

Practical Applications: 22 Guidelines for Counseling and Psychotherapy

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This article describes 22 principles for the conduct of therapy or counseling, most of which are also applicable to all human relationships. The creation of a safe space and a caring, trustworthy relationship is essential to therapy and basic to the helping process. Conducting therapy requires the application of the highest ethics and ideals.

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Psychotherapy and counseling take many forms, but there are basic principles or guidelines that can be applied to all therapy and ultimately too all human relationships. Originally developed for the treatment of deeply disturbed persons, these guidelines in some ways reflect a practical applications of Martin Buber's (1968) "I-Thou" relationship, which treasures the other human being. These guidelines draw on several of my earlier publications, including the *Heart of Being Helpful* (Breggin, 1997a) and *Dimensions of Empathic Therapy* (Breggin, Breggin, & Bemak, 2002).

In more extreme circumstances, therapy requires us to relate to individuals who feel unable to relate to other people in their lives at home, at work, or elsewhere. Sometimes these injured persons have withdrawn from human beings into a private world of their own making. At other times, their problems may not be as severe, but in all cases, the therapist must find a way to relate to people who feel distressed and in need of care and reassurance.

These guidelines are adapted from the final chapter of the recently published second edition of my book *Brain-Disabling Treatments in Psychiatry* (2008). I have added two new guideless to this version: "Address your client's feelings of helplessness" and "On the importance of not having emergencies."

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

The Quakers speak of relating to "that of God" in each person. Humanists see every human being as having inherent value. Find your own way of conceptualizing your respect and concern for the preciousness of each individual human life. Build your helping relationships around this kind reverence for the other. When you tend toward feeling superior, repeat to yourself the mantra of good therapists: "There but for the grace of God go I."

In a more humorous vein, I have described "A Dangerous Assignment" that I sometimes give my patients—for one week to treat everyone they meet with kindness and interest,

and to see how often it is returned (Breggin, 2000). Why it is a dangerous assignment? Because your client may learn to expect the same kind of wonderful treatment from you.

2. Dare to be caring.

Of course, everyone knows that it can be scary to be caring. Caring risks rejection. It can be misunderstood and even taken advantage of by distressed or unscrupulous people. It doesn't seem "professional." It can get out of hand and lead to the breaking of boundaries in most unfortunate ways. Yet a caring relationship is the core of healing.

By caring, I do not mean a sad or even sympathetic attitude. It does not help to be dragged down by your patients' plight. In *The Heart of Being Helpful* (Breggin, 1997a) I call this *induced emotional suffering*, where the witness to the suffering actually becomes relatively helpless or even incapacitated by the induced emotional pain. Induced suffering makes people feel guilty and angry, and may lead them to avoid or even to harm the other person.

Empathic suffering is different, especially in regard to feelings of guilt and helplessness. As a subtle aspect of caring—a way of keeping close company with the individual's suffering—it is critical to all forms of therapy (Breggin, 1999; Breggin & Stern, 1996). True empathy brings us closer to the other human being and makes us more able to listen, to hear, and to offer comfort and direction. Although it must be protected and limited by professional restraints, a genuine caring relationship can evolve in therapy, helping to restore the individual to human connectivity and, in the case of very disturbed people, it can help to lift the individual out of psychosis.

3. Create and maintain a safe, comfortable, and trusting relationship.

Conflict is inevitable in all relationships but it should not be elevated into a good in itself. In therapy, therapists should strive to create a relatively conflict-free relationship, one that feels comfortable and safe for both the client and the therapist. If either the client or therapist feels disrespected or threatened, that issue should be addressed and resolved. In the process of working on the creation of a mutually safe relationship, the disturbed client learns, perhaps for the first time, what it is like to feel close to someone without causing turmoil and without feeling endangered.

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

Most severe psychological disturbances reflect in part a loss of trust in other people. The creation of a safe space promotes trust and provides the opportunity for its growth. Trust is easily broken by any hint of ridicule or humiliation. Relate to your client as you would to an exquisitely sensitive person who will run at the first hint of embarrassment.

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

As an expansion on the first three guidelines—treasuring the individual, expressing care, and creating safety—therapy should be like a mini-utopia in which the therapist

can be at his or her best as a person and therefore able to reach people whom others have found impossible to deal with (Breggin, 1974). This mini-utopia is made possible by the limits placed on it, such as restricting the relationship to the office, avoiding any outside entanglements, and establishing rules for courteous and rational relating. Within these limits, the therapist should strive to create an ideal relationship, one that will help the client learn how best to relate to all the people in his or her personal life. This requires the therapist to uphold very high ethical standards, especially in regard to the autonomy of the client (Breggin, 1971).

