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Although I am a psychiatrist, it seems to me that social work, along with counseling, embodies my own values as much as any of the mental health professions. Yet I've noticed in recent times that social workers have increasingly come under the influence of the traditional psychiatric biological model rather than under the influence of their own psychosocial model of democratization, social change, and empowerment of the client. If I can accomplish one thing today, and I hope this in no way sounds paternalistic, I would like to reempower you as social workers so that you can empower your clients in one of the traditions of the social work profession.

I became involved in psychiatry by what can be called a social worker case aide route. I was a Harvard undergraduate in my freshman year when a friend came by and said to me, "Get off your rear end. Let's go out and volunteer at the state mental hospital." His brother had just started the Harvard-Radcliff Mental Hospital Volunteer Program. It was 1954. If we date my reform work to that day, I've been doing reform work for more than 46 years.

When I stepped onto the state hospital wards, the scene evoked images from my Uncle Dutch's description of liberating a concentration camp, an extermination camp in Nazi Germany. The patients-the inmates-were humiliated, beaten down, living in rags, malnourished, and often subjected to horrendous physical and emotional abuse. They were lobotomized. they were electroshocked, and they were given overdoses of insulin to put them into comas.

Medical experiments were carried on without any concept of the need for patients to give informed, voluntary consent. The Nuremberg code, which had evolved following the atrocities in World War II Nazi extermination camps, had not permeated Metropolitan State, or probably any of the state mental hospitals in the United States at the time. The hospital was truly a snake pit.

The year, remember, was 1954, when neuroleptic drugs, the so-called antipsychotics arrived in North America. They reached Metropolitan State within a year or so after I did.

In the second and third year of the program, as its director, I heard psychiatrists tell me things that would require years of training or indoctrination to swallow. Since I had no training, I didn't believe the state hospital doctors when they explained that electroshock killed bad brain cells or that "schizophrenics" were less sensitive to the freezing winters or the sweltering summers in the concrete wards. Because I hadn't been indoctrinated by medical training, I knew that anybody would be demoralized after a few hours or days in the hospital, let alone after years and years without end. In fact the hospital was so bad, that, as college volunteers, we used to have to debrief each other after each visit. As young college kids, we developed debriefing techniques to get over just a few hours on the wards. I never did recover from my shock on finding a former Radcliffe student languishing forever on one of the back wards.

In the second year of the program I went to the superintendent of the hospital and I said, "We want to have some of our own patients." We were flooding the hospital with 200 volunteers, we were cleaning up the wards and holding social gatherings. Our very presence reduced the frequency of rape and emotional abuse perpetrated by the personnel against the patients. But we wanted to do more. A group of us wanted to have our own individual patients.

Of course, the idea of college students becoming "case aides" met with a great deal of professional upset and opposition. The president of the Psychoanalytic Institute of Boston said we would ruin the patients. However, I had never seen a psychoanalyst on the wards. After some controversy, 14 of us were allowed to form a group under the supervision of a social worker, David Kantor, and were assigned our own individual patients from the back wards of the hospital.

I have written about the experience and its result in Chapter 1 of my book *Toxic Psychiatry* (1991). We visited our patients once a week throughout the school year, except for Thanksgiving and Christmas break and during exam week.

We started out modestly, wanting to get to know our patients and to provide them companionship. We eventually learned to identify their basic needs and tried to fulfill these needs. Did this person need to reunite with family? Did he or she need to get false teeth that were good enough to eat with and to talk properly? Did another person need eyeglasses? Did this person have health problems that needed medical evaluation and treatment? And, of course, was this individual lonely and in need of companionship-- to which the answer was always yes. Loneliness was the hallmark of existence in the state mental hospital.

Despite our modest goals, we got all but 3 of our 14 patients out of the hospital before the end of 1 year. After a year or 2 follow-up, only three of those eleven returned. We didn't need a control group to know this was "statistically significant" because the whole hospital was the control group, and hardly anybody ever got out. The current recycling of patients through mental hospitals had not yet begun.

