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FROM EMIL KRAEPELIN TO R. D. LAING.

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POLITICAL PHENOMENA OF SCHIZOPHRENIA
FROM EMIL KRAEPELIN TO R. D. LAING

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAII IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN POLITICAL SCIENCE DECEMBER 1977

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ABSTRACT

This is an exploration and critical review of the political implications of selected psychiatric, psychotherapeutic, and psychoanalytic theories and therapies of the disease concept and/or the human phenomena of schizophrenia. It focuses on the nature of medical authority, the wide variety of models of schizophrenia propounded since 1900, and its relation to creative human experience. In practice, the therapy of Silvano Arieti demonstrates the frustrated attempt to balance the assertions of organic etiology and the counterclaim that schizophrenia is a human disorder for which no technological or medical therapies are adequate.

Emil Kraepelin invented the concept of schizophrenia in the early twentieth century, and Eugen Bleuler renamed and established the theory and therapy of schizophrenia as an organic illness of unknown etiology and grim prognosis. For these founders (and for Carl Jung as well) schizophrenia was a dangerous organic disorder. Orthodox medical psychiatry continues to view schizophrenia in this way. The political implications of the theories and therapies of these scientific pioneers are examined.

Harry Stack Sullivan's social psychology is based on his understanding of schizophrenia as a human disorder. A
critic of normal, well-functioning family and social systems, Sullivan, as therapist, empathizes with the cause of the patient and avoids the institutional role of disciplining psychiatrist. Frieda Fromm-Reichmann's demonstration that schizophrenia is a completely human cultural phenomena, fully treatable by therapists, that can enhance the creative powers of afflicted individuals, makes her a significant figure in psychiatry.

Marguerite Sechehaye, Harold Searles, Theodore Lidz, and John Rosen claim they have developed therapies that effectively treat diagnosed schizophrenics. For Sechehaye, a profound and extended commitment resulted in a solid therapeutic achievement. However, her intolerance of regression and her commitment to the medical-scientific version of psychoanalysis are seen as limits in this study. Searles, a successor to Sullivan and Fromm-Reichmann, asserts that regression is always potentially advantageous to the schizophrenic. Lidz demonstrates the dangers of ideological posturing in his approach to schizophrenia, and Rosen does the same in his assembly-line therapy in the service of foundations and governments.

Although the genetic/chemical researchers assert that a medical or organic treatment and cure is possible given enough resources, they have not succeeded in curing the disease or establishing its etiology, and yet, they dominate the funding and public interest. The work of Franz Kallman and that of the articulate proponents of medical authority,
Abram Hoffer, Humphry Osmond, J. R. Smythies, and Miriam Siegler are critically weighed. The advent of anti-schizophrenic drugs is explored from a political viewpoint.

Thomas Szasz, a thorough polemicist, intermixes a laissez-faire psychiatry with modern liberal politics. His criticism of public psychiatry is often useful, his vitriolic stand against Laing notwithstanding.

R. D. Laing's theory and empirical evidence demonstrates his understanding of schizophrenia as a natural healing process. His role as a social critic and his authority as a medical doctor are examined to explore the future role of the human sciences in the evolution of schizophrenia. Schizophrenia has evolved from an organic disease to a political and cultural phenomenon of importand dimensions leading to the understanding of alienation, creativity, and the social function of medical knowledge. Two competing models of schizophrenia and of psychiatry are prevalent today: one based on an organic medical etiology, the other on a vision of political possibility.
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CHAPTER I

Introduction

"Schizophrenia Laid to Misshapen Protein in Brain"

A Detroit researcher carried the search for schizophrenia a major step forward yesterday. He blamed it on a tiny corkscrew-shaped protein that has run amuck in the emotional center of the brain.

The enzyme that regulates that protein is missing from the brain of schizophrenics, but present in normal brains, Dr. Jacques S. Gottlieb told the American Psychiatric meeting here [in Dallas].

In that sense, he said, schizophrenia is like diabetes. In diabetes, an absence of insulin in the blood prevents the conversion of sugars into protein.

Gottlieb . . . said it will take him five years to turn his laboratory findings into treatment methods for the nation's estimated millions of schizophrenics. . . .

It appears most probable, therefore, said Gottlieb, "that DMT is being produced in excess in certain parts of brains of schizophrenic patients and this could be responsible for some of the manifestations of the illness."

"In effect," he said, "the schizophrenic is his own drug abuse factory." Honolulu Advertiser, June 20, 1973.
Dr. David Rosenthal, chief of the psychology laboratory of Intermural Research Programs, National Institute of Mental Health, listed major mental illnesses--or "behavioral disorders" as some scientists prefer to call them--and cited studies implicating genetic inheritable faults in all of them.

"There is sufficient evidence for genetic factors in all behavioral disorders for us to take the genetic hypothesis seriously," Rosenthal said.

He said there may be more than 60 million schizophrenics in the U.S. population of 210 million. These are persons who are afflicted to some degree with loss of contact with the real world and subject to many kinds of behavioral disorders.

In addition, he said, there are 9 million Americans with "a serious drinking problem" and their number increases by about 200,000 annually. It is estimated that one child in five between ages 10 and 17 will wind up in Juvenile Court. . . . "When you add in the neurotics [he said] . . . you get into figures regarding those affected, almost impossible to estimate."

Honolulu Advertiser, June 15, 1972

"The Sane and the Insane" by Nigel Hawkes

Eight perfectly normal people, by shamming symptoms of a mild kind, successfully gained admission to psychiatric wards where they remained undetected for as long as they could stand it. Once admitted, their behavior was normal in every way, but doctors and nurses continued to treat them as disturbed. In every case but one the diagnosis was schizophrenia. Once they were labelled as mentally ill, everything the
"pseudopatients" did tended to confirm the diagnosis in the eyes of the medical staff, though other patients in the hospital were much less easy to convince.

The experiment was carried out under the supervision of Professor D. L. Rosenhan of Stanford University, himself one of the eight fake patients. Writing about the experiment in Science, he concludes:

We cannot distinguish the sane from the insane in mental hospitals . . . how many people, one wonders, are sane but not recognized as such in our psychiatric institutions? . . . How many have been stigmatized by well-intentioned, but nevertheless, erroneous diagnoses?

In Professor Rosenhan's view the hospital itself is an environment that distorts judgment.


"Hints on the Chemical Nature of Schizophrenia"

New hints that some forms of schizophrenia may have chemical causes and might someday yield to chemical treatments are contained in experiments reported last week.

When some scientists injected a natural animal substance called beta-endophin into the brains of rats, the animals began to behave very much like the victims of a kind of schizophrenia known as catatonia. . . . The experimenters found they could reverse the effects of the beta-endophin, which has some of the characteristics of morphine, by injecting naloxone, a chemical used as an antidote for morphine overdose. . . . As for naloxone, the researchers cited an experiment in Sweden: the auditory hallucinations of two schizophrenics stopped just two minutes after a
naloxone injection. ... Scientists have argued endlessly about the disorder. "Schizophrenia is not a disease, it's an opinion," says Seymour Kety, an authority in the field. ... Today most experts agree that at least some types of schizophrenia have genetic roots, although an environment trigger may be needed to set off the disease. The New York Times, "Week in Review," November 7, 1976.

* * *

Schizophrenia is a major unresolved problem of the medical and psychiatric professions. Don D. Jackson found that

Schizophrenia is one of our major medical problems. Incidence is estimated at from one to three per cent of the population. It keeps one quarter of the hospital beds in this country occupied. Medicine and psychiatry have made little or no progress against this illness.¹

Philip Solomon and Vernon D. Patch, in their Handbook of Psychiatry, argue on the basis of the theoretical work of Seymour Kety, one of the most prominent and respected of contemporary schizophrenic researchers, that, "a significant genetic contribution to the etiology of this illness exists."² Their quotation from Kety, however, leaves one a bit confused. Kety goes on to state that, "the genetic factors in schizophrenia are multiple and ... what is transmitted is not schizophrenia as such but a vague personality characteristic that may move into the schizophrenic spectrum."³
Solomon H. Snyder asserts that: "there is abundant genetic and clinical evidence that the disease entity of schizophrenia . . . is genuine. The difficulty of the psychiatric community stems from the lack of a simply physical indicator of the disease." Although science has not isolated a physical indicator establishing the disease, the search proceeds with vigor.

Fredrick C. Redlich and Daniel X. Freedman, in a standard textbook of psychiatry, are less genetically or chemically oriented in their approach to the problem. They assert that

There is no generally accepted definition of schizophrenia . . . the important questions of diagnosis, prognosis, etiology, and therapy are still unanswered and constitute psychiatry's greatest challenge. 5

And:

The question of etiology . . . in a word we are still groping in the darkness. 6

Redlich and Freedman describe the development of schizophrenia as follows:

When schizophrenias change from incipient to advanced and easily recognized forms, they pass in a rather lawful fashion through certain more or less delineated phases: (1) the early or initial phase; (2) the phase of disintegration or clear-cut schizophrenic dissociation; (3) the phase of deterioration. Schizophrenias may run the whole course to the bitter end, but many become arrested at an earlier stage. Under stress, symptoms may recur at any time. There are also reversals of the pathological processes—we speak of "remissions"—in which reparative actions gain the upper hand. At present we are, in spite of a few leads, unable to account for factors that determine a benign or malignant course. 7
A capacity for "unexpected performance" distinguishes the schizophrenic from the victim of organic brain deterioration. They find that hospitalization without attention is perhaps the worst possible treatment for schizophrenics. Care and attention are essential, according to Redlich and Freedman. The authors take a middle-ground position on electro-shock therapy (ECT):

Very massive treatment with one or more shocks daily, in our opinion, is not justified. It regresses the patient, makes him apathetic, and produces temporary deficit states. In general, ECT need not be used as a routine, but rather as an emergency 'sedative' with schizophrenics.

The purpose of ECT is ostensibly to control the patient's apathy and tendencies toward withdrawal and regression. Redlich and Freedman seem to be saying, however, that ECT encourages apathy and regression; whereas other psychiatrists claim it counters apathy and regression.

Redlich and Freedman also point out that schizophrenics do not contribute to a good marriage or family life, but, "on medical eugenic grounds we are not justified in recommending sterilization. There is no evidence that such measures could lead to an elimination of the disorder, even over long periods of time."

Solomon and Patch are greatly concerned about schizophrenics having children, as are most writers on the subject from a genetic perspective. They report that
at the turn of the century the reproduction rate of schizophrenics was only half that of the general population. Over the last 60 years it has increased to almost 90% since, with modern treatment, schizophrenics are spending less time in hospitals. This tendency of the reproduction rate to approach that of the general population will eliminate any selective disadvantage schizophrenics may have had in terms of human evolution. There is a great need, then, for genetic counseling to prevent as many schizophrenics as possible from reproducing themselves. 12

Silvano Arieti, in a number of articles and books, has assembled research findings and formulated a body of theories which represents a good synthesis of current professional views on the subject of schizophrenia. In his major work of review, synthesis, and theorizing, Interpretation of Schizophrenia, Arieti evaluates the importance of the study of schizophrenia for himself and demonstrates its cultural importance. He observes that

The study of schizophrenia transcends psychiatry. No other condition in human pathology permits us to delve so deeply into what is specific to human nature. Although the main objective of the therapist of the schizophrenic is to relieve suffering, he will have to deal with a panorama of the human condition, which includes the cardinal problems of truth and illusion, bizarreness and creativity, grandiosity, loneliness and capacity for communion, interminable suspiciousness and absolute faith, petrifying immobility and freedom of action, capacity for projecting and blaming and self-accusation, surrender to love and hate and imperviousness to these feelings. 13

After a lengthy review of the psychiatric literature on schizophrenia, Arieti advances his own theory, the
regression theory of schizophrenia. For Arieti, the disorder of the psychological functions is the predominant symptom. He finds that

re-emergence of the lower functions . . . determine a state of disequilibrium and psychological splitting, which is so characteristic of this mental disorder. How does the organism defend itself from this disorganization? With further regression. The process thus repeats itself in a vicious circle that may lead to complete dilapidation.\textsuperscript{14}

For Arieti, "It is the psychological process itself that may sooner or later bring about a disorganization of neuronal patterns."\textsuperscript{15} Chemical or genetic factors are clearly secondary in Arieti's formulation.

As for therapies, Arieti disapproves of frontal leucotomy as an "artificial attempt to integrate the schizophrenic at a lower level [which] removes permanently a great part of the essence of man. . . ."\textsuperscript{16} He recommends drug therapy if psychotherapy fails. The patient who can conquer his illness by psychological means is greatly preferred to the one who must resort to drugs. ECT is recommended for patients who do not respond to either psychotherapy or drug therapy. "After the course of ECT the capacity to experience anxiety is diminished and the patient is more reachable."\textsuperscript{17}

Reviewing the genetics literature, Arieti concludes that both biological and psychodynamic origins "are necessary to engender schizophrenia."\textsuperscript{18} Since genetic
factors cannot be altered, "We must thus try to alter or prevent psychodynamic or environmental factors."  

Arieti, as a practitioner of psychotherapy, theorist, and writer, is dependent upon chemical and genetic researchers to provide information and evaluations of their research findings. Unlike more biologically or chemically oriented research therapists, however, Arieti holds out for the primacy of the psychological factors. As if somewhat awed by his scientific brethren, Arieti seeks to cover all research in the field. He steers a middle course, seeking compromise among competing research perspectives, excluding only what he believes to be extremes of all kinds. No responsible scientific research is excluded. 

In biochemical research, Arieti reports, based on Kety's summaries of ongoing research, that "serotonin and its metabolism play an important role in the central nervous system. What this role consists of, however, we do not know as yet." Because some researchers posit schizophrenia as caused by too little serotonin while other researchers correlate schizophrenia with too much serotonin, the cure has not been discovered quite yet. 