5. Do not ignore or enable obnoxious or threatening behavior, but also do not overreact to it.

Therapists should let their clients know that, like all human beings, they are vulnerable to threatening or humiliating behavior. Therapists should explain that, again like all human beings, they cannot be at their best when feeling threatened. In doing this, therapists also teach their clients about vulnerability and the need to protect themselves from threatening behavior. They learn new standards for how they should be treated, including a refusal to accept or tolerate bullying, abusive, and controlling behavior on the part of family members and other people in their lives.

If your client begins making you feel uncomfortable with hostile remarks, gently draw attention to it, express your concern, and ask if you have done something to contribute to the angry reaction. Your vulnerability will actually reassure most people. Tell the truth; explain that it is hard for you to be at your best if you are feeling defensive.

Some patients believe that therapy is the place where they are freed to say anything to the therapist, no matter how frightening or humiliating. Instead, patients need to learn that therapy is a place in which, perhaps for the first time, they can learn to relate in a rational, loving, and respectful manner while dealing with painful emotional issues. The object is to develop good communication—not to express anything that comes to mind without regard for the consequences.

Few things are as frightening to people as their own out-of-control impulses. People feel safer when they stop being provocative. Nearly every client I have known has responded well to my encouragement of a mutually friendly, respectful, and even caring attitude.

6. Take notice of odd behavior, gently call attention to it, and ask what it is about.

Ignoring odd behavior is tantamount to ignoring the person. If your client is staring over your head, making odd gestures, or cocking his head as if listening to voices, gently ask about it. Taking odd behavior seriously shows your interest in and concern about your patient. Odd behavior always has meaning; it is always carried out for a purpose. It will help both you and your patient learn what it's about.

In families with disturbed children, the parents often enable bizarre and even risky behavior on the grounds that their children cannot control themselves. Hold even the most impaired children to a normal standard of behavior and discourage bizarre behavior. However, strange or disturbed behavior should never be ridiculed. It should be taken seriously without encouraging it.

Once the therapist and family begin to take notice of the odd behavior, it will tend to diminish because the person will feel that you are actually paying attention in an interested fashion. Odd behavior is usually driven by feelings of loneliness and isolation. Sometimes it is aimed at getting attention; sometimes it is aimed at relieving awful feelings;

sometimes it is an expression of irrational experience, like hearing voices. By asking about the behavior, you encourage more genuine and direct communication. If you can do it in a caring manner, it is useful to remind the person that odd behaviors distress or scare other people and cause doctors to implement coercive psychiatric interventions. When parents set a new standard for their children—one that excludes odd behavior—children often begin improving on the spot. Within minutes, children can begin to learn that they can take responsibility for how they conduct themselves, and they quickly see how much better other people respond to their improved conduct.

7. Get to know the person as a fully developed human being with a complex life story, not narrowly as a “mental patient.”

Therapists should focus on helping their clients learn their own life stories and to do so in as positive a light as possible. If a diagnosis comes to mind, such as schizophrenia or panic disorder, expunge your thoughts and start over again. The moment you start thinking of diagnoses, you will lose your sense of the person’s uniqueness, and you will stop trying to get to know him or her. People can sense when a mental health professional is squeezing them into a diagnostic category and, conversely, they can tell when you are interested in them as a unique human being.

Therapists should not think diagnostically about their patients; emotionally distressed people do not have circumscribed illnesses; they have life stories gone awry. If diagnoses must be made for insurance purposes or other practical reasons, discuss the least harmful diagnosis with your patient and reach an agreement on it before writing it down or communicating it to anyone else.

8. Help your patients learn their own life stories and help them take charge of how these stories will unfold in the future.

Instead of diagnosing your patients, learn about their lives, especially what has helped and harmed them along the way. They reconstruct their own biographies—what happened to them that helped and what happened that harmed, what they did right and what they did wrong in response to life’s challenges.

If a person has undergone a very abrupt and acute break with reality, it can be very helpful to examine the precipitating trauma. The trauma may be culture shock for a student visiting from another country. It may be the death of a loved one. It may be an ongoing abusive relationship that restimulated the effects of even worse abuse in childhood. It may be the stress of leaving home for college for the first time. Life stories, and the traumatic events that abound in them, are infinitely varied.