By the way, the subsequent high discharge rate from state hospitals had almost nothing to do with the advent of neuroleptic or antipsychotic drugs. It had nothing to do with improving the lives of patients. It was simply an administrative change. In the old days it was easy to get anyone admitted into a state

hospital and almost impossible to get anyone out. Now it's hard to get someone into one of these facilities and then they throw you out as soon as possible. The reduction in the size of the state mental hospital population was an administrative or political change.

Our program was so successful, it was written up in the early 1960s in the President's Commission on Mental Health report. We were described as one of the hopes for psychiatry. I was able to turn the program into a credit undergraduate course at Harvard. This was in the 1950s; students were not supposed to have an impact on the curriculum in those days.

The program went on for decades, but it no longer exists. If such a program did exist today, what would it mean about the power and authority of biological psychiatry? If untrained volunteers supervised by a humane, caring social worker could get most of the patients--the vast majority of chronic patients they see--out of a hospital, then what is the value of lobotomy, electroshock, and toxic drugs? What is the worth of all the medical approaches if what people need is people--human relationships in which their basic needs can be identified and met?

That's how I got started in psychiatry--as the equivalent of an untrained social work case aide. So why didn't I become a social worker instead of a psychiatrist? At the time of the decision, I called my father on the phone. My father was like a psychoanalyst in that he only spoke about once a year and when he did speak, you really listened. I said, "Dad, I don't know what to do. I'm being supervised by a social worker, he's wonderful, and I also love the psychology department at Harvard, but I could become a medical doctor and a psychiatrist. I already know many respected Harvard psychiatrists." My father asked, "Well son, who has the better trade union?" And so I went to medical school to become a psychiatrist.

I was also interested in biology and the relationship between mind and body. My first peer-reviewed published papers were about the biology of anxiety. But I quickly became reconfirmed in my belief that the source of most human emotional disturbance is human relationship and that the solution to almost all severe human disturbance and incapacity is a helping human relationship. And by "relationship" I don't exclusively mean psychotherapy. I also mean workshops and seminars, and a variety of family, community, school and church experiences.

If we go back to the roots of social work, the basic principles sound a lot like what I've been describing today. Social work grew out of the misery of the industrial revolution, the dislocation of peoples. In fact, so did psychiatry, but psychiatry took an entirely different, contradictory direction. If you look at the history of psychiatry, you will find that the state mental hospital lies at its origin. The state mental hospital was society's attempt to remove from sight the socially alienated, poverty-ridden people flooding into the 'urban centers. The state mental hospital system then gave birth to organized psychiatry as a profession, including the first psychiatric journals and psychiatric associations.

The state mental hospital became the safety *trap* rather than safety *net* for the poor and the disenfranchised, and, only as a part of that, for the impoverished who became deeply disturbed and appeared to be crazy. Being poor and old was, for many generations, the surest ticket into a state hospital. Metropolitan State was packed with elderly, poor women.

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Thus psychiatry during the Industrial Revolution took over the social and political task of locking up people against their will under civil commitment laws in a medical setting where the methods of control were strait jackets, seclusion, emetics and purges, poisonous drugs, and, in the 1930s, shock and lobotomy--basically assaulting the body to control the soul.

What was social work doing during that time? Without unduly idealizing this profession or its efforts, and without glossing over social workers' social control functions, one can say that social work was trying to act on principles of democratization instead of force. Many social workers were acting for empowerment rather than the medical oppression of its patients. Above all, social work aimed at teaching people to help themselves. The literature of the time often emphasized people helping people to help themselves. Instead of diagnosing and drugging human beings, social work sought to inspire and to help people take over their own lives. You will find almost no such literature in psychiatry at any time in its history. From Carl Rogers to Eric Fromm, the professionals who have promoted autonomy, personal growth, and empowerment have rarely been physicians and psychiatrists. In fact, the sponsor of this lecture, Ephraim Lisansky, stands out as a rare exception to that rule.

My aim is to re-empower social work on the basis of it having more fundamental truth than my own profession of psychiatry, in particular biological psychiatry, and on it having a much richer, more meaningful tradition to which to cleave with all your courage. It takes courage in this day and age to talk about the things I'm talking about and even more courage to live by them in a potentially hostile environment dominated by biological psychiatry.