Advocating psychotherapy as the therapy of choice, Arieti quotes warnings from M. K. Horwitt to biological and chemical researchers that 

Symptoms that are usually considered artifacts in other studies are often erroneously accepted as
biological aberrations in the evaluation of the schizophrenic patient. . . . The sum total of the differences reported would make the schizophrenic patient a sorry physical specimen indeed: his liver, brain, kidney, circulatory functions are impaired; he is deficient in practically every vitamin; his hormones are out of balance, and his enzymes are askew. Fortunately many of these claims of metabolic abnormality are forgotten in time with a minimum of polemic, but it seems that each new generation of biologists has to be indoctrinated--or disillusioned without the benefit of the experience of its predecessors. . . . 22

As for Laing, Arieti states in one place that he cannot discuss Laing's method since it has never "been reported in the literature."23 Yet Arieti does find fault with (his understanding of) Laing's theories of schizophrenia. The schizophrenic distorts reality. These distortions have no "adaptional value." In fact, they are "inimical to any form of adaptation even within a liberal community of men."24 And,

Contrary to Laing's conceptions, in by far the majority of cases we cannot consider the patient in his predominant characteristics as an asserter of truth, a remover of the masks . . . the fragments of truth that he uncovers assume grotesque forms, and that he will apply these grotesque forms to the whole world to lessen his insight. . . .25

Schizophrenic art is private. It pertains merely to the "artist's way of seeing the world."26 It does not elicit a collective response. The patient purported to be doing art does not succeed or convince us, according to Arieti, "because he has not been able to control the eruption of primary process mechanisms."27
Likewise, poetry is inadequately written by the schizophrenic, according to the research studies reported by Arieti, because the schizophrenic is a slave to language while the poet is the master of his language. The schizophrenic trying to be a poet has difficulty distinguishing levels of abstraction and "differentiating the concrete from the abstract," we are told. Arieti, however, allows that "in some cases" creative works by sick schizophrenics, "can be a great enrichment. Together with the greatest terrors and greatest impoverishments I have at times found great truths and enrichments inherent in psychosis." Arieti warns his readers that they must not glorify the schizophrenic and make him think that he is anything more than a very sick and disturbed person. He tells us, "there is an important difference between the rationalizations of normal people and the absurd rationalizations of the schizophrenic." The rationalizations of schizophrenics, of course, are not based on a realistic congruence between "external facts," and "psychodynamic meanings and needs. It is only when the patient is told what he is doing and when we share with him the anxiety of the knowledge of what was once repressed that he will be less likely to resort to implausible rationalizations."
Arieti finds that schizophrenic thinking violates the laws of Aristotelian logic. He provides this example of the paleologic thinking process, "which must be considered inferior to the Aristotelian."\(^{32}\)

A patient thought that she was the Virgin Mary. Her thought process was the following: "The Virgin Mary was a virgin; I am a virgin; therefore I am the Virgin Mary." The delusional conclusion was reached because the identity of the predicate of the two premises . . . made the patient accept the identity of the two subjects (the Virgin Mary and the patient.)\(^{33}\)

This diagnosed schizophrenic could not function well in society since her logic failed to distinguish properly between her experiences and her fantasies created through the exercise of her primitive logic. Mircea Eliade, in contrast to Arieti, finds that for man to possess the ability to create symbols, he must be able to recognize, "the coexistence of contradictory essences."\(^{34}\)

Eliade reports that magico-religious experience makes it possible for man himself to be transformed into a symbol only insofar as man himself becomes a symbol . . . [then] all systems and all anthro-cosmic experiences [are] possible. Man no longer feels himself to be an "airtight" fragment, but a living cosmos open to all the other living cosmoes by which he is surrounded.\(^{35}\)

In the hands of Arieti, Aristotelian logic becomes the chief bulwark of normality against the perceived threats of schizophrenic thinking. John Vernon, in his study of the impact of schizophrenia on twentieth century
literature and culture, finds a severe problem with Arieti's analysis of schizophrenic logic. Vernon argues that

Arieti's definition is a perfect example of the impossibility of defining the concept "symbol" with the structures of Western thought. . . . The true sense of symbol is the opposite of the mapping function by which a symbol stands for something else. This is so radically true in schizophrenia that one patient has described the feeling of words in his mouth as the very objects those words stand for: "When I say 'street,' the whole street would be in my mouth, and it would be difficult for me to pronounce it."

Vernon finds Arieti's Aristotelian logic to be inferior in its possibilities for symbol formation to the logic of the schizophrenic discussed here. (Marguerite Sechehaye's patient Renee provides some additional examples of this schizophrenic symbolism.)

The Arieti theory and therapy centers around an educational effort to teach the patient the nature and virtues of reality. His case studies illustrate this convincing operation in action. Steering a middle ground between competing theories of etiology, Arieti consistently rejects all extremes as being non-professional. Yet, he doesn't take seriously the biochemical research or methods of therapy; while at the same time he manages to reject Laing and find the work of Sullivan less than fully adequate.
Arieti has branched out from his study of schizophrenia to write studies on human nature and creativity. The *Will to be Human*, published in 1972, won a major national book award for science. This volume constitutes a defense of advanced civilization against those who preach the virtues of the primitives, the psychotics, and so forth. Discussing shamanism, Arieti states that the shaman is supposed to have supernatural powers making him a medicine man, prophet, and leader. Shamans, we are told, communicate with spirits by going into trances:

> The trance is a sleeplike state of altered consciousness and dissociation . . . characterized by reduced sensitivity to stimuli, marked decrease of awareness and understanding of what is happening, and abolition or decrease of voluntary activity. The person has the feeling of being possessed by, or under the control of, an alien spirit, a dead person, a deity, a shaman, or an enemy shaman. . . .

Given this psychiatric analysis, Arieti finds it hard to imagine how a practice or institution which requires giving up one's will can be recommended. For him, going under the domination of an alien force is not an act of liberation.

The purpose of this attack on shamanism, which at first seems totally out of context and of questionable professional rigor, is to attack what Arieti describes as "Primitivization." This includes "all the mechanisms and habits which foster the primitive function of the psyche at the expense of higher level functions. Prominent among these functions are decontrol of the sexual and aggressive drives,
craving for immediate satisfaction and return to magic and shamanism." He finds Laing liable to simplify the problems of ordering the forms of mental illness and thus of advocating, or seeming to advocate, primitivization and the replacement of (or confusion of) medicine for politics.

When we call an event medical and not only political, we make fewer headlines, but we embrace more dimensions. I do agree that the world is by and large hostile, and ... I recognize that there is a relation between social hostility and the pre-psychotic and psychotic experiences. The hostility of the environment and the schizophrenic disorder, however, are two different sets of phenomena. The relations between these two sets are by no means so direct or so simple as some authors visualize them.

The difference is that, "whereas the simple psychopath can be seen as following a style of life based on the philosophy popularly attributed to Epicurus, the complex psychopath follows a style of life that combines some tenets of Nietzsche and some of Machiavelli." Arieti's understanding that he must defend liberalism in ethics and science against those whom he sees as opposing it are clear in this statement: "According to almost all ethical writers, the good life entails almost the opposite of what Nietzsche advocates. It means to stand for justice, equality, and goodness for the largest number of men and not to serve the gratification of the handful of Julius Caesars." No elaboration of this interpretation of ethics is provided. If Arieti becomes aggressive and somewhat confused upon entering the realm of philosophy and politics, he does not redeem himself with a foray into the arts in his next book.
His *Creativity: The Magic Synthesis*, develops a lengthy analysis of the major psychological traits and capacities needed to produce creativity. Unfortunately he doesn't understand very well the arts he purports to criticize. He states in a note that "some apparent exceptions, like cacophonous music, arhythmic poetry, and so on ... do not concern us." Richard Gilman reviewed Arieti's theory of creativity in *The New York Times Book Review*:

He offers nine "conditions" for what he calls the "creatovogenic" society and 10 for the creative personality (I'm reminded of a grade school art teacher who kept shouting at us that good paintings are characterized by "emphasis", "balance", and "rhythm"). He tells us like a social director or health columnist that "creativity is recommended for people of all ages," and solemnly declares that "art, music and literature are essential to achieve a spiritual level of life in which discord and hatred are less likely to occur."45

Arieti represents a middle range position in psychiatry: he seeks a median position between the biochemical and the genetics researchers; between those who utilize frontal leucotomies or ECT (i.e., physical therapies) and the psychotherapists; and between the threat of primitivization from Laing's supposed confusion of illness with normal reality, and the achievement of real creativity for all people. For Arieti, an attack on scientific research in schizophrenia is equivalent to an attack on all science and the progress of medicine. Yet he rarely makes use of research findings and is affronted by the rejection of
psychotherapy by those who practice physical or chemical therapies. Arieti embraces all prospectives, but rejects all extremes.

Although he does not seem to have much firsthand experience with chronic or severely deteriorated schizophrenics, he acknowledges the dangers of long-term hospitalization. As a psychotherapist, his own efforts are directed at countering the regression of the schizophrenic by painstakingly teaching his patients that it's bad to hallucinate, assume catatonic stances, and so forth.

There are conflicting, even contradictory, techniques in psychiatry for establishing the etiology, treatment and possibility of cure of schizophrenics. Arieti straddles the fence, preaching respect for science, moderation and liberalism as he understands these virtues, as the basis of a professional psychiatry of schizophrenia. The problems of moderation and common sense appreciation of simple, objective and normal reality become apparent when he ventures into anthropology to discuss the human condition, or into the arts to articulate the ground rules for creativity. Arieti's stance, however, demonstrates and reflects the dilemmas and splits within the field of psychiatry as it pertains to schizophrenia.

This thesis examines the development of the concept of schizophrenia from Emil Kraepelin to R. D. Laing. Instead of a progressive evolution, the simultaneous elaboration of contradictory, mutually exclusive assertions about
etiology and prognosis is the situation in the psychiatry of schizophrenia. Only with the work of Laing does schizophrenia come fully to be a concern of the human sciences. Laing creates a social theory based upon his model of schizophrenia. He portrays the schizophrenic as a hero desperately seeking an alternative to the normal split consciousness of contemporary man.
CHAPTER II

THE FOUNDERS OF SCHIZOPHRENIA:
KRAEPELIN, BLEULER AND JUNG

1. Emil Kraepelin

Emil Kraepelin (1855-1926) is renowned in psychiatric history as the great systemizer. Among his achievements he combined the syndromes of katatonia, hyperphrenia, etc., to formulate for the first time the disease concept of dementia praecox.

Dementia praecox for Kraepelin was a form of organic disease. He classified brain-related diseases according to the degree of internal, organic causation versus external, environmental causation involved in each one. "Dementia praecox was an endogenous illness, that is, one not caused by external causes."¹ Later Kraepelin believed dementia praecox to have had a metabolic origin.²

Kraepelin's Lectures on Clinical Psychiatry contains his great system of mental diseases. Vivid, clear-cut, objective, and precise lectures on each disease accompanied in the text by presentations of real, live persons as models of the various diseases under discussion. The gamut of diseases presented to the "gentleman" audience and the reader is quite wide-ranging. Lectures run from "Introduction: Melancholia," to "Cretinism--Concluding Remarks," and juxtapose such forms
of insanity as "Circular Stupor," "Dementia Praecox," "Kata
tonic Stupor," "States of Depression in General Paralysis," "Epileptic Insanity," "Alcoholi
c Mental Disturbances," "Insanity in Acute Disease," "Morphinism and Cocainism," "Dementia from Coarse Brain Lesions," and "Imbicility--Idiocy."³

His Lectures contain no references or footnotes to the work of others. A few colleagues are recognized in the text itself. The asterick footnotes in the volume indicate what has been the fate of the various diseased individuals who were discussed in the text. The theme tying together the various diseases of insanity in this study is the assumption continuously made that general deterioration into premature death is the expected result of any form of insanity. For Kraepelin, "One diagnosed by prognosis, as it were, and if the prognosis proved ultimately correct, the diagnosis was considered correct."⁴ Such fatalism about the diseases is obviously not an especially therapeutic response to the patient.

Kraepelin did not prove his assertions about increased morbidity and deterioration among the examples he provided--complete with footnotes telling of the fates of his patients--but rather utilized these individuals as specimen. The people presented never had names. They were
simply the best examples of the disease in residence. As Gregory Zilboorg points out, "The personal side of the patient's illness is but incidental or accidental," for Kraepelin's systematic biological conception of mental illness.

As his *Lectures* show, Kraepelin presided over a hospital which functioned chiefly as a diagnostic center to name and categorize various disease of insanity, make a prognosis (a prediction) about the outcome of the disease, send the case studies back to families or nursing homes to live out their diseases, and conduct an autopsy to verify the prognosis in order to improve the doctors' abilities to predict and diagnose. His systematic enumeration of mental disease stands as the highest achievement of this diagnostic art form—a system utilized with continuing modifications even today by the American Psychiatric Association.6

Patient No. I suffered from being depressed and from not having pursued his life opportunities with vigor and spirit. Such apparently healthy persons are really suffering from the dread and incurable disease, dementia praecox.

Gentlemen, you have before you today a strongly-built and well-nourished man, aged twenty-one, who entered the hospital a few weeks ago... He sits quietly looking in front of him, and does not raise his eyes when spoken to, but evidently understands all of our questions very well, for he answers quite relevantly, though slowly and often after repeated questioning.
He can only give a very meagre account of the general events of the last year. In answer to our questions, he declares that he is ready to remain in the hospital for the present. He would certainly prefer it if he could enter a profession, but he cannot say what he would like to take up. 

This peculiar and fundamental want of any strong feeling of the impression of life, with unimpaired ability to understand and remember, is really the diagnostic symptom of the disease we have before us. It becomes still plainer if we observe the patient for a time, and see that, in spite of his good education, he lies in bed for weeks and months, or sits about without feeling the slightest need of occupation. 

We have a mental and emotional infirmity to deal with, which reminds us only outwardly of the states of depression previously described. This infirmity is the incurable outcome of a very common history of disease, to which we will provisionally give the name Dementia Praecox. 

This patient "afterwards returned to the care of his family unchanged. He has now been in an asylum again for three-and-a-half years, dull and demented," according to the appropriate footnote. 

Lack of mental activity, interest, and energy are characteristics of dementia praecox. These are such fundamental indications that they give a definite stamp to the condition." Along with the symptom of "weakness of judgment, they are invariable and permanent fundamental features of dementia praecox, accompanying the whole evolution of the disease." When a person has dementia praecox, he proceeds to demonstrate the symptoms as the disease evolves and he organically declines.
Patient No. II demonstrated hallucination symptoms, a lack of appetite, and refusal to obey orders when given:

As he sometimes related, he heard voices which said all manner of things before him or called them to him. . . . He also saw flashes of lightning and a comet with a long tail. The sun rose on the wrong side. . . .

It is also to be noticed that for the last few days the patient has suddenly refused to eat, without any cause, so that it has been necessary to feed him artificially. He declined the suggestion that he should write to his wife, on the ground that he had more important things to do. He did not wish for a visit from her: it would really not be worth while. When told to show his tongue, he opened his mouth, but rolled back his tongue with all his strength against his soft palate. Once, for a short time, he suddenly became blindly violent against his surroundings, without being able to give any account of his reasons afterwards.11

Patient No. II was quite strong-willed and assertive against his doctors. This attitude seemed to be his major disease symptom. This patient made a "spontaneous" recovery of questionable validity. It was "an extraordinary recovery physically, but with no proper understanding of his ailment . . . apparently cured. . . ."12

The next patient suffered from advanced symptoms and was subjected to harsh treatment from the examining doctors in order to demonstrate the seriousness of his (physical) symptoms to the audience. Patient No. III

is a merchant, aged twenty-six, who comes into the room under guidance with closed eyes, hanging head, and shuffling gait, and at the earliest opportunity sinks limply into the chair. On being spoken to, his pale expressionless features do not show any animation; the patient does not reply to questions or obeys orders. If you stick a needle into his forehead or his nose, or touch the cornea, there follows a most slight blinking or flushing, without any attempt at defense.13
This patient later, "improved somewhat, but was twaddling and imbecile . . . taken home into family custody . . . Later on he went to a nursing asylum, where he died after the whole illness had lasted five years."\textsuperscript{14}

Patient No. IV was able to work at a menial job, was "physically healthy and capable of work, but wanting in ideas, unintelligent, dull and inaccessible. . . . she works, but lives in seclusion and associates with no one."\textsuperscript{15} This patient's capabilities to work, think, and socialize were drastically diminished, we are told, by the onset of dementia praecox.

