On the Incompatibility of the Biological and Empathic-Relational Model

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Dimensions of Empathic Therapy

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Biological psychiatry and psychosocial psychotherapy are two distinct ways of trying to help people. I believe they are polar opposites of each other, and therefore incompatible and un-integratable. I should know because I have practiced within both models. I trained and practiced in the biological model for about 10 years. The second model, which I prefer to call the "empathic-relational model," relies on the healing power of relationships rather than on mechanical or chemical manipulations of the brain. I have been practicing within this model for about 4 years. My skills for working within this model are still developing, but already I see dramatically better results and have far more satisfaction in my work.

Actually, most psychiatrists don't see themselves as practicing within just one model. Although some consider themselves to be pure psychopharmacologists, most consider themselves to be practitioners of a blended or integrated model. For years, I saw myself as practicing a blended model. Indeed, I was highly regarded because I spent more time with patients and took more interest in their own perspectives than most psychiatrists did, even though I relied mostly on medications. But I eventually came to see that the models don't mix. They are based on diametrically opposite assumptions. The models can no more mix than can communism and capitalism, or religion and atheism. Attempts to integrate them result in confusion, contradiction, and a marked diminution in the power of empathy. Only by divorcing the medical model can one unlock the full power of the empathic healing relationship.

To make this more clear, I need to discuss each model in more detail. When typical psychiatrists listen to patients, they are listening for symptoms. In their minds, they try to match those symptoms to *DSM* diagnostic criteria and to medication effects. For example, if a patient says "I've been so depressed I can't sleep," the doctor thinks to himself, "depressed; could be depression (with psychotic features?), or just dysthymia, or possibly bipolar." He also will begin thinking of antidepressants, particularly those that are sedating since insomnia is a symptom in this case. He will likely ask the patient some questions along this line of thinking: "How long have you been depressed?" "Have you ever been manic?" "What antidepressants have you tried in the past?" This particular line of questioning may be in line with the

patient's own train of thoughts, but most likely not.

In contrast, a doctor working within the empathic-relational model would not likely impose a line of thinking on the patient, but rather, would stay with the patient's own flow of thought. For example, the same patient, unimpeded, may go on to talk about a difficult conflict in a relationship. An empathic listener would be very interested, since this may well be the heart of the issue. A typical psychiatrist may never hear about the relationship conflict, or if he did, would be interested only to the degree that it may reflect further symptomatology ("Could this be manic irritability? A personality disorder? PTSD?"). Other than that, the conflict will be seen as irrelevant, or as a side product of the mental illness, or as a nonspecific stressor that tipped the (genetically?) depression-prone patient over into a full depression.

Psychiatrists usually don't state it explicitly, and may not even think about it, but they view symptoms as meaningless and purposeless. Symptoms are thought of as products of mental illness. They are best gotten rid of or suppressed as much as possible. We could say this is an anti-empathic viewpoint, since empathy involves meanings and purpose. But ironically, the patient may experience the psychiatrist as being superficially empathetic in that the patient usually doesn't understand his symptoms either, and often (unconsciously) wants to deny or conceal their meanings. The patient may be relieved to hear the implicit message that the symptoms mean nothing. But the doctor, in this case, is participating in and reinforcing a system of denial.

In contrast, the empathic listener receives and holds the patient's communications (including symptoms), assuming them to be meaningful even when the meanings are not readily apparent. The patient can then, through thoughtful dialogue and interaction, eventually come to understand these meanings and accept previously unacceptable or unthinkable aspects of himself. This process is ultimately experienced by the patient as profoundly empathic.

For example, depressed patients presenting in a psychiatrist's office, quite commonly do not know why they are depressed. The empathic listener will hold to the idea that the depression has understandable meaning, even if not understood yet. In the course of an interview, obvious sources of depression usually come to light. Sometimes a longer more intensive search is necessary. I have never yet (since reforming my practice) encountered a depressed patient whose source of depression could not be

eventually found and understood. In my early years of practice, I would usually pick up the more obvious sources or "meanings" of depression, such as divorce, trauma, and loss, but I would often get stumped in more complex or subtle cases. That's when I found myself wondering if the depressions were "endogenous," that is meaningless, and I would often pull out the prescription pad. Typical practitioners will see and understand the source and meaning of symptoms to a point, but beyond that point, they assume that no meaning exists. Empathic practitioners, in contrast, always see human experience as meaningful.