Often, an individual’s current problems stem from self-defeating viewpoints learned in childhood. It may have been safer as a child to avoid close contact with an alcoholic, unpredictable father, but in adulthood, avoiding or shrinking from men in authority will become self-defeating. It may have been necessary in childhood to hide feelings from other people, but this kind of emotional guardedness impedes meaningful relationships in adulthood. It may have been necessary in childhood to remain in a heightened state of suspicion in dealings with an older, abusive sibling, but in adulthood, this can turn into self-defeating paranoia about your peers. Learning to apply new and better lessons to life is central to therapy.

Examining difficult times and bad lessons learned in childhood can only be effective when the individual is not mired down in helplessness and victimization. This brings us to the next guideline.

9. Be optimistic.

The importance of being optimistic may seem so obvious that it need not be stated, but in fact, modern psychiatry is deeply pessimistic, even profoundly negative, in its attitude toward patients. What can be more demoralizing than being told that you have a genetic disorder and biochemical imbalance, forces over which you have no personal control?

Psychiatrists nowadays rarely have the knowledge or inclination to build therapeutic relationships with their patients and, as a result, they have no idea about the healing power of good relationships. Instead, they have been taught that they cannot “talk to schizophrenia,” and so they pessimistically turn to prescribing drugs and electroshock. Commonly, they instruct patients to take their medications for the rest of their lives, sending a clearly pessimistic message. Biopsychiatric pessimism about the capacity of human beings to take charge of their lives reinforces their patients’ worst view of themselves as helpless in the face of their problems. By being pessimistic, health care providers—including most psychiatrists—make their patients dependent on them and end up doing far more harm than good.

Especially for disturbed patients who have already been overwhelmed by psychiatric pessimism, make clear how optimistic you feel about being able to help them to live better, happier, more productive and loving lives.

10. Be confident.

Confidence is an aspect of optimism. Be confident about your ability to help this very disturbed person and expect that he or she will show signs of being less disturbed, even within a few minutes. You might even remind the patient that success in therapy depends more on the patient than the therapist. A responsible, hardworking client is likely to find help even from a marginal therapist, while a helpless, dependent client is likely to find little help anywhere.

While expressing confidence that this person will shortly discover how useful therapy can be, also be humble enough to realize that it is ultimately up to the individual to decide how he or she feels about you and your approach. Trying too hard is one of the worst mistakes a therapist can make. It reeks of desperation and disrespects the autonomy of the other. Yet you want to communicate a quiet confidence that the individual in the room with you can work with you in an understandable and productive manner.

11. Be willing to improve your own attitudes.

If you are finding it difficult to become caring, empathic, optimistic, or confident about a particular client, then it is your job—your professional obligation—to find the necessary resources within yourself. In *The Heart of Being Helpful* (Breggin, 1997a), I call this *empathic self-transformation*—the willingness and ability to find the human-to-human resources necessary for the work of being a psychotherapist with each individual patient.

In the job of helping people with their psychological problems, the therapist cannot self-indulge feelings of helplessness, resentment, or pessimism. These feelings have to be overcome. Knowing that there are no exceptions to this rule will help you to maintain a positive outlook as a therapist and make your hours of therapy relatively stress-free and satisfying to you and, ultimately, to your client.

12. Avoid using artificially contrived therapeutic techniques, especially with very disturbed persons.

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

Working with disturbed people requires you to offer them a genuine human relationship, even in the face of their craziness. You, in turn, should not introduce anything out of the ordinary into the session. Your goal is to build a genuine relationship. Again, what makes this possible with disturbed patients is the utopian quality of the therapy setting, including its limits, its safety, and the skills of the therapist in maintaining a genuine relationship with people who tend to drive others away.

Again in a more humorous vein, I was asked to contribute to a book about my most creative strategies or techniques in therapy, and I responded with what I called, "Humility, Augmented by the Deep Breath Technique" (Breggin, 1997b). As my technique, I advised therapists who feel overcome with the urge to try a technique on their patients to instead "take a deep breath" and not do it. Instead, I recommended trying harder to build the relationship.

13. Avoid starting patients on medication or to referring them for medication evaluation, especially if they are very disturbed.

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

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

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

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

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

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

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

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

There is no law that specifically requires a doctor or other health care provider to lock up patients against their will. However, the law in most states does require doctors to take preventive measures of some kind if they have reason to believe that a patient is likely to commit violence against a specific person. This is called "the duty to warn." I can recall exercising this option on only one occasion many years ago, and the outcome was most remarkable. I was afraid that a man was going to assault his wife that very night after the

session was over and so I discussed my legal duty to warn his wife of the danger. I did not want to do anything behind my patient's back and, somewhat to my surprise, he gladly went along with my calling his wife while he sat in the office with me.