Case No. V is Kraepelin's dramatic masterpiece of psychiatric analysis. Patient No. V suffered from katatonic excitement and must have given the assembled gentlemen quite a performance, in conjunction with his alienist:

Gentlemen, the patient I will show you today has almost to be carried into the room, as he walks in a straddling fashion on the outside of the feet. On coming in, he throws off his slippers, sings a hymn loudly, and then he cries twice (in English), "My father, my real father!" . . . He does not look up even when he is spoken to, but he answers, beginning in a low voice, and gradually screaming louder and louder. When asked where he is, he says, "You want to know that too; I tell you who is being measured and is measured and shall be measured. I know all that, and could tell you, but I do not want to." When asked his name, he screams, "What is your name?" What does he shut? He shuts his eyes. What does he hear? He does not understand; he understands not. How? Who? Where? When? What does he mean? When I tell him to look, he does not look properly. You there, just look! What is it? What is the matter? Attend; he attends not. I say, what is it, then? Why do you give me no answer? Are you getting impudent again? How can you be so impudent? I'm coming! I'll show you! You don't turn whore for me. You mustn't be smart
either; you're an impudent, lousy fellow, an impudent, lousy fellow, as stupid as a hog. Such an impudent, shameless, miserable, lousy fellow I've never met with. Is he beginning again? You understand nothing at all—nothing at all; nothing at all does he understand.16

Impudent Patient No. V was later handed over to the care of his family and was said to be doing well.17 This patient seems to have a remarkable ability to engage his doctor and to stand his ground, although Kraepelin appears to have the best of him in the dialogue of trading insults. The patient's side was never expressed.

The most frequent result of dementia praecox is "incurable mental infirmity."18 The significance of Kraepelin's ability to diagnose is "that we are now able, at the very beginning of the illness, to predict its resulting in a state of feebleness... complete and permanent recovery doubtful."19 Any improvement to be noted is doubtful and usually only temporary. "There is a great danger of relapse, usually in more serious form."20 Infirmity and general decline are imprecise, difficult to measure, but ever present realities in dementia praecox. Personality changes resulting from brain or metabolic causes are the normal course of events in Kraepelin's dementia praecox.

Family counseling and identification of the disease by general physicians is important to prevent the creation of false hopes for recovery. "Family physicians again can often help to prevent the marriage of the insane, or to those seriously threatened with insanity," because of tainted genetic inheritance.21 Remember
how great a part is played, in the daily round of ordinary medical practice, by the correct diagnosis of more or less morbid mental incidents. I need hardly mention that, for various reasons, such a diagnosis is in constant demand by the public authorities, courts of law, and trade societies. 22

Why this is so is not explained by Kraepelin. Genetic therapists such as Franz Kallman later take up this perspective with a vengeance. 23

In summary, the symptoms of dementia praecox specified by Kraepelin in his case studies include: negativism, automatic obedience, stereotypy, muteness, mimicry of speech, and greedy hunger combined with a refusal to eat proffered food. In Kraepelin's schizophrenia the patients, even if their deliberation is not affected in itself, involuntarily first follow that impulse which presents itself to them, only persistently to answer it in the most stubborn way with the counter impulse, or to repeat some senseless action or other innumerable times, in every case without any regard for their own weal or woe. It is clear that such a loss of connections between thoughts and actions, which perhaps rests on the profound destruction of the sensory life must quite rob the action of the inner unity and logical accuracy which we regard as the issue of healthy mental personality. 24

Kraepelin's quest for objective data to develop his system of classification and his diagnostic ability, combined with his organic and metabolic theories of etiology served to deny the possibility of treating his patients as persons. The therapeutic role of the doctor lost out to the scientific role of biological classifier. Kraepelin's upholding of the humanist Hippocratic Oath was lost in his quest for the ultimate system of scientific classification.
This split between therapeutic helper and scientist continues to be a dilemma in schizophrenic research and psychiatry. Eugen Bleuler, the next student of dementia praecox to be surveyed, managed to bring the humanist perspective of medical therapy back into the picture in a limited way. Assigning the etiology and prognosis of schizophrenia to chemical, biological or hereditary origins seems to drastically limit the role of helpers to alter or affect the onset or course of schizophrenia. Kraepelin and other early students of schizophrenia clearly demonstrate the problem of organic determinism versus human possibility. It is possible that Kraepelin's patients suffered such unfortunate fates because of the preordained theory of organic decline and early death they learned from Kraepelin. Kraepelin's dementia praecox may have been a self-fulfilling hypothesis.

2. Eugen Bleuler

Eugen Bleuler (1857-1939) headed the Burghozli, a large mental hospital facility near Zurich, during the early part of the twentieth century. He is responsible for a large amount of research and theoretical work on the concept of schizophrenia. Bleuler, in fact, created the new name for Kraepelin's dementia praecox and considerably humanized the prospect and understanding of schizophrenics. Bleuler was still, however, caught in the framework of nineteenth century mechanistic psychiatry. The analogies and metaphors utilized in his explorations of schizophrenia,
sound as if the "disease" constituted a series of mechanistic or chemical alterations in a human-body-as-machine. Ultimately, Bleuler admitted that no cause or cure had been identified.

For Bleuler, schizophrenia was a "group of psychoses whose course is at times, chronic, at times marked by intermittent attacks, and which can stop or retrograde at any stage, but does not permit a full *restitutio ad integrum.*" The uniqueness of schizophrenia for Bleuler was that it is characterized by a specific type of "alteration of thinking, feeling and relation to the external world which appears nowhere else in this particular fashion." Splitting of the psychic functions occurs in every case. In advanced cases, the personality of the patient "loses its unity; at different times different psychic complexes seem to represent the personality." At this point in Bleuler's discussion, it becomes unclear exactly what sort of *restitutio* he was referring to. He could have meant restitution to psychological or social normality; or perhaps to physiological or chemical restitution to a pre-attack or pre-disease state of the organism. Bleuler specified that, "In spite of all my effort I have been unable to see a true motor disturbance in dementia praecox. . . ." But he also said that "there are phenomena resembling brain pressure." Addressing his fellow professionals, Bleuler
wrote always as if schizophrenia were an organic disease, based primarily, in some unknown way, in the human organism.

Bleuler distinguished between a schizoid, or latent schizophrenic and schizophrenia as a mental disease:

Latent schizophrenics are very common under all conditions so that the 'disease' schizophrenia has to be a much more extensive term than the pronounced psychosis of the same name. This is important for studies of heredity. At what stage of the anomaly anyone should be designated as only a 'schizoid' psychopathic, or as a schizophrenic mentally diseased, cannot at all be decided as yet. 30

Psychopathic criminal behavior is here linked suggestively with the disease of schizophrenia. No evidence is presented, but the reader is encouraged to speculate on the latent, psychopathic, schizoid state, and its connections to the disease proper when he speculates on "hereditary burdening," the increase in crime in the contemporary world, and so forth.

Further on in his Textbook, Bleuler stated that, "Great importance is undoubtedly to be attached to hereditary burdening." 31 Yet, he did not pursue this position statement with empirical or theoretical research. Such discussions of psychopathology and hereditary burdening almost seem to be obligatory bows to the professional ideological beliefs of Bleuler's day. Yet they do seem to form a significant part of his legacy to current studies of schizophrenia.
Latent schizophrenics among the youth often become active, diseased individuals at adolescence when sexual capacities are activated. "Young people are nearly always schizophrenic who want to become something out of the ordinary just at the time when they are really failing, and who then believe that by particular tricks . . . they can free themselves from the situation and then neglect the essential thing in favor of the means."\(^3^2\) Such advice to guidance counselors and school authorities suggests that the function of psychiatry is to enforce particular models of normality among groups of potentially non-conforming individuals.

Bleuler saw schizophrenia as the major problem of psychiatry:

Except for the great group of mental defectives, dementia praecox is the most common mental disease. . . . Since for the most part, the schizophrenics remain incurable, fall sick early, and die late, their numbers among the permanent hospital inmates is larger than their number among general hospital admissions. Schizophrenic patients comprise 71 per cent of the men and 79 per cent of the women patients, or 75 per cent of the patients in our mental hospitals.\(^3^3\)

His study of simple schizophrenics among "eccentric people of every sort who stand out as world saviors and world reformers, philosophers, writers and artists," led Bleuler to suggest that the disease was far more widespread than previously thought. Bleuler related a fascinating illustration of this point about schizophrenia among eccentrics:
A young Swiss, who had successfully completed his studies in the commercial field, chose to become a naturalized German citizen in order to take up a subordinate officer's position in the German army. As such he took part in the war of 1866 and 1870, after which he became a photographer and wondered about from job to job as an assistant photographer and traveling salesman. Two attempts to become independent failed miserably; he lost all his money in these deals. His marriage at the age of forty did not alter the situation. He became increasingly more incapable and more indifferent, and finally stopped working altogether. He did not concern himself much with the fate of his children after his wife's death. He stayed home or sat around in bars, without, however, any real alcoholic indulgence. It was only at the age of fifty-two that he was admitted to a hospital for the first time. In this case, the presence of schizophrenia was revealed only by the fact that, without good reason, he gave up his vocation and changed his nationality.  

Distinctions were made by Bleuler between schizophrenics and epileptics and organic cases. While epileptics and organic cases, "withdraw into themselves," assuming attitudes resembling autism, the schizophrenics, "place themselves in conflict with and opposition to reality. Moreover, in non-schizophrenics, the isolation from the outside world is not complete in our patients." Non-schizophrenics may not be involved in the world happenings around them in this comparison, but they do immediately respond to it when addressed.  

Blockings (mental blocks) for non-schizophrenics are "transitory phenomena for which there are always some definite reasons that can be discovered." In schizophrenia,
the blockings seem to be insurmountable, not easily
discernible, and expansive, "outside their connection
with the complexes." No reasons could be found for
them in Bleuler's investigations.

Bleuler, who was a contemporary of Freud, believed
that Freudian psychoanalysis and emphasis on the sexual would
make it possible "to explain the special symptomatology of
schizophrenia in whose complexes sexuality does not play a prominat role." Yet Bleuler did not particularly utilize
Freud beyond honoring him. Bleuler's examples and case
studies tend to startle the reader with their applications
of psychoanalysis. In a supposed demonstration of the
importance of Freud, Bleuler related that

a novel of a well-known author enabled me to
predict many years in advance that he would
separate from his wife. . . . The correctness
of our diagnosis was established only later on.
A certain type of facial expression can lead us
to conclude that the patient practices fellatio;
a delusion may reveal the bad conscience of a
pederast.

The physics-like statements of causation found in
Freud seem to have been very attractive to Bleuler. His
explanation of schizophrenia, however, was not particularly
indebted to Freud or to the psychoanalytical model. Bleuler
adroitly blended mechanistic, organic, and psychological
explanations into his theories. Only when he says something
outrageous do we clearly glimpse his balancing act of
synthesis. Following is a listing of the major symptoms of
schizophrenia according to Bleuler, and an outline of his theory of symptoms.

The symptoms include:

(1) Impairment of reason and logic. Logical operations are faulty and yield incorrect results. Deviations from, "the ordinary train of thought given by experience also usually lead in wrong directions." For example, "All sorts of bad actions are motivated by the fact that the causal connection, if there is any at all, is the just the reverse."  

(2) Dereism. "Schizophrenics lose contact with reality, the mild cases inconspicuously in one respect or another, the severer cases lose it completely."  

(3) Will impairment. Weakness of the will manifested as apathy as well as in lack of persistence of the will, is a common symptom. Thinking, willing, and execution are all obstructed according to Bleuler. Thus, "The patients want something and at the same time want the opposite or when they want to execute an act, a counter impulse or cross impulse intervenes. . . . The patients believe they think and act under the influence of strange people or powers."
Being hypnotized, performing compulsive or automatic acts, command automatism, and so forth, are all examples of the impairment of will.44

(4) Delusions. In the schizophrenic, delusions tend to be expansive and have little or no logical connection between themselves. They are often chaotically disorganized. But they can become organized into affective needs: "The patients want to be more than they are and this results in the delusion of grandeur. They do not get what they wish for, and as they themselves do not want to admit that they are incompetent, the result is the delusion of persecution."45

(5) Flawed thinking process. For schizophrenics, "thinking operates with ideas and concepts which have no, or a completely insufficient connection with the main idea and should therefore be excluded from the thought-process. The result is that thinking becomes confused, bizarre, incorrect, abrupt."46 The chain of thought is sometimes interrupted, and "after such 'blocking', ideas may emerge which have no recognizable connection with preceding ones."47 For the healthy person, unimportant ideas are not bothered with; whereas the schizophrenic, "for whom nothing is of importance,
often jumps from one affect to another. By important, Bleuler seems to have meant logical and properly connected thoughts. Given this value, the schizophrenic flitting around among numerous thoughts, is found to be sadly wanting, according to these standards.

(6) Loss of boundaries. Some thoughts can become so powerful in the schizophrenic's system that they attain, "a certain degree of autonomy so that the personality falls to pieces. The fragments can then exist side by side and alternatively dominate the main part of the personality, the conscious part of the patient." Therefore, the patient, "may not only permanently feel himself to be the Emperor but he may also have lost his entire past. To be sure, he usually still knows [that] which he has formally experienced, but he ascribes it to another person; he himself has not experienced it."

(7) Delusions. The delusions are most characteristic of schizophrenia when they are not developed in the strongest contrast to the simplest reality, and expressed during periods of, "apparently clear consciousness." So that, "when a person continually produces entirely illogical ideas of persecution in a state of full clarity
of consciousness he is nearly always a schizophrenic; if the characteristic hallucinations are also present, the diagnosis is certain."\(^51\)

(8) The entire psychic environment. In schizophrenia, the diagnosis in ordinary cases is fairly easy. Bad affective rapport, inability to discuss matters, delusions, hallucinations, physical sensations, pronounced catatonic symptoms: all allow for easy recognition of the disease. "If the examination does not yield definite indications one should carefully ask whether there are people who annoy the patient; whether there is anybody in his neighborhood who is hostile to him. Often a secretive persecutory mania will then come to light. But nowhere as much as in schizophrenia are all individual symptoms to be evaluated in terms of their entire psychic environment.\(^52\)

There is no sure correspondence between the symptoms and the nature of the disease since the nature and cure for this disease is unknown. Therefore all symptoms are secondary. Bleuler did not know the primary symptoms. If he did, he would have known the "cause" and the "cure" of schizophrenia. His hypothetical theory of secondary symptoms sounds very mechanical.
According to Bleuler's Theory of Symptoms, wrong pathways--"pathways deviating from experience"--result from the loosening of the associations. The patient is forced to operate with fragments of ideas since certain parts are following or aligned with wrong pathways of association. "The latter abnormality leads to displacements, condensations, confusions, [improper] generalizations, clang-associations, illogical thinking, and incoherence."53

Thus, when the logical functions are stricken and weaken, the affects predominate. Blocking of unpleasantly-toned associations occurs at their very inception. And whatever conflicts with the affects is split off. This mechanism leads to the logical blunders which determine (among other things) the delusions; but the most significant effect is the splitting of the psyche in accordance with the emotionally charged complexes. Any unpleasant reality is split off by the operation of autism or transformed in the various delusional states. The turning away from the outer world can assume the form of negativism. The association-splitting can also lead to pathological ambivalence in which contradictory feelings or thoughts exist side by side without influencing each other.54

In some contexts, the patient behaved and responded normally--along properly developed experiential pathways. In other contexts, however, the patient demonstrated confusions characteristic of schizophrenia: "In a certain context a father believes that he is the mother of his children, by ignoring existing attributes of his own person and substituting attributes belonging to his wife."55
If the logical functions are weakened by the pathology in schizophrenia, the influence of the affects in their new association patterns spreads. As this process continues, "blocking which was limited at first to a specific thought or idea began to spread so rapidly that it quickly became impossible to talk to the patient about anything."56

As the blocking spreads, so does the splitting. In splitting, "the most inappropriate impulse can be transferred into action just as well as the right impulse."57

The term schizophrenia refers to two kinds of splitting, according to Bleuler:

behind the systematic splitting into definite idea-complexes, we have found a previous primary loosening of the associational structure which can lead to an irregular fragmentation of such solidly established elements as concrete ideas. The term schizophrenia refers to both kinds of splitting which often fuse in their effects.58

Taken together, the overt or secondary symptoms of schizophrenia represent, in part or entirely, "the more or less successful attempt to find a way out of an intolerable situation." At least three kinds of escape are outlined by Bleuler as his theory of symptoms:

(1) "refusing to let it touch him (autism)"

(2) "transform reality in accordance with the patient's wishes," or

(3) actual transformation of the accessible portion of reality, "in the sense of escape: they become manifestly sick," and take flight into disease.59

In these passages, Bleuler was strikingly modern on the one
hand with his references to an intolerable personal situation; yet quite mechanistic and disease oriented with his discussion of the hopeless flight into disease.

