Psychotherapy in Emotional Crises without Resort to Psychiatric Medications

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ABSTRACT: Mental health professionals are being pressured to rely upon the medical model, including psychiatric diagnosis and medication. But there are many reasons not to turn to psychiatric drugs in emotional crises, including their impact on the brain

and mind, and their disempowering effect on the morale of clients and therapists alike. Meanwhile, there are sound, empathic psychotherapy principles for helping clients in severe, acute distress. This article presents the case for therapists relying upon these psychotherapeutic interventions instead of drugs in dealing with emotional crises and emergencies.

There are innumerable kinds of crises and emergencies that psychotherapists and counselors deal with in community service agencies and private practices, including threats of suicide and homicide, potentially violent behavior, trauma from rape or battery, newly discovered cancer or HIV, separation and divorce, death of a loved one, sexual or physical abuse in a family, illness in a loved one, bankruptcy, unemployment and homelessness.

Sometimes these emergencies seem situationally determined by recent life events: a family with few resources abruptly becomes unemployed, loses its social service support, or becomes homeless; a young man or woman is diagnosed with a fatal disease; a chronically ill patient loses his or her insurance coverage; or a child is killed in an accident. Sometimes the cause of the emotional crisis seems more rooted in longstanding psychological distress or interpersonal conflicts: a middle-aged woman gradually lapses into depression and becomes suicidal, a young college student unexpectedly goes on a rampage, a child steals money for drugs and runs away from home.

Within psychiatry, psychotherapeutically oriented practitioners increasingly feel pressured to offer medication. This pressure comes from biologically oriented colleagues, from some patients, and from managed care providers. Psychologists, counselors and other non-medical therapists are also feeling coerced to adopt the medical model, especially in dealing with crises or extremes of misconduct and emotional turmoil, The American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* has become a significant part of counseling and psychology school curricula and professional certification examinations. Students are routinely taught that they should refer their more difficult clients or situations for psychiatric evaluation and possible medication.

The use of psychiatric diagnosis and medication as a "last resort" too often goes unquestioned. As an unintended result, the psychotherapist's self-confidence in handling difficult situations and crises is bound to be undermined and to deteriorate. The care of clients also deteriorates when their options become limited to medication (see below). The vitality of humanistic psychology is threatened by these trends.

Psychotherapy and to some extent humanistic psychology has sometimes defined itself as the profession that deals with "normal" rather than "abnormal" psychological development. Thus Nugent (1994 [17]) observed:

> Counselors are trained to work with a person's normal developmental conficts, while other mental-health workers generally are trained to diagnose and treat pathology and work with dysfunctional behavior or chronic mental illness of clients and their families. (p. 7)

This definition of counseling (or humanistic psychotherapy) encourages a reliance on psychiatric interventions for more difficult clients and situations. It also increasingly fails to describe the actual activities of non-medical therapists who, as Nugent himself acknowledges, are frequently being called upon to take more comprehensive roles in health maintenance organizations (HMOs), community agencies, and other settings.

Nor have humanistic psychologists historically limited themselves to "normal" clients. They have applied psychotherapy techniques to the paradigm of extreme mental disorder, patients labelled schizophrenic (Stevens, 1967; Rogers, 1967 [18]). This author's mental health career began as a college student volunteer case aide using empathic psychotherapy techniques with profoundly impaired inmates of a state mental hospital during the mid-1950's (Umbarger, Dalsimer, Morrison &

Breggin, 1962 [24]; also described in Breggin, 1991 [5]). The volunteer program succeeded in getting the majority of our patients discharged from the hospital.

The distinction between normal and abnormal psychology may itself lack validity. Szasz (1961 [23]) reasoned that all psychiatric diagnoses ultimately turn out to be "problems in living." That is, they are better understood from a humanistic psychology paradigm than a psychiatric or pathological model. Criticism of the medical model continues to this day (Breggin, 1997b [7]; Mosher & Burti, 1994 [16]; Sanua, 1996 [21]). Psychologists are being urged not to support or join the psychiatric establishment in its reliance on medication (Sanua, 1995 [20]).

