where emphasis was placed on engaging the interest of each individual child. Tony has done well ever since at home and in school.

Millions of parents in the United States are told that their behavior and attitudes as parents do not affect how their children feel or act. Although this may relieve their "guilt," it disempowers them as parents, leading them instead to place their faith in the experts and in drugs. These biomedical beliefs also undermine their faith in their children's capacity to learn from adults how to behave more effectively at home and in school.

Biopsychiatry forces on children the false and debilitating belief that there is something wrong with their brains and minds. It discourages children from believing in their own capacity to control their behavior and to become responsible, effective young people. The biomedical crushing of the child's self-esteem and sense of personal efficacy can haunt children for the rest of their lives.

Parents need a restoration of faith in themselves and in their children, along with a rededication to taking responsibility for providing the best possible parenting. The schools, of course, should find new ways to meet the genuine needs of modern children instead of drugging them into submission. Society needs renewed faith in education—even when it requires reforming the schools and the ways in which we teach children. All of these positive alternatives are discouraged and even destroyed by faith in biopsychiatry.

THE ESSENCE OF THE HUMANISTIC APPROACH

In the humanistic, existential approach, human beings are seen as endowed with unique capacities, yearnings, and aspirations. They seek to overcome and transcend suffering through self-understanding, ethics, community, and enriched lives. In this model, people must take personal responsibility for their lives, including the quality of their mental condition and relationships with others, including children.

The corresponding psychotherapeutic model does not reject the existence of the body or attempt to address complex mind-body issues. Its emphasis is more focused and even practical: First, the

human suffering dealt with by psychiatrists and other mental health professionals is almost always psychological, existential and social in nature, rather than biological; and second, psychotherapeutic rather than biological interventions are safer and more effective for these problems. (When patients do turn out to have a real physical problems contributing to their psychological suffering, such as a chronic head injury or thyroid disease, they need specific medical treatments and not psychiatric drugs.)

ASPECTS OF BEING A PERSON

There are many traditional ideas about the human nature that are particularly relevant when trying to reject or to withdraw from psychiatric drugs.

- Pain and suffering have meaning. Emotions are signals, not symptoms; they tell us about our physical and psychological condition. When we blunt our emotions, we blind ourselves to our inner feelings and needs and suppress our human nature.
- Heroism is required to live a principled life in the face of the inevitable pain and suffering that all human beings endure.
- There are no short cuts to making life less painful or to achieving peace of mind. Hard work and rational, consistent principles are required to achieve a state of contentment or satisfaction, and such a state always remains fragile.
- Human beings thrive to the extent that they live by ideals and refuse to compromise them.

In recent centuries, philosophy and psychology have added to concepts of the human nature, the self, or the soul. Following are some of these more contemporary humanistic or existential principles:

- Individuals seek self-actualization or self-fulfillment through the development and expression of their unique capacities and will suffer if this pursuit is inhibited or thwarted.
- Empathy—the capacity to understand and to care about the feelings and viewpoint of others—is central to an ethical and fulfilling life. Empathy is also the basis of healing (Breggin, 1997b).
- Successful people take personal responsibility for choosing the principles by which they conduct their lives.

- Emotional and psychological suffering can come from many causes—from early childhood trauma to unhappiness in marriage or work. It can also come from the failure to find a meaningful way of life. Triumph over psychological suffering requires self-understanding, responsibility, and commitment to sound principles of living.

This traditional model of human nature and human suffering with its contemporary modifications has been given many different names in modern times to emphasize different aspects. It has been called humanistic or existential. It can also be viewed as the basic psychotherapeutic model.

PSYCHOACTIVE DRUGS AND HUMAN VALUES

Many claims have been made over the centuries for the value of drugs in enhancing the human experience. Alcohol in the form of wine, for example, is used in the celebrations and sacraments of Judaism and Christianity. However, only small portions of alcohol are employed for these purposes. The aim is ritualistic, without chronic use or intoxication.

Almost all societies have made use of one or another psychoactive substance. Many Native American cultures, for example, used a variety of substances to enhance their rituals. In some cases, the drugs were taken to the point of intoxication, as in some vision quests and rites of passage of adolescent boys. However, Native American cultures did not make use of psychoactive substances on a regular basis to enhance living, to overcome emotional suffering, or to subdue troubled or troubling people.

Although few, if any, societies have given official encouragement to the routine use of psychoactive substances, individuals throughout recorded history have attempted to enhance or at least to anesthetize themselves on a daily basis through mind-altering drugs. Drunkenness is as old as recorded history. In our own century, a significant portion of the 1960s generation believed, for a time at least, that they could be brought to new levels of spiritual awareness through the regular use of marijuana and hallucinogenic drugs. Few have maintained these views throughout adulthood, and many now deeply regret their prolonged experimentation with

these drugs. Some feel that they have permanently injured their mental capacities.