Treatment was possible in Bleuler's program, as opposed to the dementia praecox of Emil Kraepelin. But what or how to cure the schizophrenic disease was unknown by Bleuler.

Schizophrenic psychoses become overt "between the ages of fifteen and twenty-five, although in a more or less latent form it has been present for a long time."60 Latent schizophrenia, the schizoid state, is a concept and category which allowed Bleuler and his associates, as well as his successors, to perpetuate the hereditary and disease etiological interpretations with little or no empirical evidence to support it. As Bleuler stated in 1911, and is still the case today, "We do not know what the schizophrenic process actually is."61

Nonetheless, Bleuler did provide his thousands of patients a thorough program of treatment and education. This program centered around the teaching of discipline and self-control. There is in this program a therapeutic intent quite different from Kraepelin's attitude of hopelessness, and perhaps very close to the therapy of Arieti.

The principle rule is that no patient must ever be completely given up, the doctor must always be prepared to take action, and to offer the patient the chance to abandon his pathological way of thinking. Sufficient funds and
personnel should be available to give the patients the necessary care in the hospitals, especially there should be adequate space . . . to provide every patient with appropriate surroundings, and treatment, at the opportune time.62

Bleuler's education is more akin to manual training for the dull-witted. His mechanistic theory of symptoms leads Bleuler to see schizophrenics as people who cannot control themselves. He seems to assume that even the bright and creative become hopelessly dull and stupid: "For young schizophrenics capable of work simple vocations should be selected that lead to a life of practical activity, and not to theory and dereism."63 Work such as cutting and carding wool, making boxes, and "any sort of simple work" 64 is the basis of this therapy program. Laziness is to be discouraged whenever possible, presumably because it can lead to increasing disorganization. Education by any meaningful standard becomes difficult or impossible when one operates under the assumption that, "no dependence can be placed on the statements of the patients themselves."65

The prognosis for schizophrenics was that, "we know of no measure which will cure the disease, as such, or even bring it to a halt."66 However, Bleuler urged those afflicted, and relatives of schizophrenics, not to give up. Improvement might occur at any time.

Schizophrenia may come to a halt at any time, just, as for example, pulmonary tuberculosis. . . . However, if the symptoms are present at all, it is a matter of indifference as far as the disease concept is concerned, whether they are barely noticeable or markedly severe: in every case
they remain within the framework of schizophrenic symptoms. . . . However, the disease does not have to advance.\textsuperscript{67}

Bleuler also warned against giving up on schizophrenics and filing them away in asylums. He urged continuing changes in environment and repeated attempts to gain and maintain contact and access with the schizophrenic.\textsuperscript{68} He challenged societal strictures against suicide. Bleuler wrote that

People are being forced to continue to live a life that has become unbearable for them for valid reasons; this alone is bad enough. However, it is even worse, when life is made increasingly intolerable for those patients by using every means to subject them to constant humiliating surveillance.\textsuperscript{69}

Bleuler's educating of his patients, his therapy, and his anti-hospitalism teachings represented advanced standards in the treatment of schizophrenia. His standards are not usually met even today. They are progressive in light of the variety of therapies developed since Bleuler's time: lobotomy, shock therapy, insulin therapy, various drug therapies, and so forth, which do little or nothing to establish or maintain personal contact with the patient. His attitudes about denying schizophrenics intellectual activities are also prevalent in contemporary psychiatry. Bleuler's theories have not been proven false as yet, nor have they been replaced in contemporary professional psychiatry by an better organic theories or any more
humane treatment programs. His mechanistic, organic theory of causation represents the major position in psychiatry today. Treatment methods by electrical and chemical "therapies" have unfortunately advanced far beyond Bleuler. These advances, however, might also be seen as declines in the human treatment of those called schizophrenics. The etiology of schizophrenia has not developed much beyond Bleuler's work. The whole concept of etiology, taken from the research techniques of medicine, is seen by Harold Searles, Szasz, and Laing as inappropriate to research on schizophrenia. They believe schizophrenia to be an interpersonal situation. Chemical and genetic researchers, however, continue to search for the definitive etiology of schizophrenia in order to cure the disease whenever it occurs.

3. Carl Jung

Carl Jung was a colleague of Bleuler at the Burghozi Asylum at Zurich. Jung wrote a monograph on dementia praecox called by A. A. Brill indispensable for every student of psychiatry, and observed that it was, "the work which firmly established Jung as a pioneer and scientific contributer to psychiatry." Jung's work on schizophrenia, included in The Psychology of Dementia Praecox, emphasized the chemical and organic approaches,
as opposed to societal or mythological perspectives. His work on schizophrenia was totally at variance to his work in other fields.

Toxins injure the brain, according to Jung, "in a more or less irreparable manner, so that the highest psychic functions become paralyzed." Written in 1907, this study concluded that with the disease of schizophrenia, new ideas and experiences cease, "and the pathogenic complex remains the last one, and the further development of the personality is finally checked." Jung captured the dynamic spirit of Bleuler and Freud with his vivid biologic descriptions of schizophrenic disease attacking its helpless victim by means of a toxin:

Looking at it from the outside, we see only the objective signs of an affect. These signs gradually (or very rapidly) grow stronger or more distorted . . . it finally becomes impossible to assume a normal psychic content. We then speak of dementia praecox. Jung then gave a description of the spread of dementia praecox from the inside:

Looking at it from the inside (which naturally can be done only by means of complicated analogical inferences), we observe that the subject can no longer free himself from the complex . . . the inevitable result being a degeneration of the personality. No discussion of experience or non-brain toxin causes was attempted by Jung in this early analysis.
The hypothesis of his 1907 work is that: "the complex creates a condition in the brain functionally equivalent to an extensive destruction of the cerebrum." Jung's early work on dementia praecox is hailed as establishing his credentials as a scientist of psychology by retreating to a chemical etiology for schizophrenia.

By 1957, in an article reprinted along with the 1907 research, Jung came to advocating a dual etiology to explain schizophrenia. We are told that up to a certain point psychology is indispensable in explaining the nature and causes of the initial emotions which give rise to metabolic alterations. These emotions seem to be accompanied by chemical processes that cause specific temporary or chronic disturbances or lesions.

In 1957, Jung saw his position on the etiology of schizophrenia as being holistic and comprehensive. He asserted that a psychology of the unconscious must combine with the physiology and pathology of the brain to establish a true psychiatry whose concern is the total man. Apparently Jung's earlier theories on brain-toxin etiology for dementia praecox were not replaced with his later psychological theorizing. Experiential, societal and familial relations to schizophrenia, however, were not pursued or discussed even when they are admitted to be of equal importance to the brain-toxin approach. Jung, who wrote so fully about mythological traditions and prototypical human experiences, apparently found no room to scientifically deal with schizophrenia in his human experiential framework.
Of these three pioneer students of schizophrenia, Eugen Bleuler was perhaps the most open to alternatives. Exactly what factors were causative in his analysis, however, remains unclear. Zilboorg insists that Bleuler ultimately found schizophrenia not only treatable, but curable as well. While this attitude does not come through strongly in Bleuler's books, it is clear that his therapeutic approaches were models of care and attention fully within the humane tradition of Hypocrates, Pinel and Freud. Treatment and care should never neglect the possibility that improvement can and does occur. Inexorable decline is not foreordained. Stabilization could occur at any time, we were assured. Unlike Kraepelin, however, Bleuler did not give his readers the empirical data from diagnoses and analytical sessions to allow the reader to investigate the sources of his theories.

Bleuler falls into the humanist tradition in terms of his therapy and hopefulness. He normally, however, expected disintegration with schizophrenia—he didn't have much faith with any given patient. He did not elaborate the full range of possibilities inherent in schizophrenia. Harry Stack Sullivan and Frieda Fromm-Reichmann carried on and expanded some of the beginnings suggested by Bleuler's work. We can also find Bleuler well-represented in the writings of Arieti and of the genetics enthusiast Franz Kallman. For these medical pioneers, schizophrenia or
Dementia praecox is a pathological medical disease of unknown etiology and grim prognosis. This is mainline twentieth century psychiatry of schizophrenia, its assumptions pervade the contemporary theory and practice of schizophrenic therapy.
CHAPTER III

HARRY STACK SULLIVAN AND
FRIEDA FROMM-REICHMANN

1. Harry Stack Sullivan

Harry Stack Sullivan (1892-1949) brought to the study and treatment of dementia praecox the perspectives and concerns of the social scientist. In a society creating increasing numbers of mentally ill, he devised an experimental hospital program to heal the heretofore untreatable schizophrenic patient. William Alanson White's description of dementia praecox demonstrates the situation in psychiatry when Sullivan started his work.

Dementia Praecox is a psychosis essentially of the period of puberty and adolescence, characterized by a mental deterioration tending to progress, though frequently interrupted by remissions. . . . While it is customary to consider this disease as hopeless so far as being able to influence it by therapeutic measures is concerned, still this pessimistic attitude does not seem wholly warranted even though, in those cases that get better, we cannot define how much of the result has been due to treatment.1

If schizophrenia or dementia praecox was cured, it was not through the efforts of the doctors. Spontaneous remission of the disease was the major curative principle.

Sullivan's major principle of psychiatric practice, developed in his work with schizophrenics, is called the
"Species Identity Theorum." It is that "everyone and anyone is much more simply human than otherwise, more like everyone else than different." Sullivan elaborates that if psychiatrists were to regard schizophrenic patients as persons when receiving them, and if we attempted to discover what continued to be of interest to them, and we attempted to adjust the environment to which they are exposed in a fashion in harmony with these particular findings, we might then discover a rather remarkable recovery rate, if you will. In other words, we might find a way of restoring a lot of these people.

Instead of trying to explain or understand what patients mean by various hallucinations and delusions—which he found "cannot quite be done"—Sullivan called for an altogether different therapeutic stance. He found that it is extraordinarily useful to these patients to be reminded that whatever happened to them must be made up of things that everybody could experience, and has experienced; in their case these things simply took on a rather novel pattern for their time of life.

Recognizing schizophrenics as fellow human beings constituted Sullivan's beginning premise in therapy. Sullivan tried to utilize and incorporate the learning of his day in formulating his theoretical position. He utilized the model of schizophrenia proposed by Bleuler, but removed the mechanical implications of the original. Schizophrenia comes as a result of the "loss of control of the contents of consciousness":

1. Sullivan elaborates that if psychiatrists were to regard schizophrenic patients as persons when receiving them, and if we attempted to discover what continued to be of interest to them, and we attempted to adjust the environment to which they are exposed in a fashion in harmony with these particular findings, we might then discover a rather remarkable recovery rate, if you will. In other words, we might find a way of restoring a lot of these people.

2. Sullivan called for an altogether different therapeutic stance. He found that it is extraordinarily useful to these patients to be reminded that whatever happened to them must be made up of things that everybody could experience, and has experienced; in their case these things simply took on a rather novel pattern for their time of life.
What ensues is that there are highly refined referential processes along with much more primitive and general referential processes, coupled with observational data which one cannot treat to anything like one's satisfaction, partly because they are primitive and deal in rather cosmic terms with things that are essentially impersonal and partly because there is interference from remaining effective parts of the self-system which were carefully organized to cut off recall of things that would imply awareness of the dissociated tendency. 

Schizophrenia is a regressive process for Sullivan. Effective help can keep the schizophrenic from settling into one or another unfortunate outcomes. Even an actively schizophrenic patient can be cured. 

Schizophrenic is the opposite of communicative. How, therefore, does a therapist respond to a schizophrenic who is trying to communicate? Sullivan found that, 

You may expect, unless the patient is very badly deteriorated in his social interests, that some of the things he says will be simply communicative; that many of the things he says will seem communicative but will be of indeterminate meaning; and that some of the things he says will seem to be completely meaningless. 

Sullivan did not assume that he, as the therapist, had a monopoly on the reality of the situation, but he operated as if the ability of the patient to communicate with him was failing. He concluded that, "you may wisely assume that it is impossible to find a person who is utterly schizophrenic, which is preposterous on the face of it." Although efforts to communicate may fail, "people
don't say meaningless things, if they can help it."9
Therefore, a treatment strategy for Sullivan was that:
"when you get no suggestion of transference of intelligence, it is, I think extremely unwise for you to join in the psychosis by making use of words in God knows what sense which will be utterly meaningless . . . to the patient."10
Therapy constituted for Sullivan an attempt to re-establish the ability of the patient to communicate interpersonally.