In an in-depth analysis of patients labelled schizophrenic and their families, Laing (1967 [14]) and Laing and Esterson (1970 [15]) found that seemingly "crazy" responses instead reflect understandable family communications and processes. They took so-called schizophrenia out of the world of pathology and grounded it in the developmental history of the family. Psychosocial approaches to patients labeled schizophrenic continue to gain clinical and empirical support (Breggin & Stern, 1996 [9]; Karon & VandenBos, 1981 [13]; Mosher & Burti, 1994 [16]). Psychotherapists should not consider their approaches to be less profound or efficacious than medical interventions. The empathic, humanistic psychology model may be the most powerful one of all for healing human distress. Later in his life, Rogers (1995 [19]) wrote:

> Over the years, however, the research evidence has kept piling up, and it points strongly to the conclusion that a high degree of empathy in a relationship is possibly *the* most potent factor in bringing about change and learning. And so I believe it is time for me to forget the caricatures and misrepresentations of the past and take a fresh look at empathy.

Notice that Rogers states that empathy may be "*the* most potent factor in bringing about change and learning." Can we have two most potent methods, drugs on the one hand, and empathic psychotherapy on the other? It is time for psychotherapists to confront that question directly.

1.1 Reasons not to use medications in emotional crises

There are many reasons not to turn to psychiatric medications in difficult situations, emotional crises, or emergencies. The following analysis of the limits and hazards of psychiatric medication is documented in detail elsewhere (Breggin 1991 [5], 1997a [6]; Breggin & Breggin, 1994 [8]).

1.1.1 The disempowering impact of reliance on medication

When we rely on medications during difficult times we disempower the client and the therapist alike by confirming that technological interventions into the brain constitute the final resort during critical situations. Where we turn for our last therapeutic resort defines our underlying philosophy and psychology. If we rely on medication in the toughest situations - when we feel stretched to the limits of our abilities - we confirm the medical model and technological interventions as the ultimate "power" in human healing. We communicate to our clients and to ourselves that human support and understanding and personal self-determination and empowerment is not enough.

Even if medication turns out not to work, the act of referring the client for a drug evaluation communicates to the client, "You do not have the personal resources to handle this crisis, and neither do I. In fact, neither does anyone else, so let's hope that drugs can help."

If, instead, we try harder to build rapport and trust, to create empathy, to develop what can be called healing presence and healing aura (Breggin, 1997b [7]), and to utilize other human resources in the family or support network, then we have defined human relationship and human services as our

ultimate resort. We have confirmed that human distress can best be handled by empathic human interventions. This is not merely a lesson for the moment but for the lifetime of the client.

1.1.2 Faith in ourselves versus faith in medication

Professionals sometimes find it very distressing that a psychiatrist like myself does not advocate *starting* the use of psychiatric drugs under *any* circumstances. (When individuals comes to me on medication, I will sometimes continue to prescribe for them if drug withdrawal proves too difficult or too hazardous, or if they don't wish to stop.) Often I will be questioned intensively by professionals who want to unearth one exception, one extreme circumstance, in which I would start someone on a psychiatric drug. Why do many professionals seem disturbed about the idea of never starting a client on drugs? Why is it so disconcerting to offer psychotherapy without the alternative of drugs? The answer in part has to do with faith and confidence - or if lack of faith and confidence - in ourselves and in human resources. If there are no exceptions that justify the use of drugs, then we have nothing to rely on except ourselves - our own personal resources - including our capacity, in collaboration with our clients, to bring other human resources to bear on the situation. The therapist's refusal to make exceptions that allow for starting clients on drugs in effect declares, "Human caring and human services are the ultimate resort." This is frightening to many professionals who hope for a greater power to rely on beyond themselves, their clients, and other mere mortals. The resort to drugs in this light becomes reliance on a "higher power" than psychotherapy itself. Faith in this materialistic, technological authority has grave limitations and implications.

If, by contrast, we refuse to turn to medical interventions, we define ourselves, and other human beings. as the ultimate resource, We communicate to the client, "You and I together, with the help of other people, and perhaps with reliance on a genuine Higher Power, possess the necessary resources to solve or transform your crisis for the better."

1.1.3 The brain-disabling effect of psychiatric drugs

There is another major reason not to turn to psychiatric drugs in emotional crises or emergencies: All psychiatric drugs exert their principle or therapeutic impact by impairing the function of the brain and mind. Conversely, none of these agents improve brain function.

There are two basic effects produced in the brain by toxic agents, including psychoactive drugs: They can narrow the range of emotions, producing varying degrees of sedation or emotional indifference, or they can create an artificial sense of well-being or euphoria (Breggin, 1997a [6]). If clinically effective, they will also take the edge off mental processes in general, reducing to some degree intellectual functions such as abstract reasoning, judgment and insight. Individuals taking psychiatric drugs, much as persons intoxicated on alcohol, are often rendered unable to accurately judge the drug effects or their overall mental condition.