Returning to the contrasting principles of psychiatry and social work, we have the state mental hospital, which still exists and we have involuntary commitment. State hospitals and involuntary treatment are the twin principles upon which the profession of psychiatry is built. They are principles of disempowerment. In fact, civil commitment or involuntary treatment was created to by-pass the criminal codes of increasingly democratic nations that ceased to allow the arbitrary detention of their citizens.

The great revolution in psychiatry did not occur in the last 10 years, as some claim, but in the 1930s. The great revolution in psychiatry was the change from the assault on the body to the assault on the brain. As I've already mentioned, psychiatry for centuries had been assaulting the body to control the inmates of its facilities: the spinning chair invented by the founder of American psychiatry, Benjamin Rush; cold baths; restraints; purgatives; bleeding. It didn't work very well. No matter how much you disabled and tortured the body, some people continued to rebel.

Then the 1930s saw the triumph of the idea that assaulting the brain itself was the best way to make patients more docile inmates for institutionalization. It was discovered, for example, that accidental overdoses of insulin made patients much more compliant and easier to handle. So insulin coma became a "treatment." Doctors knowingly killed large numbers of brain cells in the name of therapy. It was also found that patients became more docile after having seizures and Metrazol "shock treatment" became one of the great tortures in the history of the western world. Patients, while awake, were injected

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with super-speed until they had a convulsion. While awake they would go into a horrendous convulsion. Compared to that, electrically induced convulsions sometimes seemed benign.

Nowadays, if you go to John Hopkins University, and I presume any other medical school, you'll be told electroshock corrects biochemical imbalances. Well, we don't have any evidence for a biochemical imbalance in the brains of people who are called mentally ill. We don't even have the technology to measure biochemical imbalances. The theory is unfounded speculation. In fact, what shock was known to do in the 1940s and 1950s was to kill brain cells. And it still does that today, but the idea of killing brain cells is no longer acceptable in the modern age.

My summary comments on the history of psychiatry and on the damaging effects of psychiatric treatment are drawn from dozens of books and articles in which I provided historical and scientific confirmation of what I am describing. You can take almost any of the sentences that I'm saying today and I've written a book that documents them scientifically. My 1979 book on electroshock was one of my first publications. It's been updated with articles and more recent books, such as *Brain Disabling Treatments in Psychiatry* (1997), *Toxic Psychiatry* (1991), *Talking Back to Prozac* (1994, with Ginger Breggin), *Talking Back to Ritalin* (1998), and *Your Drug May Be Your Problem* (1999, with David Cohen). Hopefully you sense intuitively and from your clinical experience that what I'm saying is true, that these agents are not good for the brain.

The medical model is a fundamental part of the involuntary treatment, the state mental hospital, and the psychiatric hospital as we know it today. The medical model is the justification for drugs and shock. **Ultimately this medical model undermines your entire social work tradition and history.** Are your clients suffering from speculative biochemical imbalances or disturbed human relationships in their past and present life? Do they need biochemical intrusions into the brain or do they need human services, and, in particular, informed ethical, professional human relationships?

If the first revolution in psychiatry was the assault on the brain, the second revolution in psychiatry was the decision in the early 1970s for psychiatry to go into partnership with the drug companies. The term partnership is interesting because I spent years trying to convince the press that psychiatry had a partnership with the drug companies and the media would reply in effect, "That's silly." Then in 1992 the *New York Times* wrote about President Bush vomiting on the Premier of Japan. The newspaper reported that the President had taken Halcion®, a very dangerous sleeping pill, the night before. The *New York Times* raised the question naively, "Why is a drug that is banned in England" -- for causing paranoia, depression and memory loss--"being given to our President before he's doing foreign policy?" In response, I wrote a Letter to the Editor of the *New York Times* stating in effect, "Well, here's one reason why: the maker of Halcion, Upjohn, just gave \$1.5 million in cash to the American Psychiatric Association, no strings attached." Whereupon the Psychiatric Association was so threatened by my letter being published that the medical director, Mel Sabshin, wrote a letter back that was also published, saying that I didn't understand that the American Psychiatric Association had a "partnership" with the drug companies ...