The patient can ironically experience the prescription of a medication as empathic since it feels like the problems are being taken very seriously and addressed with a powerful-sounding treatment. The patient may eagerly comply. If at all reluctant, the patient is told that taking medicines for depression is just like taking insulin for diabetes or wearing corrective eyeglasses. Most patients have great misgivings about surrendering their mind to a chemical, but they may be desperate for relief and understandably trusting of a medical professional. So many accept a drug. We know that the results are not good. Antidepressants leave most patients still with significant impairment (Antonuccio, Danton, DeNelsky, Greenberg & Gordon, 1999; Fawcett & Barkin, 1997). The majority of patients on antidepressants feel that their psychiatrist "doesn't really understand them" (National Depression and Manic-Depressive Association, 1999). Most patients drop out of treatment within a few weeks or months (Ramirez & Rush, 1995)—usually without discussing it with their psychiatrist. Those who go back to complain are given a higher dose or one or two more medicines to augment the first. When they try to go off the medicines, many, perhaps most patients, will relapse or have a "rebound" depression simply because of the effects of medication withdrawal (Breggin & Cohen, 1999). They complain again to the psychiatrist only to be told that lifelong medications are needed, probably in ever higher doses with ever more augmentation. The empathic rift grows. Psychiatrists do not acknowledge these facts and are unable to accept the patient's viewpoint. Instead the patient is "educated" more and more about the need for lifelong compliance.

This is a stark contrast to an empathic healing relationship, which, although often slow and sometimes painful, will almost inevitably lead to a greater sense of feeling understood and to greater understanding of the previously split-off aspects of the self. How does this work? An exact understanding of the healing effect of human connection is a profound mystery. But there is a lot we know. Infant research is revealing more and more about how the mind develops and many of the principles hold true in adulthood. For example, it appears that the infant is very much dependent on the mother (or person

in the mothering role) for not only relief and soothing, but also for the development of mental processes, or a system of meaning. The baby cries out to the mother in a chaotic, panicky state, which the mother receives and "metabolizes" into something meaningful and solvable—hunger, wet diaper, sleepiness, and so forth. The baby eventually grows to understand and internalize these meanings. I believe that empathic relationships serve much the same function throughout the life cycle.

The therapist, like a good mother, provides relief and soothing by accurately receiving the patient's mental state, and doing much of the work of "mentalizing" the patient's experience and reflecting it back to the patient. The patient grows to understand himself and accept aspects of himself that had been unthinkable or unknowable. He also develops the ability to reflect on his own experience. The ability to be reflective and to mentalize experience appears to be what provides the capacity to endure pain and trauma (Ammaniti, 1999). Without this ability, the pain seems overwhelming and meaningless—like a black hole.

Of course, this is a very sketchy portrayal of a wonderfully complex process, but it should suffice to illustrate how antithetical it is to medical psychiatry. Psychiatry is a bit like the synthetic hands that reach into the sterile incubator to tend to hospitalized newborns' most rudimentary needs. They provide a transient relief of hunger or stomach gas, but without the healing presence of the mother—her arms, breast, warmth, voice, and gaze— the baby will eventually die. Patients given medications for their symptoms may get transient relief, but they are not helped to reflect on or mentalize their experience. In fact, they become even more alienated from themselves and more hopeless.

Mrs. B., is a 54-year-old woman referred to me by her family doctor because she was considering suicide. She reported to me that she had been recurrently suicidal throughout her life and that the wish to die was sometimes so strong that she would plan out her suicide in detail and then come within inches of carrying it out before stopping herself. Sometimes she wouldn't stop herself, but she had always survived the attempts somehow. After a brush with death, she would experience relief and be in a good mood for several weeks or months before the cycle would start over again. She did not understand why she went through these dramatic mood cycles and found it odd that I expressed curiosity about it. "All my other psychiatrists told me I had a chemical imbalance, but you seem to be assuming there is more to it." Several months went by in which she made small but significant gains in understanding herself vis-a-vis

her relationship with me, but the suicide cycles continued. A breakthrough occurred 7 months into treatment when she uncharacteristically began quietly crying during our session.