Only in recent years has the routine use of medically prescribed psychoactive drugs become widely accepted as something positive that many individuals *should* do. Biological psychiatry has carried this to the extreme. Many individuals are *encouraged* and even *pressured* or *forced* to take drugs for their entire lives. Indeed, they are considered irresponsible and even "mentally ill" if they refuse psychiatric medication.

This new promotion of lifelong dependency on drugs is presented in the language of medicine as a treatment for what are claimed to be "mental illnesses." No issues are raised about drug effects on higher human faculties, such as the ability to love, to care, or to create. Concerns about "sexual dysfunction" are as close as the drug companies or biological psychiatrists usually come to concerning themselves about the effects of their drugs on human relationships or love. Seldom do drug advocates attempt to evaluate the impact of the drugs on higher faculties, such as the ability to love, to take responsibility, to be sensitive to others, or to create. Remarkably, the FDA approves drugs without requiring neuropsychological testing and without directly assessing how the medications affect the faculties of the mind, such as memory and abstract reasoning.

But what effects do drugs have on higher human faculties?

Drugs can only dampen or flatten awareness, causing at best an unrealistic, artificial feeling of well-being called euphoria (Breggin, 1991, 1997a). The qualities of love and empathy are impaired by any drugs that affect the mind, including psychiatric medications. Although individuals sometimes claim to have "mind expanding" experience on psychoactive agents, efforts to use these experiences in therapy have not born fruit. Meanwhile, few, if any, such claims are made in regard to contemporary psychiatric medications.

BIOPSYCHIATRIC MECHANICAL MODEL OF HUMAN LIFE

When people choose to become patients of a psychiatrist who prescribes drugs, they are doing a great deal more than merely "seeing the doctor." They are subjecting themselves to a very spe-

cific and limited model of thinking about human suffering and failure. The widespread adoption of this mechanistic model is relatively new in the history of humankind. It demands that we think of ourselves as broken machines or flawed mechanical devices. It requires blind faith in doctors and scientists, combined with a materialistic faith in molecular causes and manipulations.

In the biopsychiatric model, we are mechanical devices similar to computers or other machines. Our suffering is caused by genetic and biological factors beyond our control. When we cannot seem to find a solution on our own, we place our fate in the hands of technicians who know how to tinker with our machinery.

In this mechanical model, we have very little personal responsibility for our condition. We are spared the painful search for the personal and psychological causes of our suffering in our lives as children and adults. We are relieved of the necessity of finding more valid and meaningful principles of living. We do not have to face our conflicts with our husbands or wives, fathers or mothers, children, friends, coworkers, or bosses. We do not have to seek more meaningful work and more satisfying relationships. Heroism and determination in the face of our suffering becomes irrelevant. We are only responsible for taking our medications as directed. For these reasons, the psychotherapeutic model cannot be successfully blended with the biological model. The biological model undermines the core of the humanistic, existential or psychotherapeutic approach in therapy.

Some professionals believe that the two models can live side by side. After all, a person can take medication to deal with defects of the body, such as heart disease or diabetes, without basing his or her life on mechanical principles.

Taking psychiatric drugs is not like taking insulin for diabetes. In psychiatry, the "target organ" is the brain, and the brain is the seat of our thinking, feeling selves. This is very different from taking drugs to modify the functioning of our hearts or livers. Consider, for example, the difference between a heart transplant and a brain transplant. If you were to exchange your old brain for a new one, you would become another person—the person who donated the brain. You, as a distinct person, would die with the death of your old brain.

But you can exchange your heart for a new one without losing your identify and without becoming the donor.

To pursue the parallel, when you take a psychiatric drug, you change yourself as a person; but when you take a cardiac drug, little about you as a person is changed.

FAITH IN PSYCHIATRY: SCIENCE OR SCIENCE FICTION?

People don't usually think of themselves as having "faith" in psychiatry. When pressed, they may instead explain that they "believe in science" or "believe in medicine." They may emphasize that there is "research" to confirm their reliance on psychiatrists and drugs.

In reality, psychiatry is a belief system that millions of people accept with unquestioning faith. The biopsychiatric belief system holds that emotional or psychological suffering is caused by genetic and biological defects and that doctors can prescribe drugs that will correct or at least ameliorate these defects. Scientifically, this is simple-minded speculation. As a faith, it is barren indeed and doomed to failure. It cannot provide people guidelines for living a more ethical, more enriched, or more satisfying life.