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The situation now in psychiatry is such that all the conferences are paid for and kept afloat by the drug companies. So are the journals. The AMA's *Archives of General Psychiatry* goes free to all psychiatrists, paid for by the drug companies. Professorships are paid for by the drug companies. In some medical centers, the entire pharmacology lab is paid for by the drug companies.

I have become an expert on the drug companies because I'm hired as a medical consultant to investigate them during product liability suits against them. I actually get to go inside the drug companies' record rooms. And I can tell you that the ones that I've looked into operate no differently than the tobacco or the alcohol industry in terms of what they hide from the public and from the medical and scientific community.

What we used to think of as state mental hospital psychiatry has become the model for all of psychiatry in America. There is no longer a large wing of psychosocial psychiatry as in the 1960s, when competing psychosocial and biological branches existed in the profession. When I was at the National Institutes of Mental Health in 1966-1968, it was a psychosocial institution. Now its orientation is pure biological psychiatry.

The two different philosophies we're looking at--the roots of social work and the roots of psychiatry--can be summed up as treating the human being as a person versus treating a human being as an object. When you see a distressed child in class and make up a story that the child has a biological and genetic disorder so you can drug the child, that's treating the child as a defective object.

In reality, we treat our children even worse than we would treat an object like a TV. Suppose you took your TV to a repairman and he said, "Well, we don't know exactly why, but your TV is putting out a lot of violence and obscenity. We think it's bad circuitry." You'd think it was absurd. You'd say, "You can't change a TV program by fussing with the circuitry. You could make the program a little blurrier, a little weaker to perceive, but it's still the same program trying to get through." And what would you think if the repairman offered to pour toxic chemicals into the TV or even to give it a dose of electric shock. You'd think the repairman was a madman for "drugging" or "shocking" such a delicate and complex instrument as a television.

We are treating our schoolchildren the way we treat state hospital inmates. We are trying to subdue them instead of finding more caring ways to resolve our conflicts with them. Consider the child who has never been properly disciplined at home and who is therefore out of control at school, or consider the child who's stuck in too large a classroom and so becomes restless. Consider the child who's too far ahead in school to be engaged by the curriculum or the child who's too far behind to be able to keep up with it. The reasons why children demonstrate poor self-control in schools are, in fact, infinite. We cannot genuinely help them by giving them a fake diagnosis like ADHD and then subduing their behavior with drugs. We need instead to realize that these children are in conflict with us--that they aren't meeting our expectations--and that it's up to us to find positive ways of resolving these conflicts.

From its beginnings psychiatry has taught us to, identify, diagnose, and suppress the weakest member of the conflict. It's a question of empowerment versus disempowerment, being versus object, of a psychosocial view of the

person versus a biochemical pseudoscientific view of the person. I don't believe the two views can be ethically or scientifically mixed. Seemingly enlightened biopsychiatrists like to say, "Well, a little of this and little of that." But a little of this and a little of that actually becomes very little psychotherapy and a lot of drugs.

Recently we had a crack in the walls of the establishment right here at the University of Maryland's medical center. Julie Zito and her colleagues published an article about the increased drugging of children 2 to 4 years old in this country with psychiatric drugs. All of the drugs are off-label, that is, unapproved for toddlers by the FDA. Some of the drugs are not even psychiatric drugs, but highly sedative agents, including dangerous drugs like the antihypertensive agent clonidine. Psychiatry will give almost anything to children if it will make them more submissive.

We're now in a national crisis where untold numbers, perhaps 6 to 7 million children, are being prescribed psychiatric drugs. The International Narcotics Control Board of the World Health Organization says that America has an epidemic of drug abuse from doctors prescribing stimulants to children for ADHD. The DEA has written paper's about the dangers of our drugging children with addictive agents.

The concept of ADHD, if looked at rationally, is foolish. It's simply a list of behaviors that require extra attention from teachers. How can that be a disease? ADHD has three arms to it: impulsivity, hyperactivity, and inattention. Under hyperactivity the first symptom listed is "squirms in seat." It brings smiles to your faces because it's so absurd. It is the kind of junk science we swallow. And why is it junk? Well, first we realize, who doesn't squirm in those seats? Any of you old enough to have kids, when you go to your child's elementary school classroom, you sit down, and you start squirming right away.