Sullivan rejected the classification of schizophrenia according to the Kraepelin and Bleuler systems. He did make some distinctions, however, as shown in this differentiation drawn between schizophrenia and hebephrenic despair:

When we are dealing with the schizophrenic, we find a person who is pretty demoralized, who has little expectation of pleasant and useful development. . . . Yet, many of his utterances leave the door open to possibilities, however improbable. . . . The hebephrenic has despaired of any effective operation. He has had such disastrous experiences in his initial, rather frantic, schizophrenic attempt at doing something, that he has given it all up as a bad job.11

The psychological arena, as opposed to some unknown organic or mechanistic etiological pursuit, is Sullivan's focus. He finds in advanced cases of schizophrenia, the experimentation of the early schizophrenic has had the effect of wiping out any thought of success, where the person has literally given up the effort at living and contents himself with existing on a sort of modified auto-biological level. . . . If a person is really in despair, there are no particular utterances, and there is no particular behavior--except that possibly if he is standing and is shoved, he will walk, not very rapidly, for sometime in about the direction in which he was shoved.12
The hebephrenic chooses despair and operation on an auto-biological level as his best alternative. Organic diseases of the metabolic system or brain do not impose such demands on the personality, as Sullivan saw the situation. He distinguished pure paranoia and pure schizophrenia as imaginary opposites. He greatly preferred to treat a schizophrenic, rather than a paranoid who had settled into a rigid outlook on his interpersonal world: "every paranoid person has at some time been schizophrenic for a little while, which means that the universe has been apprehended and dealt with by much more primitive and less refined referential processes than those which later make up the substance of the paranoid state." Paranoia and hebephrenia are both possible outcomes of the radical opening of the personality system which characterizes the schizophrenic process. Sullivan was not impressed by assertions about hereditary burdening. Hereditary burdens, "may prove, when we finally learn to measure them, to be so general in their occurrence among the population as to be of but slight importance." The very title of his study of schizophrenia establishes Sullivan's stance on etiology: schizophrenia is a human process. Discussing the development of therapeutic research into schizophrenia, Sullivan concluded that, "Presumably
the archaic conception of mental disease and Kraepelinian
preordination has had a good deal to do with arresting the
clinical imagination and curiosity."\textsuperscript{16} And Bleuler's

Textbook continues to be a book of "asylum illnesses,"
sharing with the work of Kraepelin . . . as a com­
pilation of observational data on the developed dis­
orders illustrated with specimens . . . collected
after the abnormal reactions had become habitual and
relatively immutable adjustments to reality.\textsuperscript{17}

For Sullivan, the normal professional treatment of
schizophrenics was seen as the institutional care and clas­
sification of those considered to be hopeless by their
doctors. Helen Swick Perry points out in her introduction
to \textit{Schizophrenia as a Human Process}, that the medical dictum
of the time was, "If the patient recovers, then he couldn't
have been schizophrenic: he was obviously misdiagnosed."\textsuperscript{18}

Sullivan posited

two unrelated syndromes under the rubric of dementia
praecoxx. . . . One syndrome is the congeries of signs
and symptoms pertaining to an organic, degenerative
disease usually of insidious development. These
patients are finally discovered to be psychotic. . . .
Their outlook is very poor--even, I surmise, under the
treatments by partial decortication that now enjoys
such vogue.\textsuperscript{19}

Apparently Sullivan did assert the existence of dementia
praecoxx as the asylum disease of organic etiology, but
argued that the interpersonal breakdown and confusion which
he called schizophrenia was often misdiagnosed as dementia
praecoxx. Sullivan admitted he knew of no effective treatment
for this organic disease, but he rejected any treatment for it reduced "the patient's capacity for being human." After this finding, which served to place a mysterious limitation on this theory of interpersonal relations, Sullivan apparently wrote no more about the distinctions between dementia praecox and schizophrenia.

The human growth and development process articulated by Sullivan constituted his model of the good society of interpersonal relations—in contrast to the aberrations of social failure and mental illness. Sullivan suggested in his social criticism of the functioning of families, teachers, and even political leaders, that a well-functioning interpersonal system could prevent the development of schizophrenia. He found that in peacetime "no one becomes schizophrenic who has achieved a really satisfactory sexual integration with another person of comparable status." He may have later given up this formulation, his final position on this idea is unclear. This hypothesis is among the most intriguing in psychiatry, but probably too imprecise to effectively test.

The adult model of successful sexual integration presented by Sullivan is based on his study of males. In *Personal Psychopathology*, a note on female adolescence reported that for females, "sexual sensations are more vague and less consciously realized than is the case with the genital manipulation with the male. . . ."
Unlike Freud, who placed stress on the first few years of life, Sullivan emphasized all early phases through adolescence. This provided him with a much wider societal field to criticize and seek to effect with his teachings.

Children and juveniles seek nothing from society, or psychiatry; "their 'problem' is really the environment's problem in 'dealing with' them. Anything done through the parents is accomplished in personalities already beaten into the mold of the past."23 Preadolescents, however, do actively seek the help and knowledge of people. With the coming of preadolescence, the interest of the male person, "swings inevitably toward an individual of his own sex. He is not happy unless he has a boy with whom to associate."24 The adolescent develops, or tries to develop techniques for intimate living with other persons. The maturation sequence postulated by Sullivan included these important steps:

Beginning near the age of nine, adolescence all but always reaches into the twenties, and frequently into the end of life. Initiated by the coming of the urge to intimacy . . . it progresses through collaborations with members of one's sex, through mid-adolescence, the era of patterning of sexual behavior, and late adolescence, the era in which the individual seeks his place in the world as shaped by his needs for interpersonal relations. One becomes an adult when one achieves a thoroughly satisfactory interpersonal integration, particularly in the field of sexual relations.25

If the boy has come to mid-adolescence with no serious warps of his personality,
the undergoing of genital gratifications as a result of the encounter is but an added incentive to personality growth. It is a sexually pleasant experience, but one that includes unpleasant experiences . . . as if in violation of the traditional and rational elaborations in his personality as to sexual activity.26

The boy then proceeds to seek a more acceptable sexual partner. But adolescent sexuality can lead to inadequate results in Sullivan's interpretation, if an inadequate or improper attachment to the mother exists:

one for example who has been seriously warped by the continued or augmented importance of a more or less primitive attachment to his mother, and who therefore is not susceptible to any marked heterosexual drives because of the attachment to the mother . . . stimulated genitally, [he] finds in the homosexual situation the satisfaction of the sexual motivation, and . . . a path out of the dilemma in which the growing sexual aspects of his personality [are asserted]. . . .27

Failing satisfactory integration at the heterosexual, or adult level, the person may stay at the adolescent level, or he may establish an inadequate homosexual integration. Prolongation of the mother attachment is the primary cause of schizophrenia as well. Very few achieve full heterosexual integration, Sullivan believed. He looked to the social structures and institutions of society to find the causes. Sullivan became a social critic to seek changes as regards the growth and development process in his society.

Objecting first to laws and social strictures which prohibit the kind of adolescent experimental sex which he deemed essential to the achievement of adulthood, Sullivan was strongly critical of the existent socialization processes.
However, "there are occasional successful growths of personality through the juvenile era, despite the prevailing state of our culture. Some people come to preadolescence with well-integrated personalities. Some fewer proceed finally to the psychobiological status of adult."\(^28\)

Parents assume a function in Sullivan's model which they are usually unable to fulfill.

Their injunctions, rules, and regulations being exteriorizations of their none too adequate personality, often the more treasured in that they represent sacred hereditaments of sainted parents "minded" all too late by the offspring, are degraded by comparison with the degenerate mismanagement of contemporary upstarts. Insecurities, private miseries from concrete disappointments in status pursuit, defensive stereotypes, a great body of parental deviations that have sought perhaps unwitting satisfaction in their child as an extraversion of personalities—all these are activated as the juvenile shows signs of coming under external influences inimical to a continued identification with a parental stereotype.\(^29\)

Sullivan found that teachers, "provide a rich field for the study of mental processes none too adjustive."\(^30\) As for politicians, Sullivan found little to be encouraged about in their role as the creators or administrators of the welfare system. The dilemma was that, "politicians depend for their living on other people's unsatisfied wishes and discomforts, and enjoy power chiefly because the public still expects miracles by which words propaganda will be converted into deeds of welfare."\(^31\) Sullivan concluded that politicians, "feed propaganda to the hungry," without feeding
them or meeting their needs. It seems that Sullivan did not have much of a philosophical appreciation of political possibility beyond the material.

Given these views of the family, school, and political systems, Sullivan's feelings of sympathy and compassion for young schizophrenics—the victims of the failed society—are not surprising. In Sullivan, the human therapist replaces the systemizer, organically-based etiologist; with his descriptions of the onset of schizophrenia, and advocacy of social and political reform. So strong were his writings on the plight of the schizophrenic patient, that the reader concludes that Sullivan must have seen the situation through the eyes and experiences of the schizophrenic himself!

In fact, think of the weak ego that makes a schizophrenic kid just before the smash get jobs in house-to-house soliciting to make a man out of himself. It is a funny meaning for "weak," isn't it? Schizophrenics are the people who suffer most intensely from the problem of "what will the next person be like?" with never a suspicion that he might be pleasant. Yet this boy I have just mentioned exposes himself to every sort of Tom, Dick, and Harry under the worst possible circumstances in order to become a man. . . . Let us talk about the extreme poverty of favorable opportunity that the schizophrenic has had for building a successful self-system because, early in life, the idea was conveyed inescapably to him that he was relatively infra-human, a burden of sorts.32

The schizophrenic was seen by Sullivan as the victim of a sequence of situations which deprived him of opportunities to develop his interpersonal capacities. Diagnosis of
cases by Sullivan apparently focused on distinguishing the interpersonal from the malignant causes of breakdown. His strategies of therapy and sympathies are clear in his case studies:

The patient is the product of an extremely traumatic childhood, during which she was deserted by her mother and later abandoned to the care of the maternal grandparents by her father, who was himself unreliable. In the grandparents' home she was treated more or less as a servant; but as she was very gifted intellectually, she managed to finish college and earn a Ph.D. in economics. She married a fellow-student in the same field and became a housewife. Her husband is extremely critical of her as a housekeeper and has frequently told her about romantic entanglements with other women, always presenting these women to her as romantic ideals. During the ten years of marriage in which two children have been born, the relationship has steadily worsened, with the husband threatening divorce and immersing himself in his work, and the wife leading an increasingly inactive and isolated life.

Sullivan found nothing "malignant" in this case of a schizoid. He found the husband, however, an "insecure tyrant" and maybe himself a "schizoid." He recommended psychotherapy for the husband, wondering about his "almost classically autistic" love affairs. Sullivan hoped that together these people might find some pleasure instead of dullness in their lives.

More specifically, Sullivan posited a general formula for situations leading to the interpersonal breakdown of schizophrenia: "schizophrenic illnesses in the male are intimately related as a sequent to unfortunate prolongation of the attachment of the son and mother." Failure of growth of heterosexual interests and persistence of autoerotic or
homoerotic interests during adolescence is the result of the failing of the mother-son relationship, according to Sullivan's model.

A person's ability to manage difficulties in his or her life varies greatly "on the basis of the experience which is the foundation of the self system, the organization of experience reflected to one from the significant people around one--which determines the personal characteristics of those events." Each personal experiential history is unique. Sullivan claimed that he found no general formulae can be applied by the psychiatrist. For example, Sullivan wrote about the Freudian position on the "effects of the mother complex," that,

I have learnt to avoid these generalizations. The significance in personality development of particular courses of events with others seems more generally to inhere in nuances than in the gross pattern. . . .

Mental illness results from experiences becoming dissociated from the self system. Sullivan suggested a formula for understanding the effects of dissociation. He reported that the larger the proportion of energy systems in a personality which act exterior to the awareness of the person, the greater the chances that he will meet some crisis in interpersonal relations in which he cannot act in the fashion which we call mental health.

One might conclude, given this model, that dissociation is bad. However, Sullivan found, according to Patrick Mullahy, some dissociated tendencies may be superior to the self system. So a breakout of dissociated tendencies resulting in
schizophrenia may be an advantage if it serves to incorporate superior attributes into the self system. Thus, an "expanding of the self to such final effect that the patient as known to himself is much the same person as the patient behaving with others," may occur. Such a psychiatric cure may be followed by a social cure which opens possibilities for "a more abundant life in the community." Sullivan didn't discuss the contribution a schizophrenic person could make to such a community.

Schizophrenia is a process of the self attempting to incorporate (unrecognized) personality attributes. A schizophrenic may be aware, "in a disowned 'they' fashion," of the attempt of the dissociated aspects of the personality to become integrated into the self system, but he cannot appreciate the attempt experientially. "Everything in his 'personal awareness'--for he now has two--repudiates any suggestion that the experiences are not real, or that they arise from unrecognized needs and desires." Therapy constituted talking to the patient in terms he can understand, helping him deal with his disorganization and confusions. Treatment of schizophrenia is successful when the patient learns "not to manifest symptoms to the environing persons," thereby demonstrating an adequate interpersonal capacity. This sounds like what Sullivan meant was self-control, the ability to reject any dissociated tendencies that might arise.

The subject matter of psychiatric research and therapy, Sullivan stated is not sick persons but "complex,
peculiarly characterized situations." In a case Sullivan reported, curative treatment "arose not by an analysis of his [the patient's] difficulties in a cooperative physician-patient relationship, but by utilizing socio-psychiatric factors. That his personal insight was not greatly increased is obvious; that his social insight, as distinguished from insight into the roots of certain of his motives, was increased to an extent sufficient to abolish the schizophrenic situation is evident." Organic-medical functions are distinguished from social scientific-interpersonal ones. And social science functions are seen as determining the outcome. No compromise with the organic or somatological factors--or explanations of their impact--was made by Sullivan. He did, however, distinguish between dementia praecox and schizophrenia.

Treatment consists of (re)creating an appropriate interpersonal environment for the person who suffers from inadequate interpersonal abilities. Education replaces medicine in this model of treatment. The patient must be taught to control his dissociated tendencies. His education is very much like Arieti's, except that Sullivan took the side of his patients, not of the social order as did Arieti.

Sullivan related how he has used this interpersonal model in the case of a schizophrenic boy,

who was delusional and has to be tube-fed part of the time. The content of the boy's verbalizations is extremely sparse, on the average of one coherent sentence for each therapeutic hour. . . . He has had a love affair which terminated by the girl marrying
someone else. Whenever he mentions this girl, it is always in terms of the fact that she is out of his mind, that the affair with her is of no importance, and so on.45

Sullivan claimed to know better, however, as he responded to the boy:

once I have startled the patient into . . . alertness by some variant of "nonsense, you like her," I continue the attack by some such remark as "And there's no reason on earth why the pleasure you had in her company should be thrown away just because the relationship didn't last forever."

What I am really doing here is something of much theoretic complexity. In so far as he was happy with this girl, he has proved that he can be human and enjoy life. Now that is far too important for me to leave it alone, no matter how ghastly the finish of this relationship was. It indicates that the patient has some asset which can be extrapolated into the future—that he might again be happy with someone.46

Maximizing the interpersonal assets of the patient was Sullivan's intention.

Working with schizophrenics is an enormously difficult undertaking, Sullivan assures us. Common sense approaches will often not work. A good deal of theoretical understanding and experience is essential.

The distress of the supposedly healthy person—his discomfort, his desire to depart, to overwhelm the disturbing other person, to correct him, to do something, all without any idea of what has happened to make him so insecure—is enough to explain much of the aggravation that schizophrenic patients undergo rather swiftly after the first appearance of the schizophrenic phenomena.47

Young physicians working with schizophrenics are notoriously subject to "transference jams"; they are being overzealous in trying to help their patients.48 Working to cure this interpersonal phenomena called schizophrenia was
seen by Sullivan to be one of the most difficult undertakings of a therapist. Therapy is feasible only if one knows what one is doing. The effort required, however, is not ordinarily available within a community.