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

Most severely disturbed patients will have seen numerous other mental health professionals before finding their way to me. If mental health professionals have already seen them, then they have already experienced coercion. All patients who display serious mental problems are quickly pressured to take drugs and are threatened, bullied, or locked up if they display too much reluctance.

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

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

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

Therapy must be voluntary for the patient; otherwise, it becomes something else, such as indoctrination, intimidation, or brainwashing. During the Moral Era of psychiatry, this was obvious to Tuke (1996) in 1813, but it continues to elude the modern psychiatrist, who refuses to let go of the power to force patients into treatment.

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

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

If involuntary treatment seems to work, it is because the client has become submissive in response to authority. Involuntary treatment teaches the victim to become docile and

to manipulate to avoid and escape punishment, and it motivates the so-called therapist to rationalize abusive acts. As I describe in detail in *Beyond Conflict* (Breggin, 1992), victims of coercion hide their true feelings from those who exercise arbitrary power over them.

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

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

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

Many well-meaning professionals attempt to provide therapy to individuals who are incarcerated against their will in mental hospitals or prisons. In theory, it might be possible to do this on a voluntary basis. But the therapist must remain acutely aware of institutional pressures on how he conducts his therapy and attempt at all times to serve the client, rather than the institution.

Unfortunately, as I have learned from many colleagues, aligning oneself with the clients, rather than with the authorities, in an institution inevitably leads to getting fired. For this reason, it is probably impossible to conduct genuinely voluntary therapy within an involuntary institution.

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

15. Welcome your patients' most painful feelings.

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

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

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

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

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

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

I also believe that a life without love is more akin to death than to life and that people thrive to the extent that they love other people, nature, life itself, or God. So my therapy promotes liberty and love.

I also believe that we must take complete responsibility for our actions, moving beyond viewing ourselves as victims. Ultimately everything I do in therapy takes place in the context of promoting liberty, love, and personal responsibility.

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

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

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

17. Address psychological or learned helplessness early in the therapy, especially with very disturbed or emotionally disabled people.

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

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

I am not talking about giving lectures to patients. I have already written more about helplessness in this article than I will talk about it in most therapies.

Usually, a few words at appropriate moments will get the point across that helplessness cannot be indulged without destroying one's own life. The actual therapy work involves learning where helplessness was engendered in childhood and then choosing and learning to overcome it in adulthood.

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

18. Be willing to offer practical advice and guidance, especially with disturbed persons who lack successful experiences.

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

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

Very disturbed people who require a protective milieu also require a great deal of guidance, even about the most simple acts of everyday survival, but it must always be provided free of authoritarianism or coercion. Keep in mind how vulnerable to humiliation people feel when they are struggling with disturbed feelings and helplessness and offer any guidance with the utmost respect for their autonomy.

19. Graciously recognize that you have no monopoly on helping people.

Therapists will naturally vary in how much they emphasize relationship, insight, historical reconstructions, and learning new principles or behavior. Similarly, patients will vary in how they feel about different therapists and their therapeutic approaches.

Starting with the importance of the empathic relationship, I practice a mixture of approaches, depending on what my individual client seems to want or need. Often, I will discuss what seems more useful to the client. I try to guide people through an examination of how self-defeating patterns—bad principles and flawed strategies—developed in childhood. As they recognize and become liberated from these self-defeating patterns, they can explore new and more self-fulfilling strategies.

Some clients reap great benefit from looking at the origins of their irrational, self-defeating personal policies of life. Some benefit more from looking at how best to apply good principles to current issues. Some seem to benefit more when their emotions are touched, others when they gain intellectual clarity. But they all benefit from whatever capacity I have to take a real, genuine, caring interest in them. From that they learn and gain the courage to care more positively for themselves.

If one of my clients wishes to seek another form of therapy while seeing me, I have no objection. Instead of feeling competitive or possessive, I support my clients' efforts to obtain all the help they need or want. I am not concerned that they will get different or conflicting ideas from another therapist; that is what a successful life is about—freely selecting for yourself among life's myriad opportunities and alternatives.

Keep in mind that if you or I as therapists cannot seem to help some of our patients, the alternative answer is not drugs. The alternative could be another therapist or no therapy at all. No treatment at all is better than being subjected to toxic chemicals that cross the blood-brain barrier and interfere with higher human functions. With a clear brain and mind, people can take advantage of all the healing opportunities afforded by life, from support groups and workshops to community activities and religious worship.