The first symptom under impulsivity is equally ridiculous: "blurts out answers before the questions are finished." What a pain in the neck that child is! Here I am speaking and you're interrupting, blurting out the answer because it's so obvious what I'm asking that you don't have to wait until I'm finished. That, of course, is the kind of behavior that wins thousands of dollars on Jeopardy, right? I do much talk radio, often right from my home office. I'm always interrupting, the show host interrupts back, we're blurting out our answers because we can figure out way down the line where the other person's going. Yet blurting out the answers is the number one ADHD symptom under impulsivity. Under inattention, the first symptom is sloppiness about details.

What holds this list of "symptoms" together? Sloppy about details, squirms in chair, and interrupts. Is there a biological center in the brain for that? Of course not. It doesn't stand up to the scientific light of day. ADHD, as a diagnosis, is a list of behaviors that annoy teachers and demand attention. The attention deficit is in us as adults, not in the children.

The diagnostic criteria for Attention Deficit Hyperactivity Disorder (ADHD) epitomize the difference between biological psychiatry on the one hand and the principles of social work, counseling, or humanistic psychology on the other. The diagnosis appears in the American Psychiatric Association's 1994 *Diagnostic and Statistical Manual of Mental Disorders, IV* under "Diagnostic

Features." After listing the diagnostic criteria, the manual explains the circumstance in which the "disorder" is likely to show up: "Symptoms typically worsen in situations that require sustained attention or effort or," and this is the good part, "that lack intrinsic appeal or novelty (e.g., listening to classroom teachers, doing class assignments, listening to or reading lengthy materials, or working on monotonous, repetitive tasks)."

The manual goes on to describe the circumstances in which the supposed disorder is not likely to show up: "Signs of the disorder may be minimal or absent when the person is under very strict control, is in a novel setting, is engaged in especially interesting activities, is in a one-on-one situation (e.g., the clinician's office)." In other words, these kids are so hungry for adult attention that even talking one-to-one with a pediatrician will calm them down, so you don't see it in the office. The manual continues that the supposed symptoms are also less likely to show up "while the person experiences frequent rewards for appropriate behavior." Thus the diagnostic manual itself makes clear that ADHD is not a disorder. It is, instead, a child's response to an environment that fails to meet the child's needs for discipline, control, novelty, and engaging educational experiences. Many of these children are in fact entirely normal. Once their environment is improved at home or at school. They often turn out to be especially interesting and engaging children.

Based on this fake diagnosis-ADHD-biological psychiatry substitutes drugs for proper discipline and engaging education. This approach is contrary to social work principles of empowering children, parents, and teachers to help children respond in a positive way to school and family life.

Of course, some children are wildly out of control. But I've never had one that wouldn't calm down in my office, with one exception I'll tell you about, a girl who required an intervention from my "therapist assistant." Parents who come to see me have sometimes had their children diagnosed down the street from me at the National Institute of Mental Health. These parents are told, and then they actually tell their children, that their children are physically unable to control themselves. One of these children did seem totally out of control in my office. But it didn't take long to realize that I couldn't calm her down in part because the interactions between her and her mom were so agitating. The child was provoking her mom, and mom would react with outbursts of temper rather than firm discipline. Later I would work successfully with the mother teaching her how to exert proper discipline, but on this occasion I asked her to step into the waiting room for a few minutes. I had her leave the door open so her child knew she was near by.

I sat for a few seconds watching the child and thinking about how distressed she seemed. She abruptly stopped her perpetual motion long enough to ask me, "What's the matter, doctor?" I asked, "What do you mean?" She explained, "You look so sad." I said, "Oh dear, I am sad. I'm just thinking about how terribly anxious you seem to feel and it makes me feel sad." She immediately began telling me about her father and how much he had hurt her feelings during their most recent visit a few weeks earlier. She calmed down considerably but not completely as she talked in a heartfelt manner about her emotional abuse and rejection at his hands. Since she was still somewhat anxious and hyper, I

suggested, "Would you like to meet my dog, Blue?" Blue was an old Sheitie (he's now deceased) who suffered from arthritis. So I urged her to be very gentle with him when I brought him into the office. Blue was pure unconditional love.