Treatment of schizophrenia is best done in special environments established for this purpose. The idea of therapy is to establish a communal situation in which the patient is made to feel that he is now one of a group, composed partly of sick persons—the other patients—and partly well folk—the physicians and all others concerned. Emphasis is laid on the fact that something is the matter with the patient, and . . . everyone who is well enough to be of help will from thence-forth be occupied in giving him a chance to get well. From the start he is treated as a person among persons. 49

So important is the organization and functioning of this hospital community for Sullivan that he equated knowledge of psychiatry with experience in the mental hospital. "The good mental hospital offers opportunities for learning interpersonal reality such as most of us encounter elsewhere only in infancy." 50

The employees of a Sullivan style good hospital must have a radically different view of patients if the community is to work. If employees ceased to regard the patients as simply "insane," and instead stressed the points of similarity between the patient and themselves, "we found that intimacy between the patient and employee blossomed unexpectedly, that things which I cannot distinguish from genuine human friendships sprang up between patient and employee, that any signs of the alleged apathy of the schizophrenic
and that the institutional recovery rate became high."\textsuperscript{51}

Between 1923 and 1931, at Sheppard-Pratt Hospital, Sullivan actually created and ran wards designed according to his theoretical specifications. Perry reports on the design of one such facility to treat schizophrenics:

This special ward, consisting of six beds . . . was housed in a relatively new building which was separated from the other buildings [and] . . . was uniquely cut off from various usual hierarchical structures that exist in any hospital. The freedom with which Sullivan was allowed to run this ward was quite remarkable. . . . In the first place, the ward was entirely removed from the supervision of the Nursing Service; in fact, no woman was ever allowed on this ward.\textsuperscript{52}

This experimental ward for treating schizophrenics sought to recreate the interpersonal situations predominant in preadolescent society to provide the (male) patient with the opportunity to develop those particular experiences associated with this time of life and thereby to allow the patient to rebuild his interpersonal capacities vital for recovery.\textsuperscript{53}

Sullivan believed that hospitals often create and perpetuate hebephrenic dilapidation. Although such a condition is reversible, "on the other hand . . . attempts at therapy are often wholly ineffectual. After a patient has been out of contact with the ordinary courses of life for several years, it is often entirely impractical to expect more than an institutional adaption to be possible for him."\textsuperscript{54} Hospitalization and the creation of back ward
situations where schizophrenics are left as hopeless, without therapeutic help, was seen as the normal situation by Sullivan in his day.

A good mental hospital, Sullivan asserted, "is the only place where one can be 'crazy' comfortably. It is used to these sorts of performances and, through its classification of patients, is more or less obviously able to deal with them intelligently." It is unfortunate, Sullivan suggested, that "until recently," voluntary admission to the mental hospital was illegal or impractical.

For Sullivan, the psychiatrist can confidently create or recreate institutions as complex as mental hospitals, for the therapeutic good of the patient. Such a possibility is new, as can be seen by comparing Sullivan's model hospital to Kraepelin's categorizing institution, or Bleuler's training center for mental defectives. Such faith in institutions does not last long in psychiatry, however. Arieti's warnings about hospitalism constitute a loss of faith in institutional possibilities even in mainstream psychiatry. With Frieda Fromm-Reichmann, in many respects Sullivan's heir and successor, we see the locus of therapy shift from large public hospitals to private small scale centers.

Sullivan, however, was more worried about the family environment that the patient returned to. "The
return following hospitalization all too often is into a 'morbid situation', often before the patient has gained sufficient insight to enable him to avoid 'immediate damage'."56 He called for the creation of "convalescent camps and communities," as half-way stations for recovering schizophrenics.

Institutional management represents a high and noble achievement for Sullivan. "The superintending physicians of mental hospitals may well give attention to the control of the commonplaces of their patients' lives and may well begin to use the knowledge at their disposal in the management of personalities towards the goal of common knowledge,"57 allowing and encouraging patients to grow in interpersonal capacities. What politicians, teachers, and parents cannot do, a well run psychiatric community can. The pernicious, destructive environments young people are forced to live in can be corrected by the proper application of psychiatric knowledge. Hopes that psychiatry will reform itself, however, appear to be shaky—probably for institutional-bureaucratic reasons. Given all the failings Sullivan found in families, schools, and political leaders, his faith in psychiatry is curious. Yet I find no false notes in Sullivan, he genuinely believes his program and theories will greatly advance schizophrenic therapy. But much of what Sullivan stated
about his theoretical system is artful and personal in its application. How many Sullivans can a profession produce in a generation? The enormously creative enterprise of therapy of schizophrenics does have its practitioners, and its former patients with expanded self possibilities. Their number, however, is probably very small almost by necessity, given the numerous constraints in the family, the community, and in badly run hospitals. The exploitation of schizophrenics is today still the norm, the expected result of undergoing this set of experiences. Therapy with schizophrenics is extremely difficult, as in Sullivan's day, it is a rare art.

The significant achievement of Harry Stack Sullivan is that he forever removed schizophrenic behavior from the "simple word salad" class of incomprehensible talk and behavior. Defining schizophrenia as a human experience of confusion and error, rather than as an organically based disease whose victims regress into the sub-human and await an early death or permanent brain damage, is Sullivan's great achievement. As he observed, "We have found in the most disorganized group of people . . . a continuation of very much that is simply human." Contributions by schizophrenics to society and culture were not discussed by Sullivan. He saw them as victims, not as persons who might choose such a state.
Surveying his work, one sees a complex mix of socio-political theories and medical authority over hospital systems as the basic sources of his solution to schizophrenia. If we give up organic etiology theories, however, what are the grounds for the therapist's authority? Sullivan's blending of social science with medicine serves to raise this question. On what criteria, therefore, can we judge his criticisms of family, school, or political leaders? This important question will be addressed in the remainder of this dissertation.

2. Frieda Fromm-Reichmann

Frieda Fromm-Reichmann (1890-1957) advanced the theory and practice of therapy with schizophrenics by her individualizing and humane treatment attitudes. She securely established, according to Walther Riese,

the liberation of psychotherapy from any preconceived nosological idea, which implies the thesis that the mechanism involved in both neurosis and psychosis are fundamentally the same. Indeed, they simply are the equipment of human nature.59

Riese places Fromm-Reichmann in the same category as Freud and Philippe Pinel for her contributions to the humanization of schizophrenic treatment.

The principles of psychotherapy that were applied by Fromm-Reichmann to schizophrenic therapy are the processes of repeating and reviving the past pathogenic situations and relations. This catharsis process constitutes the major tool of the psychotherapist. Fromm-Reichmann carries this therapy
to the psychotic patient "with intelligence, caution, and
diplomacy as perhaps never before" in the history of medi­
cine.60

Although Fromm-Reichmann has expanded the psychother­
apeutic model of treatment to include psychotics, institu­
tional psychiatry has generally failed to follow her lead or
to emulate her achievements. This disjunction opens some
interesting questions about the goals and purposes of insti­
tutional psychiatry for schizophrenics, and other severely
disturbed persons. Fromm-Reichmann demonstrated and assert­
ed the human nature of this heretofore thought to be organic
brain disease. Yet genetic and chemical researchers con­tin­
ue to dominate the psychiatric treatment of schizophrenics.

Compared to other therapists who have achieved
theoretical breakthroughs in the therapy of psychotics,
Fromm-Reichmann has written very little. Her one book,
Principles of Intensive Psychotherapy, a standard teaching
manual in the profession today, has been supplemented by a
volume of her papers written in the United States, edited
and published by her students after her death. Her theo­
retical points are few and quite explicit. The four pre­
mises of her therapy with psychotics, called the "Philosophy
of the Problem," are:

(1) Psychosis can be successfully treated;

(2) A psychotic patient can emerge as an artist of rank;
(3) Human experiences differ in degree, not kind;
(4) Sensitiveness, alertness and consideration of
the patient are the skills needed by the psycho-
therapist. 61

Unwilling to make any qualifying limits, Fromm-Reichmann
moved beyond Sullivan in asserting clearly that all psy-
chose can be treated. There are no distinctions here (as
there are in Sullivan) between schizophrenia as a human
interpersonal problem and dementia praecox as an organic
disease leading to brain damage, deterioration and eventual
death.

Further, she found that it is possible for the psy-
chotherapist to see (and help) patients convert their
"mental liabilities into various types of assets." 62 The
mysterious phenomenon of spontaneous remission is not part
of her therapy. Fromm-Reichmann reported that a patient
of hers became a good poet by converting the "utter lone-
liness and isolation," which first made for the development
of her mental illness, "by expanding her ability to express
her lonely strivings in poetic language." 63 A former psy-
chotic patient can use powers and skills developed "to
counteract his difficulties in living, and the mental symp-
tomatology derived from it toward a creative end." 64

Finally, a mental patient can rechannel his creative ener-
gies by the process of sublimation into artistic achieve-
ments. Citing examples of a number of artists and writers,
discussing their achievements together with their psychotic experiences, Fromm-Reichmann found that schizophrenia can result in enhancing one's creative explorations.

Intensive psychotherapy has not been used much to help the schizophrenic; Fromm-Reichmann attributed this to a "lack of psychiatric skill and knowledge among professional therapists." Most psychiatrists, observed Fromm-Reichmann, work for the society that pays them to achieve "a conventional adjustment to society" rather than for the needs of the patient. Fromm-Reichmann's resolution of this control problem, however, raises a series of additional questions.

For psychotherapy to be effective, the patient must be elevated from the object of therapy to an equal partner of the therapist. Therapy which aims to modify a patient's basic interpersonal attitudes to allow him to live with satisfaction, whatever the psychiatric diagnosis, was according to Fromm-Reichmann, following Freud and Sullivan--"radical therapy." It is presumably radical because it seeks to improve, not merely adjust the patient's life situation and possibilities.

As to the value neutrality of the therapist in dealing with the psychotic patient, Fromm-Reichmann followed Sullivan in rejecting the "Victrola-Record" attitude of traditional psychotherapy. Therapy with psychotics requires "the attention of a psychiatrist who is careful to show that he is genuinely concerned with the patient's welfare and
that he is methodically trying to re-establish the lost spontaneity of the patient in active interaction."\(^69\) Such an objective recording-attitude, without personal response, may serve, Fromm-Reichmann suggested, to "mask the analyst's personal timidity."\(^70\) She thereby rejected the "scientific" attitude underlying much of psychiatry, that the therapist must not demonstrate a subjective appreciation by siding with the patient. She found that such value neutrality is not the criteria needed to make psychiatry a human science.

Fromm-Reichmann recognized that changes in the world situation can and have greatly changed the context of therapy and the role of the therapist. Discussing severe anxiety in her patients, she posited that, "No matter how painful the experience of severe anxiety is, it is less painful than the fear of becoming a victim of atomic warfare."\(^71\) Anxiety, and psychotic behavior that may result therefrom, had become an increasing concern to therapists because of its potential massive proliferation in the post-atomic era.

"Most psychoanalytic authors maintain that schizophrenic patients cannot be treated psychoanalytically because they are too narcissistic to develop with the therapist an interpersonal relationship that is sufficiently reliable and consistent for psychoanalytic work."\(^72\) Following Sullivan, Karl Menninger, and so forth, Fromm-Reichmann reported successful treatment of psychotics at
her Chestnut Lodge Sanitarium. To demonstrate that schizophrenics can develop workable transference reactions, Fromm-Reichmann provided this example, chosen from a number reported in her book and papers. A suspicious patient,

after two days of fear and confusion ushering in a real panic, became stuporous for a month--mute, resistive to food, and retaining excretions. In spite of this rather unpromising picture, I sat with him for an hour everyday. The only sign of contact he gave to me or anyone was to indicate by gestures that he wanted me to stay; all that he said on two different days during this period was: "Don't leave!"

One morning after this I found him naked and masturbating on the floor of his room, which was spotted with urine and sputum, talking for the first time, yet so softly that I could not understand him. I stepped closer to him but still could not hear him, so I sat down on the floor close to him, upon which he turned to me with genuine concern: "You can't do that for me, you too will get involved." After that he pulled a blanket around himself saying, "Even though I have sunk as low as an animal, I still know how to behave in the presence of a lady." Then he talked for several hours about his history and his problems. Finally I offered him a glass of milk. He accepted the offer, and I went to get it. When I came back after a few minutes his friendliness had changed to hostility, and he threw the milk at me. Immediately he became distressed: "How could I do that to you?" he asked in despair. It seemed as though the few minutes I was out of the room was sufficient time for him to feel that I had abandoned him.

His confidence was regained by showing that I did not mind the incident. And for eight months of daily interviews he continued to talk.73

Although psychotherapeutic sessions were going well, this patient was removed from the sanitarium before his therapy was completed.

A good part of Fromm-Reichmann's technique revolved around her refusal to give up on a patient under any
circumstances, even in the face of physical threats or abuse:

A catatonic patient refused to see me. I had disappointed him by responding to his request that someone should spend the whole day with him by promising to make arrangements for a nurse to do so instead of understanding that it was I whom he wanted. For the following three months he threatened me with physical attack when I came to see him daily, and I could talk with him only through the closed door of his room.

Finally he accepted me and at the end of a two-and-a-half hour interview stated very seriously: "If only you can handle this quite casually and be friendly and leave the young people [the nurses] out of it, I may be able to work things out with you." The next day in the middle of another hour of confused hallucinatory talking, he went on: "This is a great surprise to us. There were lots of errors and misunderstandings between us and we both learned quite a bit. If you could arrange for me to see my friends and to spend more time on an open ward, and if you remain casual, we might be able to co-operate." It is scarcely necessary to suggest that we acted in accordance with his suggestions.

Responding to the patient as if he knew his own mind and could help direct his own therapy is extraordinary in the psychiatry of schizophrenia! Fromm-Reichmann's willingness to assume that the patient is an equal partner is readily demonstrated by this exchange.

Sympathetic understanding and handling of the mutual relationship between therapist and patient, and not the intellectual or cultural understanding of schizophrenia, is the decisive factor in therapy for Fromm-Reichmann. Dogged persistence and patience seem to be qualities that make her a distinguished therapist. If successful therapy
is eluding the therapist, and her relationship to the patient is stormy and unpredictable, Fromm-Reichmann believed that "it is due to the inevitable errors in the analysts' approach to the schizophrenic, of which he himself may be unaware, rather to the unreliability of the patient's emotional response." 75

Analysts know very little about the language of the schizophrenic unconscious, "and our access to it is blocked by the very process of our own adjustment to a world that the schizophrenic has relinquished." 76 As a consequence of this understanding, Fromm-Reichmann "was even reluctant to offer interpretation herself and preferred to listen, without theoretical prejudice, to the schizophrenic patient." 77 No single interpretation was thought to be the correct one. If these operations and her case study fragments are accurate representations of her therapy, Fromm-Reichmann did indeed achieve a remarkable degree of openness and sympathetic listening to her patients.

An important matter in schizophrenic therapy is the time period allowed for the therapy. "These patients simply cannot be hurried, and it is worse than futile to try." 78 Incredible patience and tact for long periods of time were the basis of Fromm-Reichmann's therapy.