Of course, biopsychiatry pretends to make no statements at all about human nature or human values. Yet it undermines any focus on human conflict and personal values by rendering these concerns irrelevant. From anxiety and depression to violence and crime, all of the struggles and conflicts generated by the human psyche and social conflict are transformed into grist for the mill of psychiatric diagnosis and drugging.

Individual patients often come to biopsychiatry with the same problems that they used to bring to a variety of other healers, from psychoanalysts to religious healers. They do so as a desperate, last-ditch attempt to place faith in something "scientific" or "medical" to relieve their suffering. But they do not think of themselves as turning to a materialistic philosophy and technology. As a result, their basic human values are eroded without their realizing it.

FAITH, NOT SCIENTIFIC KNOWLEDGE

People who go to doctors for psychiatric drugs rarely have any direct knowledge of the scientific or medical literature. They don't

know whether there is evidence for the supposed genetic or biological factors, the capacity of drugs to improve these deficits, or the risks entailed. Even if they have read a few scientific papers, they have little or no idea how to analyze or to evaluate them. They do not know that there have always been hundreds of "scientific" studies claiming to prove the efficacy of this or that now-discredited biological treatment, including morphine and lobotomy. In general, people who go to psychiatrists will believe what they are told. Nowadays, they have been prepared in advance by years of bombardment with biopsychiatric and drug company marketing as it appears in advertising and molds the major media.

Even the doctors themselves seldom have much direct knowledge about the research used to justify the use of psychiatric drugs. The vast majority of physicians have little or no capacity to criticize the published research or to place it within its proper political context. They don't know how the pharmaceutical industry dominates research or how the journals tend to reject any articles that criticize biopsychiatry. They have little notion of what a closed, highly controlled circle the researchers live within. If they did understand these aspects of medicine and psychiatry, they would realize that the entire basis of biological psychiatry is largely a matter of drug company promotion and biopsychiatric propaganda—that there are no known biological causes of the suffering expressed by their patients and that there are no curative drugs. They would realize that the system is maintained by gorging itself on drug company money and by excluding as much as possible any criticism from skeptics in the professional arena.[1]

The growing reliance on biological explanations and psychiatric drugs is one of the most remarkable phenomena of modern times. Although the trend has certainly been noticed and even criticized in the media, its deeper meaning has gone unrecognized. Biological psychiatry has become a religion, *the religion*, of opinion leaders and seemingly informed individuals in fields as diverse as the medicine, the media, politics, education, and religion. It is the *faith* to which they turn in time of despair, distress, and psychological or spiritual need.

Through their extraordinarily successful public relations campaign, political lobbying, and, most recently, television advertising, biological psychiatry and the drug companies have largely succeeded in convincing a generation of people that suffering emanates from a broken brain rather than from human suffering and

frustration, such as painful or confusing past experiences, misguided principles of living, psychological and social conflicts, or spiritual emptiness. According to the drug companies and modern psychiatry, our emotional problems emanate not from the soul or mind but from biochemical imbalances in the brain that can be corrected by psychiatric drugs. Millions of people now accept this as an article of faith.

Some of my remarks may create concern in people who rely on psychiatric drugs. They may react to this critique as if their *faith* in psychiatry and drugs is being undermined. Ultimately, challenging this faith is a necessary part of the process of becoming free of dependence on harmful psychiatric treatments.

Stopping psychiatric drugs can be as dangerous, or more dangerous, than starting them. Stopping drugs, like starting them, should be an independent, personal decision made on the basis of sufficient information. Withdrawing from psychiatric drugs can be painful and sometimes dangerous. Drug withdrawal should usually be done slowly and, if possible, with the guidance of an experienced, informed clinician (Breggin & Cohen, 1999, describe methods for withdrawing safely from psychiatric drugs.).

Tragically, modern, well-informed people too often put their faith in psychiatry and its drugs. This has become the equivalent of putting one's faith in the pharmaceutical industry. Drug promotion panders to the most superficial values in the culture: the hope of short cuts around the need for personal responsibility and personal growth. In doing so, the drug companies and biological psychiatry do more harm than good. Mental health professionals need to reclaim their professional knowledge and skills. They should strive to help their clients and patients to reclaim their faith in fundamental values, including personal responsibility, empathy and love, and principled living.

NOTES

1. There is insufficient space to review the data in support of these descriptions of how science is distorted by drug companies and biopsychiatry. However, the process has been documented in detail in other sources (e.g., Breggin, 1991, 1997a, 1998; Breggin & Breggin, 1994, 1998; Cohen & Cohen, 1983; Fisher & Greenberg, 1989, 1997; Jacobs, 1995; Mosher & Burti, 1989; Ross & Pam, 1995).

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