Individuals frequently choose to diminish their mental function in order to ease suffering. They do this with non-prescription agents such as alcohol and marijuana or with illicitly obtained sedatives or uppers. There is no doubt that these individuals, like many people who received psychiatric drugs, feel grateful for a respite from painful emotions. But should psychotherapists support these methods? Is it consistent with the empathic, humanistic or existential principles of therapy to promote mind-dulling or artificially stimulating agents?

During crises individuals need their full mental function in order to transform these emergencies into opportunities for growth. They need unimpaired mental faculties and a full range of emotions. A therapist should welcome a client's painful feelings as signs of life and as signals pointing to the source of the problem. When a client does welcome a client's most painful feelings, the client is likely to view these emotions in a far more positive light, one that transforms helpless suffering into

a positive energy.

1.1.4 Confirming genetic and biological myths

There is yet another reason not to turn to drugs at a critical time in a person' s life. The use of psychiatric diagnoses and drugs gives the false impression that emotional crises are caused by genetic or biochemical factors that are amenable to pharmacological interventions into the brain. There is no evidence that any emotional crises routinely treated by professionals are caused by genetic or biological defects. Even the classic psychiatric diagnoses, such as schizophrenia and bipolar disorder, have never been proven to be genetic or biological in origin (Breggin, 1991 [5]).

There are many mutually contradictory speculations about physical causes for psychological suffering and none of them are supported by a convincing body of evidence. In regard to the acute or emergency situations treated by psychotherapists, the genetic and biological speculations are even more flimsy.

Even if some emotional crises are in part caused by a defect in the brain, all currently available psychiatric drugs further impair brain function. None of them improve brain function or correct a specific biochemical imbalance and psychiatric disorder (Breggin, 1991 [5], 1994 [8], 1997a [6]). None of them can do anything to ameliorate the effects of a presumed abnormal genetic endowment.

Finally, it is worth noting that the efficacy of pharmacological interventions has been vastly exaggerated by the psychiatric establishment (see critiques in Bleuler, 1978 [4]; Breggin, 1991 [5], 1997a [6]; Breggin & Breggin, 1994 [8]; Fisher & Greenberg, 1989 [10]; Greenberg, Bornstein, Greenberg & Fisher, 1992 [11]; Mosher & Burti, 1994 [16]). In contrast, the efficacy of psychotherapeutic interventions, even for severely disturbed persons, has been more documented than is generally appreciated (Antonuccio, Ward & Teaman, 1989 [2]; Beck, Rush, Shaw & Emery, 1979 [3]; Breggin, 1991 [5]; Breggin & Stern, 1996 [9]; Fisher & Greenberg, 1989 [10]; Greenberg, Bornstein, Greenberg & Fisher, 1992 [11]; Karon & VandenBos, 1981 [13]; Mosher & Burti, 1994 [16]; Wexler & Cicchetti, 1992 [25]).

In regard to emergencies or crises, there is even less evidence for the usefulness of psychiatric medications. The efficacy of psychiatric drugs in this regard seems limited to the capacity of neuroleptics to physically subdue or pharmacologically straitjacket extremely excited (manic) inmates in confinement. The testing protocols used for the approval of psychiatric drugs by the Food and Drug Administration (FDA) usually eliminate any clinical subjects who are in an emergency state (Breggin, 1997a [6]; Breggin & Breggin, 1994). The FDA has never approved a drug specifically for the prevention or control of suicide or violence. There is no significant body of research demonstrating that any psychiatric medication can reduce the suicide rate or prevent violence. Instead, there is substantial evidence that many classes of psychiatric drugs - including neuroleptics or antipsychotics, antidepressants, and minor tranquilizers - can cause or exacerbate depression, agitation, suicide, and violence (Breggin, 1997a [6]; Breggin & Breggin, 1994 [8]). Overall, there's no compelling evidence for the efficacy of psychiatric medications in emotional crises, let alone in situational emergencies created by real-life stressors, such as divorce, bereavement, lifethreatening illness, or loss of a job.

1.2 An empathic psychotherapy approach to emotional crises

At the root of almost every emotional crisis lies a feeling of personal helplessness combined with alienation from other people. The individual feels both personally overwhelmed and incapable of getting adequate support from anyone else. Empathic psychotherapy aims at overcoming the client's sense of helplessness and alienation. This section draws on the principles of empathic psychotherapy described in *The Heart of Being Helpful* (Breggin, 1997b [7]).