> "I have to tell you something." She said: I've been wondering to myself for a long time why you haven't put me on medications yet, but I've been afraid to bring it up with you because I thought it was because you didn't really care about me, or you didn't get the message yet about how suicidal I am; like maybe you didn't believe me or take me seriously. Every psychiatrist I've ever been to put me on medicines right away—everything from Elavil to Haldol. Some have even tried to put me in the hospital, which you also have never even mentioned. But I just now realized that you do care about me. In fact, you care more about me than I cared about myself, because you treat me like a human being. You treat me like all my craziness makes sense even though I didn't think any of it made sense until you helped me see it. And you know, all those other psychiatrists were just scared of me I think. They were giving me pills because they didn't know what else to do. They just wanted me to stop being suicidal so they wouldn't have to worry about me, so they could sleep at night. But you are different. You understand me as a person. And I'll tell you something else; I think if you had prescribed drugs for me you would have never seen me again.

Mrs. B.'s therapy has progressed over the 2 years since that time. We have gone through many ups and downs together, but she has never been suicidal since that session. In fact, she told me recently that for the first time in her life she knows what it is like to feel happy. And she remains drug-free.

I have been using the example of depression so far, but the situation with psychotic patients is even worse. They suffer terribly in the (synthetic) hands of psychiatry. Most psychiatrists know what it is like to feel depressed since all people feel sad from time to time, but few understand what it is like to be overtly psychotic. Psychiatrists very quickly run up against the limits of their ability to understand meanings when dealing with psychotic patients. Psychotic symptoms then, are nearly always viewed as abnormal products of a defective brain. The singular goal becomes the suppression of the psychotic symptoms—and with them, the patient. A psychiatrist may have respect for a depressed patient's wish to rely on psychotherapy rather than medication, but never a psychotic patient's. Psychotic patients are cajoled and coerced into accepting not only medication, but the psychiatrist's view of their symptoms. The empathic gulf between doctor and patient is wide and deep. I believe this is why psychiatric treatments fail to improve the course of psychosis in any way (Kane & Freeman, 1994). In fact, outcomes for schizophrenia in this country are getting worse despite the advent of and possibly because of expensive new medications (Warner, 1994).

I want to say more about attempts to integrate the two opposing models. Some readers may still think—as I used to—that we should borrow from the best of both worlds. We should provide

symptomatic relief and at the same time provide an empathic relationship that promotes self-understanding and healing. Probably Mrs. B. debunks this way of thinking more eloquently than I could. I think that all patients in their heart of hearts have the same sense of things as Mrs. B. had, although they may not be aware of it any more than Mrs. B. was at the start. I received an e-mail recently from someone who said her psychiatrist would "dismiss her" by handing her a prescription at the end of their therapy sessions. She said that she eventually came to see that she "was being dismissed in more ways than one." Actions always speak louder than words. No amount of empathic listening will undo the clear message of the prescription pad.

The NIMH conducted an enormous multicenter study to compare medication, psychotherapy, and the combination for the treatment of depression. The data appeared to show psychotherapy to be at least as effective as medications or the combination, but the conclusions are frequently questioned and debated. One important finding often gets overlooked, however. Certain therapists in this study seemed to consistently get much better results than other therapists or other forms of treatment. The study was unusual in that it recorded provider variables. This allows us now to go back and determine the characteristics of those "super-therapists." It turns out that age, sex, years of practice, and theoretical orientation were all non-predictive. Only two factors were statistically significant predictors of the super-therapists: First, they did not believe in psychiatric medications, and second, they expected therapy to work, but expected it to take longer than most therapists did. This finding supports my contention that efforts to mix medicine with therapy end up hamstringing the treatment or condemning it to superficiality or outright failure.

The right hand cannot welcome with empathy the very same aspects of the patient that the left hand is prescribing a drug to suppress. This is why I had to radically change my practice and my way of relating to patients. I invite all of psychiatry to follow my example so that it may become a healing art rather than what it is now—an industry of suppression.

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