With schizophrenic patients, Fromm-Reichmann had learned, "the seemingly meaningless and inappropriate
stereotyped actions of schizophrenics are meaningful. . . . They serve to screen the appropriate emotional reactions which are at their bottom. Unless we are with the patient for sufficiently long periods of time, we may have the opportunity to see only the manneristic screening without discovering what it hides." Fromm-Reichmann learned the cause of this screening tactic from one of her patients. This patient explained that the basic underlying reason for every reaction is that "we run away from fear of another rebuff." And further "investigations must show whether . . . it is actually only the danger of expressing hostility which furnishes the incentive to the schizophrenic to screen his feelings by stereotyped actions." Stereotypes call for an open response since they might be seeking to cover-up friendly feelings. Since physical running away is unacceptable behavior--the patient is placed in a hospital and often in restraints to prevent his being on the loose--screening and stereotypes serve to enforce privacy from fearful contact.

As to the hospital staffing problem that troubled Sullivan so much that he created an alternative institution within the larger organization, Fromm-Reichmann solved this problem by working in a private institution run according to her therapeutic principles, apparently with ample resources. "In our hospital," Fromm-Reichmann reported,
there is a weekly staff meeting for the discussion of new admissions and current administration problems. In addition, there are two weekly conferences . . . for a clinical presentation, discussion of the psychological mechanisms of progress or failure in psychoanalytic and administrative therapy, and discussion of the present status of the patient and further psychoanalytic technique, therapeutic management, and nursing care. When there are analytic disagreements between administrative and psychoanalytic therapists about managing a patient, the decision lies with the staff. Weekly, one of the physicians confers about a patient with the nurses and the recreational and occupational therapy workers. Every month there is a meeting of the entire therapeutic hospital staff at which the occupational therapy department presents a patient for general discussion. All the supervising nurses, some of the practical nurses, and the recreational and occupational therapists have been or are being psychoanalyzed. 82

Consultation, meetings, and staff training were the orders of the day at Chestnut Hill Lodge. These administrative and hospital consultation and education programs are admirable given generous resources and support facilities. It is clear that Fromm-Reichmann's success as a therapist of schizophrenics was anchored on a solid base of staff support services and superb physical facilities. Chestnut Hill Lodge is a private facility servicing very wealthy patients and their families.

Given the theoretical framework and the institutional support, Fromm-Reichmann found that the biggest problem is the anxiety of the therapist. She believed that stool-smearing patients of previous periods in psychiatric development were sometimes destined to deteriorate and become incurable. This was not because of the inherent gravity of the symptom but because of the atmosphere of awe, disgust, and gruesomeness which it evoked in their moralistic pedagogically minded psychiatrists and which they unwittingly conveyed to the patients. 83
Fear of physical violence from the patients constitutes a significant difficulty when working with schizophrenic patients. Acting fearful to patients who threaten physical violence is unacceptable, according to Fromm-Reichmann. If necessary, restraints should be used to provide security from fear for the psychotherapist. When this is done, the reason should be explained to the patient. Here is Fromm-Reichmann at work on this problem:

A woman patient succeeded in making me afraid of her. She threatened repeatedly to hit me, throw stones at me, or get me jammed in the door as I entered or left the room; however, nothing much actually happened except for a few slaps in my face. Having worked with potentially more dangerous aggressive male and female patients without being afraid, I knew that there were unconscious reasons for my fear of this patient. Following a discussion of this negative countertransference of mine, I became conscious of the reasons, upon which it subsided.

After the discussion, I met the patient on the grounds of the hospital, and she greeted me as usual, shouting, "God-damn your soul to hell." I replied, "For three months you have successfully tried to frighten me, yet neither you nor I have gotten anything out of it, so why not stop it?" "All right," she said, "God-damn your soul-to-heaven?" "That would not help you either, because if I should die, I could not try to be of use to you." By then she had become aware that my fear, which had been an offense to her, was gone; she bent to the ground, picked a flower, and handed it ceremoniously to me, saying, "O.K., let us go to your place and let's do our work there," which we did. Constructive psychotherapeutic collaboration between the patient and me was resumed.84

Uncontrolled anxiety leads to schizophrenia, according to Fromm-Reichmann. Psychotherapy with schizophrenics, to be successful, must be based on the ability of the therapist to avoid contributing his own fear and anxiety to the
relationship. To complicate the problem of schizophrenic therapy even further, Fromm-Reichmann posited the existence of an uncanny ability of the schizophrenic to "sense and comment upon some of the psychotherapist's assets and--what is more frightening--his liabilities, which had been beyond the limit of the psychiatrist's own realization prior to his contact with the schizophrenic patient." An insecure therapist can quickly become anxious and even preoccupied with his own defenses in such a situation.

Fromm-Reichmann wrote that the schizophrenic should not be expected to adjust to the "customary requirements of our culture," whatever the therapist considers them to be. A therapist must be content in encouraging the schizophrenic to make whatever adjustments he can or must to function in his world. This is a mandatory approach because, "as a rule, a schizophrenic's recovery will not include the change of his premorbid schizoid personality to another personality type. Schizophrenia, in this sense, is not an illness but a specific state of personality with its own ways of living." Here again, Fromm-Reichmann carried on and fulfilled Sullivan's theories relating schizophrenia to the failure of interpersonal communications. Change--presumably for the better--by allowing for effective functioning with others rather than adjustment is the expected outcome of therapy with this model. The inability of the psychiatrist to appreciate the schizophrenic's own needs, rather than reading into the situation the needs of the "non-
schizophrenic, conforming, good-citizen psychiatrist," is the crucial therapeutic principle to be followed according to Fromm-Reichmann.

Understanding the hostility, fear, anxiety, defensiveness, and dichotomy among experiences of the schizophrenic is the key to effectively responding to these people in therapy. She demonstrated the human nature of schizophrenia, its potential assets to the patient, and its curability in a masterful and insightful way. Fromm-Reichmann's work should be interpreted as more than the triumph of human kindness over brutality and inhumanity. Riese, a medical historian, addresses this point in evaluating the work of Pinel:

Though the author is far from underestimating the humanitarian aspect of Pinel's work, he intends first of all to bring the eminent alienist into focus with regard to the intellectual and moral spirit of his time, to his medical philosophy shaped by the great thought currents of the eighteenth century, and above all, by the basic principles of Hippocratic medicine.

The theories of Pinel and Fromm-Reichmann were based upon the basic principles of Hippocratic medicine. The premises of medicine underlie the work of Pinel and of modern psychotherapy, as Riese interprets it:

There is a strong observational element in Hippocratic medicine. ... With Greek medicine, about 2500 years ago, the study and careful examination of the sick came into being. Time and again the tradition was lost in the march of time and in the course of medical history; speculation, dogma, and so-called medical systems were substituted for observation. Pinel was a frequent adherent to undogmatic observation
and to Hippocratic medicine . . . a scholar and philosopher, not a sentimental apologist.\textsuperscript{89}  
The Hippocratic approach Pinel followed in his treatment of the mentally ill was that mental illness constituted "an historical chapter in an individual's life." It is true, however, that a "resourceful psychotherapist of Pinel's caliber may occasionally turn to 'tender loving care' or milieu therapy, none of which, however, reach the full scope of moral treatment in its authentic meaning."\textsuperscript{90} Morality and ethics are involved in Riese's interpretation, but they are not determining factors with Pinel and Fromm-Reichmann. This view sees psychotherapy as an important constituent part of medicine. Riese repeatedly warns his reader not to interpret Pinel's science as a part of his ethics. "It remains true, however, that Pinel's treatment made a strong appeal to moral concepts such as respect, self-esteem, and dignity for both patient and physician."\textsuperscript{91}  
In Fromm-Reichmann's therapy, the etiology or cause of schizophrenia is not dealt with. According to Riese, in order to explicate and understand the work of Fromm-Reichmann, we must look beyond the concerns of ethics or humanitarianism. Perceptive and sophisticated observation constitutes the basis of therapy in Riese's view. In spite of the medical terminology, this approach seems to be fully humanitarian—allowing, as we see in Fromm-
Reichmann for the full recognition of the mentally ill as human. Riese's denegation of ethics as a subject of less importance than medicine was not a problem for Fromm-Reichmann perhaps because of her strong interest in the creative potential of her patients. We can see in her work, for the first time, the demonstration that schizophrenia can enhance a person's life rather than destroy his body and mind with organic deterioration. Her attitude and model of treatment is based upon a thorough understanding of the multiple problems of transference and anxiety between therapist and patient.

Fromm-Reichmann differed from Pinel, and from Sullivan, because she did not pay professional attention to public matters, or to the political implications of mental illness. Away from the conditions of public hospitals, blessed with fully adequate staffing and funding, Fromm-Reichmann's therapeutic model works quite well in its setting. Success might have been more problematic in less than ideal conditions. But here we do have the achievement of effective therapy for those thought to be hopelessly ill or demented. More than any other person, she was able to unify the tradition of medicine with the human aspect of creative potential in schizophrenia. Following her, the split becomes quite pronounced (again) between the two approaches.
CHAPTER IV

MARGUERITE SECHEHAYE AND

HAROLD SEARLES

1. Marguerite Sechehaye

Marguerite Sechehaye (1887-1975) was a French-speaking Swiss psychoanalyst, not a medical doctor, who developed a technique for treating schizophrenics in the tradition of Freudian psychoanalysis. She wrote three books, one an autobiography about and with her patient, elaborating the theory and practice she developed in treating a single patient, Renee, over a twelve year period.

This presentation and discussion of her work will focus first on Renee's experiences; and secondly, upon the theoretical system elaborated by Sechehaye to explain her success in treating this disease--condition--thought by Renee's doctors and her medical colleagues to be beyond the ability of psychoanalysis or of medicine to handle. Establishing a transference by means of a series of symbolic objects and gestures created by the analyst was the key to Sechehaye's success.

The case of Renee, according to Sechehaye, was not a case of simple remission (return to a former state), but one of real recovery: from the psychological viewpoint the state of our ex-patient
involves a new and progressive evolution, with a continuous capacity for new intellectual acquisitions as we find it in normal development. Since her recovery this patient has finished her studies, obtained a diploma and university prize; and published two very remarkable works.¹

Such a therapeutic triumph is further enhanced by Sechehaye's recitation of the early experiences of Renee. The source(s) of this anamnesis is not clear from Sechehaye's writings. From what is presented, the reader must conclude that this is a case of schizophrenia, evolving almost from the prenatal experiences of the child. Renee's early experiences constitute a textbook on how to inculcate psychological trauma into a young human being.

Chapter 2 of Symbolic Realization recites a formidable listing of experiences: The baby was quite, "healthy and beautiful, and the object of admiration of the nurses at the clinic. Only the mother found her ugly. She was unable to breastfeed the child and was obliged to give her the bottle."² The mother mistakenly put too much water in the formula and the child refused it and continuously cried. "This repugnance led the doctor to suspect a stomach weakness and he suggested as the best treatment further dilution of the milk."³

The situation was remedied for a time by the arrival of Renee's grandmother to take charge of the situation. During feeding times, Renee "clenched her tiny hands and (to avoid the baby's cry of distress) it was necessary to use two spoons so that there was no interval between swallows,
otherwise the child cried with anxiety."\(^4\)

Following the departure of the grandmother at eleven months, the child urgently demanded her food upon awakening. The parents responded by laughing at her and deliberately making her wait. "The father made Renee understand that he would take the mother away from her, because the mother belonged to him. He could beat her and eat her, if it pleased him. He would then pretend to bite the mother hungrily..."\(^5\)

At fourteen months Renee received a pet white rabbit "which she adored. One day the father killed the rabbit, unfortunately in the child's presence."\(^6\) Other recounted experiences continue in the same vain:

Renee's father like a good laugh, and to amuse himself would lift up the little girl's clothing and tease about her nakedness. Renee was only two years old, but she nevertheless felt vaguely uneasy until a servant girl said to her: "Someone must have cut something off of you!" After that she felt mortified and indignant with her father.\(^7\)

Renee was threatened with the replacement of her mother "by a big negress with big teeth," and was warned she would be placed on a farm where cows would eat her.\(^8\) At one time her father proposed to her that since they didn't like life any more, the two of them would kill themselves together.

The reported experiences conclude at age 18 when Renee is sent to Sechehaye by her doctor with the admonition that "there is not much that one can do, she is headed
for the expected disintegration. . . . But she can be relieved temporarily; try to get her to talk."  

Renee herself reported in her Autobiography that her first experience of unreality occurred at age 5 when she was walking past the school:

It seemed to me that I no longer recognized the school, it had become as large as a barracks; the singing children were prisoners; compelled to sing. It was as though the school and the children's song were set apart from the rest of the world. At the same time my eye encountered a field of wheat whose limits I could not see. The yellow vastness, dazzling in the sun, bound up with the song of the children imprisoned in the smooth stone school-barracks, filled me with such anxiety that I broke into sobs. I ran home to our garden and began a play to make things seem as they usually were: that is to return to reality.  

Unreality experiences and hallucinations continued all through childhood. At 17 or 18, Renee began to play with dolls like a little girl again. Sechehaye commented that: "This objectively, indicates a regression due to the development of the disease."  

Sechehaye believed regression to be pathological--something to be stopped or cured.

During her first year of analysis, Renee did not believe she was ill. She thought that she lived in a strange country during her bouts with unreality:

It was rather a country opposed to reality, where reigned an implacable light. Blinding, leaving no place for shadow; an immense space without boundary, cold as the waters of the North Pole. In this stretching emptiness, all is unchangeable, immobile, congealed, crystallized. Objects are stage trappings, placed here and there, geometric cubes without meaning.
People turn weirdly about, they make gestures, movements without sense; they are phantoms whirling on an infinite plain; crushed by the pitiless electric light and I—I am lost in it, isolated, cold, stripped, purposeless under the light. A wall of brass separates me from everybody and everything. In the midst of desolation, in describable distress, in absolute solitude. I am terrifyingly alone; no one comes to help me. This was it; this was madness.

... Madness was finding oneself permanently in an all-embracing unreality. I called it the "land of light" because of the brilliant illumination, dazzling, astral cold, and the state of extreme tension in which everything was, including myself.

Familiar people became charged by some "apparently purposeless mechanism, so that they acted like puppets on a string, maniacs; or they rolled on the floor in a rage." Everyone was mad and moved around without reason, "encountered each other and things which had become more real than they." Trying to carry-on with her school work, she was ordered by "the system" to burn her hand, or perhaps the building where she was studying. And:

I cannot say that I really saw images; they did not represent anything. Rather I felt them. It seem that my mouth was full of birds which I crushed between my teeth, and their feathers, their blood and broken bones were choking me.

Or I saw people whom I had entombed in milk bottles, putrefying, and I was consuming their cadavers. Or I was devouring the head of a cat which meanwhile gnawed at my vitals.