When he came into the office, the little girl sat down in a completely quiet and peaceful manner and began to pet him. She was still carefully and gently petting him when I invited mom back into the office.

I pointed out how quiet and totally self-disciplined her daughter had become and said, "Mom, if this was cerebral palsy, would my dog Blue cure it? If this were a brain tumor, if this were physical, would it go away because of the instant relationship with a loving, loved animal? Of course not. We need to learn to be like Blue with your child. We need to find the key to helping her become more peaceful and more under her own self-control." My points made sense to the child's mother and we were able to begin our work.

How many pediatricians or psychiatrists have a canine assistant therapist? I wish more of them did. In fact, most pediatricians and psychiatrists, and other doctors who prescribe stimulants to children, know little or nothing about how to relate to children, or how to evaluate and to improve the child's family and school life. I now recommend that parents avoid taking children to professionals with medical degrees for treatment for emotional or educational problems unless they know that the doctor is an exception who really understands children and their family and educational needs. Certainly: you should go to a pediatrician to make sure that your child doesn't have a physical problem underlying the behavioral problem, but don't go to a pediatrician for an understanding of how to best help your child with problems in the home or school.

I recently took a child off four different psychiatric drugs over a period of several months. On the first visit, the mother looked at the father and said, "My God, we've been to all these psychiatrists, they've loaded our son up on drugs, and no one ever looked at us and said, "Would you like some help with discipline?" The child has been off drugs for two years and is doing fine. The parents have learned better ways of disciplining this formerly out-of-control youngster. In this case, not only the parents but the 11-year-old boy responded to my combination of psychological and *ethical* teaching. Yes, I actually talk about right and wrong ways for parents and children to behave toward each other.

My colleagues forget that adults are moral beings who can be appealed to on that basis. They seem never to have known that children are moral beings, too. When you see people as objects, the last thing you imagine is teaching lessons about right and wrong (in a kind and gentle manner) to a child. The drugging of six million or more children in this country is antithetical to the principles of social work and counseling, but somehow social work has gotten caught up as much or more than other professions in submitting to the principles and practices of biological psychiatry.

Our reform group, the International Center for the Study of Psychiatry and Psychology (see [www.breggin.com](http://www.breggin.com)) has several hundred members on its board of directors and our advisory council. Many are psychiatrists, psychologists, counselors, or nurses; but comparatively few are social workers. A major exception is David Cohen, PhD, Professor of Social Work at Florida International University who is co-editor of our peer-reviewed journal. *Ethical Human*

*Sciences and Services*, and co-author with me of the book *Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications*. I hope that many more social workers will become involved with our efforts to reform psychiatry and to promote psychological and social services.

Recently a social worker of some prominence said to me, "I agree with you that it's wrong to be diagnosing children with ADHD and drugging them but," she explained, "I'm only a social worker, so I can't say anything." Only a social worker! Social workers as a group know much more than psychiatrists about identifying and meeting the needs of children. Social workers need to stand up to biological psychiatry on behalf of empowering children, parents, and teachers.

I have a painful mental image of the mature, thoughtful social worker who stands before a first-year resident in psychiatry and thinks that the resident knows something he or she doesn't know. But there is no genuine knowledge in the young resident's tradition of biological psychiatry the way there is in social work, counseling, and psychology. There is no rational or scientific justification for a social worker submitting to a psychiatrist on matters of how to treat human suffering. It is a matter of finding the courage to stand up for social work principles of human empowerment.

In concluding, let me return to the experience I had as a college volunteer in a state mental hospital working with the most injured and disturbed patients under the supervision of a social worker. Through that experience I first learned that people--and not pills--are the answer to human psychological suffering. Through that experience I learned that all of us are made of the same spiritual stuff with the same basic needs for human support, an opportunity to grow, and improved principles of living, and that a physical agent like a drug or a jolt of electricity can never substitute for a professional relationship with an informed, caring human being.

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