This point is so important and so misunderstood that it needs emphasizing. It is the height of arrogance for therapists to think and say, "My client wasn't benefiting enough from therapy, so I suggested medication." That implies that clients have only two alternatives in life: their professional relationship with you, or prescribed drugs. In effect, the recommendation of drugs covers up the real problem: the therapist's failure to help the patient. It is far better to recommend that the client shop around for another therapist or another type of therapy, while you continue to offer your therapy to the individual and try your best to improve your approach. Every therapist should remember, "If I cannot help someone, then another therapist may be able to do so."

It is foolish and self-serving for therapists to believe that any particular patient must benefit from their relationship and their kind of therapy or accept being medicated. Yet the grip of drugs is so powerful in the mental health field that it is a common delusion among therapists that the patient's choice lies between their particular therapy or a drug.

20. Address your client's feelings of helplessness.

There is an important caveat to the usefulness of exploring one's past. No attempt to understand the past will be useful as long as the person feels and acts in a helpless fashion. Instead, past emotional injuries will become fuel for increased helplessness and

for blaming others, rather than for self-empowerment. Therefore, feelings of helplessness must be addressed and overcome early in the process of therapy and before attempting to understand traumatic, stressful past experiences.

Emotional helplessness is different from physical helplessness. A woman may be confined to a wheelchair or a man may be confined to a prisoner of war camp, creating genuine physical helplessness. But one person will respond to these potentially overwhelming stressors by giving in to self-pity, while another will renew his or her determination to make the most out of the situation and out of life. Learning not to cave in to feelings of helplessness is one of the most important lessons in therapy and life (Breggin, 1997a, 1992).

Having emphasized the importance of addressing helplessness, it's important to also emphasize how sensitive people are about their feelings of helplessness. This is an area requiring the utmost tact.

21. On the importance of not having emergencies.

Many of the worst mistakes made by therapists are driven by the therapist's feelings of helplessness in the face of a frightening emergency in the office (Breggin, 1997a, 1998). When the patient seems to become more acutely disturbed, suicidal, or violent, the therapist can panic. Of course, the therapist may not experience his or her own panic but instead will focus on the need to make a drastic intervention, such as starting or increasing medication or committing the patient to a hospital. Even nonmedical therapists, living fearfully in the shadow of the psychopharmaceutical complex, can feel compelled to refer the patient for these potentially destructive interventions (Breggin, 1991, 2008).

Here is a better solution: When your patient is having an emergency, make sure you don't have one as well. If you remain confident, calm, and optimistic—that is, if you follow these guidelines for therapy—your patients are likely to quickly observe that you are not overwhelmed by their thoughts, feelings, or behaviors. From this they will conclude that all is not lost and that help is available from you.

The concept of therapeutic or helping *presence* is critical here (Breggin, 1997a). If you remain in touch with your ability and strength as a therapist, your frightened, helpless-feeling patients are likely to calm down quickly and get to work on the issues and stresses in their lives.

22. Make clear your last resort, both to yourself and to your patients.

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

Other human beings and a personal relationship with a Higher Power are far better last resorts than drugs. In fact, life itself, with all its varied ways of healing, is the alternative to a medication-impaired brain. Your clients will do much better if they understand that the restoration of their mental balance or sanity can best occur from a combination of their

own internal resources and the people in their lives as well as from their most profound values and devotion to community and to a higher power, if they believe in one.

I have somewhat arbitrarily divided human relationships into three kinds of dynamics: liberty, love, and coercion (Breggin, 1988–1989, 1992). Liberty provides the opportunity for creativity and the fullest expression of human nature including love. Coercion suppresses human spontaneity, alienates people, and makes it difficult and dangerous to love. Love is the fullest expression of our potential in relationships with others.

Love, both the offering and the receiving, can be one of the most healing last resorts, whether that love is conceived in human or divine terms. I define love as a joyful awareness and treasuring of any aspect of life, including other people, animals, nature, work, and personal creativity, as well as higher ideals and God (Breggin, 1992). Finding a way to love again can be the individual's last resort, as well as the individual's first resort, in living a satisfying life.

CONCLUSION

Except for a few specific aspects, such as examining the influence of childhood, the principles for conducting therapy and counseling are not substantially different from the principles required for relating well to anyone, including family and loved ones. In everyday life, there may be no compulsion to be at our best all the time. But if when we choose to act as therapists, we become *professionally obligated* to conduct ourselves in the most principled, caring, and empathic manner possible; that approach in itself will enhance the healing of the patients we treat.

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