Whether or not help is actually available, the individual who experiences an emotional crisis has

usually lost faith in his or her capacity to benefit from it. Once confidence is restored, "solutions" or improved approaches can almost always be found.

Emotional crises offer potential for escalating growth as the individual learns to handle the worst imaginable stresses. As confidence is regained, crises can be transformed into periods of exceptional growth. The individual learns that even his or her worst fears can be handled, overcome, and turned into opportunities.

1.2.1 Focus first on the person, not the crisis

Every human being wants to be recognized as an individual with unique attributes and special value. This, of course, is an axiom of psychotherapy, but it's easily forgotten when a client presents for help amid great fear, turmoil and hopelessness. When clients arrive in crisis, don't focus on the details of their "emergency" ahead of offering a warm greeting and welcome. Don't put "fixing them" ahead of appreciating them as human beings.

If you as a counselor or therapist can feel and demonstrate that you're happy that your distressed client is alive, that you're glad to make his or her acquaintance, and eager to learn more about the person and then the problem - you may find that the acute emergency begins to abate before your eyes. If your client does not immediately feel more secure and confident, you have at the least laid the initial groundwork for your work together in an empathic relationship.

1.2.2 At the heart of every emotional crisis can be found a resurgence of child-like feelings of fear and helplessness

From the start, the therapist must be careful not to get dragged emotionally into the client's helpless and fearful state of mind. Instead, the therapist should address these feelings of helplessness and fear in himself or herself and in the client. Often it is useful to openly discuss the underlying feelings of helplessness and fear, and how they relate to our heritage as children.

1.2.3 Most emotional crises involve a sense of alienation or abandonment

The individual undergoing an emotional crisis no longer has faith in the healing capacities of other human beings or in his or her own ability to connect to other people. The psychotherapist's task is to become a person with whom the client can relate with a feeling of safety, confidence, and human caring.

If the psychotherapist feels the need to involve others, he or she can begin by asking the client if it would be useful to involve family and friends - even through a brief phone call. Involving extended family and friends can be life-saving. They can provide support, encouragement companionship, good ideas, or direct help in the form of money or shelter. Also, the therapist's desire to help by involving other people sends a message of caring and confirms that people are the ultimate resource.

1.2.4 An empathic relationship in itself call often quickly ease a client's feelings of fear and helplessness, and alienation

Emotional crises often require what can be called empathic self-transformation (Breggin, 1997b [7]) - finding the resources within ourselves to feel empathic with the other human being. As we learn to find the strength and understanding in ourselves to remain calm, caring, and in touch during severely stressful situations, we communicate confidence, safety, and hope to the client.

The psychotherapist should focus on a *rational, loving*, and *confident* (but realistic) center in himself or herself that does not get caught up in the "emergency." This requires working on one's sense of healing presence (Breggin, 1997b [7]) - the capacity to find an empathic attitude within oneself regardless of the fear and helplessness, anguish and alienation, generated in oneself during the apparent emergency.

1.2.5 Beware defining emotional crises as emergencies requiring desperate interventions

When faced with a client who feels hopeless and doomed with nowhere to turn, it is tempting for the therapist to gear up for emergency mode. This only confirms the client's worst fears. A psychotherapist should avoid joining the client in feeling desperate.

It can be easy for a therapist to lose perspective and to identify with the client in a way that promotes the client's feelings of fear and helplessness. The antidote for ourselves as psychotherapists is to understand our own vulnerabilities so that we do not overreact. If we are terrified of cancer or AIDS, then we must remain especially alert not to encourage our clients' terror in the face of these health crises. Similarly, if we are uncomfortable with our own suicidal or violent impulses, we may push our client into greater fear of his or her own anger and aggression.

1.2.6 Resist doing something to the client; instead, calm yourself and find your healing presence

The therapist should put more emphasis on his or her own feelings of comfort rather than power or potence. Some emergencies may call for quick action, but this is relatively rare. Almost always, if we can maintain our sense of calm and connectedness, the client will begin to feel more safe and secure, more rational, and more able to find positive new approaches.

1.2.7 Overcomemie's own judgmental allitudes by finding a personal experience that resonates with what the client is undergoing

Conducting psychotherapy can test our capacity to feel sympathy and caring for the client. We can become unsympathetic toward their fear and helplessness, intolerant toward their negative or destructive behavior, impatient with their failure to take more responsibility for themselves. In these instances, it can be helpful to find within ourselves our own experience of emotional distress that most closely resonates with our client's. Very probably our judgmental attitude toward the client reflects an intolerance toward our own similar vulnerabilities. We need to recognize and then to welcome this aspect of ourselves and our client.

1.2.8 Most emotional crises build on a chain of earlier events, often reaching back to childhood stresses and trauma

Although the current event seems like the sale or primary "cause" of the client's distress, it's more likely the proverbial straw that broke the camel's back. If possible, help the client understand this chain of prior events in order to provide more perspective on the present crisis.

People vary enormously concerning their responses to even the most devastating threats and losses. Even when there are very real objective threats, the individual's subjective response to it remains the key to healing. One person may be demoralized by learning they have cancer; another may mobilize to improve his or her life. One person is devastated by a separation while another feels liberated. It

can help a client to realize that human beings are capable of persevering and even growing in the face of seemingly overwhelming threats.

1.2.9 Advice and direction may be useful, but too often they disempower the individual

It is tempting to come up with advice, directions, plans or strategies in handling an emergency. Too often this involves turning to experts, in the extreme, a psychiatrist for possible medication. Sometimes people do need guidance, but it will fall on deaf ears as long as the client feels terrorized by his or her situation or emotional condition. The crisis as such is likely to abate when a safe, caring relationship is established. Only then is advice likely to be useful and then it may no longer be necessary to the client who has become empowered to think for himself or herself. Instead of your own power and authority, enhance your client's sense of self-determination by providing moral encourage and human connection.

1.2.10 Avoid all forms of coercion

It can be tempting to use emotional threats or even direct force such as commitment to a mental hospital, in order to handle a crisis. These interventions may stave off an immediate suicide, for example, but in the long run, by disempowering and humiliating the individual, they can do more harm than good. It may be necessary to point out to a client that there are alternatives, such as crisis centers and psychiatric hospitals, but bringing up these alternatives can indicate to the client that the psychotherapist is afraid the situation cannot be handled through their mutual personal resources.

There are no studies that confirm the usefulness of emotional bullying or more formal measures such as involuntary psychiatric treatment. Intuition and empathic self-insight are likely to convince us that people don't benefit from being forced into conformity with the therapist's expectations. The development of an empathic relationship requires mutual respect rather than coercion.

1.2.11 Emotional crises are opportunities for accelerated personal growth for the client and sometimes for the therapist

Crises provide a window into an individual's greatest vulnerabilities. They allow the opportunity to explore the client's worst fears. They bring out into the open the individual's worst feelings of personal helplessness. It introduces the person to raw material of human existence. The self-understanding gained from this can be applied throughout life, enabling an individual to have a deeper psychological awareness of self and others. They not only gain a new understanding of themselves, they gain new insights into the human condition itself.

When individuals face and understand their own worst fears, and then overcome them, they feel greatly empowered. Having faced and overcome their most self-defeating emotional reactions, they can gain in confidence and faith in themselves. They learn that they can triumph over seemingly impossible threats to reach new heights of psychological or spiritual transformation. This also increases their confidence in everyday living.

Hanna, Giordano, Dupuy, and Puhakka (1995 [12]) recently studied "Agency and transcendence: The experience of therapeutic change." They describe "major change moments" involving "distinct psychological or metacognitive acts such as intending, deciding, willing, detaching, and confronting, as well directing awareness, thought and affect." They go on to point out, "Many of these changes also had to do with such acts as deliberately tolerating anxiety or ambiguity and recognizing the limits of one's own decisional and thinking abilities" (p. 150). These critical moments often occur during emotional crises in which the modern therapist will be tempted to refer the client for medication.

It is important to keep in mind the power of "deliberately tolerating anxiety or ambiguity" in the process of taking charge of one's life in new and creative ways.

1.3 Conclusion

In one of his later publications, Rogers (1995 [19], p. 140) wrote of a growing "willingness on the part of many [professionals] to take another look at ways of being with people that locate the power in the person, not the expert." Medication and the medical model place power in the doctor. For Rogers, the time was ripe for another alternative that would truly empower the client-empathy as the center of the healing process.

Nowadays, if the emotional crisis or emergency is severe enough, the non-medical therapist is likely to feel compelled to refer the client to a psychiatrist for medication. The myth of medication efficacy grips the mental health profession and undermines the human service interventions that are far more likely to handle the emergency to the ultimate empowerment of the client. It is time for the psychotherapy profession to return to its basic roots in empathic human services. Human beings, not medications, must remain our ultimate resort. Psychotherapists should not shrink from this truth. The well-being of our patients and clients, and the vitality of psychotherapy and humanistic psychology, depend upon taking a principled stand on these issues.

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