(This is very similar to Vernon's description of the writings of William S. Burroughs, to be discussed later.) With this sort of reaction to daily reality, Renee was soon unable to function in her expected roles of family member and student. Sechehaye speculated on Renee's desires at this point in her therapy:
she is paralyzed in all her actions, because she would have pleasure only in being wicked, and is held back by the fear of Hell. Consequently, she desires to lie motionless in bed without light, food or sleep.18

After two years of analysis, Renee continued to deteriorate. This time is characterized by stereotype behavior, visual and auditory hallucinations, and by multiple suicide attempts. Renee experienced this as a period when she is getting younger and younger, going toward the age of zero. "Soon her fear of becoming zero becomes an obligation; she must become zero. On the other hand, she says that she is nine centuries old."19 Zero means not being born for Renee and being nine centuries old "means staying within the mother's body, becoming a foetus."20 She will eat only green (not ripe) vegetables and apples. Sechehaye explains that

Green apples hold to the tree, i.e., to the mother. It is the milk from the mother's breast. But ripe apples are detached from the tree, have fallen to the ground; they represent boiled milk, cow milk. . . . Renee picks green apples right from the trees. She must pick them herself since the mother does not give them to her. Scolded, and forced to eat like others at table, by the boarding house manager, she quits eating and runs away.21

The analyst confronted Renee with the fact that she has been given as many apples as she wanted. Renee pointed out that she does not want store apples for big people, but instead wants "'apples from Mummy, like that,' pointing to my breasts. 'Those apples there, Mummy gives them only when one is hungry.'"22 Sechehaye then formulated the first example of her theory of symbolic realization:
I understand at last what must be done! Since the apples represent maternal milk, I must give them to her like a mother feeding her baby: I must give her the symbol myself, directly and without intermediary and at a fixed hour. To verify my hypothesis, I carry it out at once. Taking an apple, and cutting it in two, I offer Renee a piece, saying "It is time to drink the good milk from Mummy's apples. Mummy is going to give it to you." Renee then leans up against my shoulder, presses the apple upon my breast, and very solemnly, with intense happiness, eats it.23

The next application of the method of symbolic realization was the gift to Renee by Sechehaye of a plush monkey. The therapist is thereby able to address Renee's ego through the monkey. "It represented Renee without really being her and it could enjoy pleasures which she herself could not indulge in."24

Renee explained her reaction to another symbolic realization, a ceramic doll named Baby Ezekiel:

All at once I experienced profound amazement that Ezekiel should receive Mama's love and affection without the occurrence of anything untoward. At any moment I expected Mama to cast Ezekiel off because I did not deserve to live. . . . Taking courage one day when Ezekiel was in Mama's arms, I pushed his head forward to test whether I had the right to live. At this, Mama pressed him to her breast and let him nurse.25

Sechehaye postulated a set of qualities needed by the therapist to develop the patient's confidence and thereby make the symbolic realization therapeutic system work. These qualities are: an understanding attitude; an attitude of "absolute sincerity in the interest and devotion shown to her"; an attitude of simplicity; an accommodating and flexible attitude; and an attitude "of
perseverance through all trials." The abilities to reassure and to guess the needs and interests of the patient are the basic therapeutic traits needed to pursue the system of symbolic realization with schizophrenic patients.  

"It is only through pleasure that one can progress. That is why imposed work for patients 'readaption to reality' does not always produce brilliant results. . . ." Previous reality has not been good for the patient. The interests of the patient are to pursue a new level of adaptation to reality. No appreciation of the positive aspects of regression is found in Sechehaye. No appreciation of the powerful descriptions of Renee's hallucinatory imagery is mentioned by Sechehaye. No political judgments about the role of psychiatry in society or in treating schizophrenia was apparently intended by these comments. Mrs. Sechehaye believed curing schizophrenia is a scientific theoretical problem of (medically-oriented) psychoanalysis. No institutional, political or societal dilemmas are involved in the curative problem or process.

In A New Psychotherapy in Schizophrenia, Sechehaye asserted that "the therapist, instead of insisting on submission to reality . . . will strive to offer him a new reality, such a reality as would have been necessary to avoid the initial, infantile trauma." This reality is strictly a process of relation between the regressed patient and the mother figure therapist. Nothing beyond this level
of concern and interaction is ever discussed by Sechehaye as part of her therapeutic program.

Guidance and interference is required in therapy with schizophrenics. Sechehaye was critical of existential analysis because "one remains powerless to bring the patient out of his 'autistic worlds' or to lead him to experience the world of reality. Understanding is not synonymous with cure." Existential analysts are devoted to phenomenologic description and not concerned with the "'why' of properly observed phenomena, and ignoring too much the functional and complexual aspect of symptoms." She tries here to maintain the organic, physical and chemical aspects of psychiatric illness as does traditional psychoanalysis. The schizophrenic must be cured, not merely analyzed and appreciated, according to Sechehaye.

There is a schizoid type of constitution, and during the healing process one could call these brusque returns to old reactivity "raptus reactions," as they are so brief. If Renee had not drawn my attention to them, I often would not have noticed them at all. These reactions testify to the biological source of deep emotions which have fed the patient's complexes. Our symbolic method has cured the complexual conflicts, but it has had little effect upon the fundamental tendencies of the schizoid constitution.

The specific nature of this schizoid constitution was not clarified. Perhaps this task is left to the medical doctor. Sechehaye's comments on this organic weakness brings her back to the theoretical position of Bleuler. However, here
we have the assertion that the schizoid constitution can be
cured or overcome by symbolic (psychological and psychoana-
lytical) methods. The relationship between the symbolic and
organic were not articulated by Sechehaye.

The preface to Renee's *Autobiography* reports that
"Actually there were long periods of hebephrenic catatonia
when her confusion made it impossible to know what went on
either around or within her."34 Sechehaye clearly accepts
the traditional categorical system of schizophrenia. Fur-
ther, we are told that "no memory traces of perceptive
impressions remained" during stuporous periods.35 This
reads as if the memory is determined by a physico-chemical
process which was acting improperly--malfunctioning--so as
to cause a failure of memory to occur.

When Renee began playing with dolls at 17 or 18,
Sechehaye wrote that "This objectively, indicates a regres-
sion due to the development of the disease."36 Sechehaye
believes that schizophrenia is an organic disease caused by
various unknown chemical, genetic or organic agents. How-
ever, a psychoanalytic cure utilizing symbolic realization
is possible, and has been achieved in the case of Renee.

Symbolic communication is critical to establish a
relationship with the schizophrenic patient. For the patient,
these symbols are the reality of the situation. "The simp-
lest means of contact which I used was to realize the un-
conscious desire, according to the symbolism presented by
the patient. . . . The symbols were . . . the only reality;
they were symbols merely for the analyst."  

Sechehaye understood the symbol system—the patient's progressive and regressive needs—by applying the Freudian framework of the unconscious.

Sechehaye provided a list of the symbolic realizations she utilized in therapy with Renee. They are:

(1) Autism, retreat from guilt is acceptable;
(2) the balloon as an offered symbol of the maternal breast;
(3) the babies are symbols of ego resumption;
(4) the gold pieces are symbol of the anal complex;
(5) the little stuffed rabbit as a symbol of the right to live;
(6) the Easter egg and the atomizer as symbols of virility;
(7) the hanged cases and paper dolls as first symbols of the brother complex;
(8) the golden balls and sending scheduled patients away early, second symbol of the brother complex; and
(9) the psychological tests, third symbol of the brother complex.

Such symbols became enlarged into a sort of play-acting sequence staged for the benefit of the patient. For example, at one point

It was necessary, then, for the mother to oppose the father. The analyst consequently was obliged to say to her husband in Renee's presence: "Renee must have her session immediately. I am sorry, if you want me to do something else, you will have to wait. . . ."
In an early sequence of this symbolic process, Sechehaye made the mistake of telling a nurse in front of Renee that since Renee liked to bathe, she was ordered to bathe as often as she desired. Renee thereupon refused to continue responding to the bathing symbol and it had to be dropped. These symbols must be authentically presented for Renee to respond.

Apparently symbols were created to respond to various symptoms displayed by the patient. As Renee mastered each successive symbol, another one was added (created) to further elaborate the Freudian system of ego development.

Sechehaye asserts that the chief difference between the schizophrenic and the neurotic "or even the dreamer is that for the former the symbol is reality." The schizophrenic's ego participates actively in the confusion. Therefore, the therapist must also take these symbols quite seriously if the therapy is to succeed.

The primitive mind, Sechehaye understood from Levy-Bruhl, participates in the confusion of symbol and reality as does the schizophrenic.

To participate means to confuse, to fuse the symbol with the signified, the word with the thing, the thought with the object. For the primitive mentality . . . the image or effigy becomes the person himself, even though distinguished from him.

Schizophrenic symbolism is incommunicable to others whereas the primitive shares his beliefs within the community. Secondly, the primitive "relates his effigy to a real individual while the schizophrenic forgets the real person and
the paper dolls absorb her affective interest." So we have a hierarchy from neurotic to primitive to schizophrenic. The exact distinctions (and reasons for them) are unclear in this theoretical effort. The constitutional, organic nature of the illness is even more blurred by the introduction of primitive shamanism.

Sechehaye's second patient was a six year old "schizophrenic." It seems play-acting therapy is most appropriate to pre-adolescent children. More elaborate dramatic stagings utilized by John Rosen in his therapy with schizophrenics can perhaps be seen as an extension of Sechehaye's method of symbolic realization; except, of course, that Sechehaye has great respect and love for her patients, whereas Rosen seems to make it a principle of his therapy that schizophrenia merits contempt as an example of human weakness. In Sechehaye we find no serious probing of social and community responses to schizophrenia, nor any appreciation of creative possibilities arising out of the schizophrenic experience that were so important in Fromm-Reichmann's approach. She did, however, find the origins of Renee's schizophrenia in her early upbringing. Sechehaye's intolerance for the psychotic phases and regression of Renee's schizophrenia serve to distinguish her view from that of Fromm-Reichmann's and Laing's.
2. Harold Searles

Harold Searles (1918 - ) is a staff physician at Chestnut Lodge, a private treatment center for schizophrenics and other mental patients near Washington, D. C. Searles was a student and colleague of Frieda Fromm-Reichmann, who was also affiliated with Chestnut Lodge during a good part of her career in America. Searles is a professional's professional psychiatrist and psychotherapist who practices and writes about the therapy of schizophrenics. He provides much of the intellectual legitimacy within the psychiatric profession for the therapy of schizophrenics practiced by Laing and his colleagues.

Perhaps Searles's most influential paper was his 1959 article, "The Effort to Drive the Other Person Crazy--An Element in the Aetiology and Psychotherapy of Schizophrenia". This paper formulated a general principle which one can apply to the multiple aspects of interpersonal causation of schizophrenia. Unlike the Bateson group's double-bind theory of causation, and some of Laing's work on family groups, Searles's formulation has the virtue of bringing schizophrenic experience into our everyday experiences. (Laing, however finds Searles's formulation in this paper too imprecise.) His general concept is that
the initiating of any kind of interpersonal interaction which tends to foster emotional conflict in the other person—which tends to activate various areas of the personality in opposition to one another—tends to drive him crazy (i.e., schizophrenic).

Searles finds that therapists and patients attempt to drive one another crazy quite often. Here is a patient's effort to drive the therapist crazy:

her efforts to drive me (as a mother-figure in the transference during this phase of the therapy) crazy were motivated at times not primarily by sadistic pleasure in rendering me more or less disorganized, or by a need to externalize upon me her own psychosis, but rather by genuine solicitude for me. At such moments the interaction between us was such as to make clear that I was in the position, as she saw me, of a mentally ill mother who needed treatment which she herself felt helpless to provide for me—entirely similar to a situation which had obtained during her childhood. . . .

Searles believes that efforts to drive another person crazy are frequent in interpersonal relationships. They are a part of the limitlessly varied personality constellation of emotionally healthy human beings; the therapists' and analysts' choice of profession is suggestive that, at least, in some instances where the personality structure is an obsessive-compulsive type, the individual is struggling against more than normally strong unconscious desires of this particular kind; and finally, because therapists and analysts are engaged in the particular life-work to which they are devoting themselves . . . it is especially difficult for them to allow themselves, of these qualitatively normal desires.

Psychotic illnesses are definitely curable by the utilization of psychoanalytic therapy, and assertions of
hopelessness demonstrate the applicability of his "drive the other person crazy" syndrome. He writes that so many psychiatrists

show a persistent readiness to regard this particular patient as "incurable"--in the face of by now convincingly abundant clinical evidence to the contrary--that one must suspect . . . the adaptation of an unscientifically "hopeless" attitude may mask, in actuality, an unconscious investment in keeping these particular patients fixed in their illnesses.56

Breaking through the mutual "symbiotic mode of relatedness to one another" to achieve progress in therapy becomes feasible once the therapist (and presumably eventually the patient) understands the principles of interpersonal relatedness involved in this approach to therapy.

Introspective about his orientation to therapy in the introduction to his Collected Papers, Searles writes:

"The Effort to Drive the Other Person Crazy" was written . . . just before the "Positive Feelings" paper, and so vigorously highlighted the significance of the patient's and my own, capacity for malevolence that it was somewhat in a spirit of contrition that I wrote "Positive Feelings". . . .57

Therapy is "to a greater degree a product of real contributions from both the patient and the therapist than we have been given to believe from the more traditional portrayals of the 'crazy' schizophrenic patient whose "purely delusional experience was depicted as being based only intrapsychically" and not upon any interpersonal contribution from the therapist, family members, and so forth."58

Schizophrenia, and the therapeutic process, are both equally interpersonal situations wherein a variety of attitudes
and ideas are at work in harmonious and contradictory ways.

In elaborating Searles's perspective on the therapy of schizophrenia, his ideas about communications, transference, the regression-death-and-growth process, and the role of the nonhuman environment in therapy will be discussed. All of these elements relate to his organizing concept of driving the other person crazy.

The advent of schizophrenia and its treatment are interpersonal situations involving both the patient and the family members or the therapist. The schizophrenic does not simply create delusional material for the therapist to analyze. Both are equally in contact with interpersonal reality—they are in communication with one another. Opening communication channels between therapist and patient, making both aware of the existence of communication channels and its potentialities, leads to increased integration of the patient. Integration entails loss of purity in the patient, and the therapist may miss this purity as well as the patient. Searles provides an example from his own experience. A woman who was at the beginning of our work some years ago, extremely unintegrated in her personality functioning. She behaved from one session to the next, like a whole galaxy of utterly different persons... Life for her now involves more continuity, less anxiety, more genuine happiness. But we have lost much too. Just how much I tend to forget until I look back through my old notes concerning our work. The beer-hall bouncer I used to know is no more.
The captured American pilot, held prisoner by the Germans but striding proudly several paces ahead of the despised prison-camp guard, is no more. The fighting lioness is gone from her den. The incarnation of paranoid hatred, spewing hostility at the whole world, has mellowed. . . . No more is there someone who tells me that I am a murderous woman who has killed my husband and am now about to kill my patient also. No longer is there someone, so far as I know, who thinks that I am a machine, sent to her room to destroy her. No one now perceives me as being, not a living person, but a pile of corpses, and so on. It is as though a whole gallery of portraits, some of them beautiful and some of them horrible, but all of them free from diluting imperfections, have been sacrificed in the formation of the single, far more complex and many-sided portrait, the relatively well-integrated person who now exists. 60

Searles finds that schizophrenics are strong, not fragile creatures as earlier thought. This determination and strength of will can lead to a dilemma in psychotherapy. When

the therapist reaches a point of desperation in his efforts to rescue the schizophrenic damsel (male or female; this is a figure of speech) from the scaly dragon of confusion which as evidenced by the increasing torrent of unintelligible words which issue from the patient's mouth, has the poor sufferer in its grip. Eventually, in those instances where the psychotherapy succeeds in breaking this deadlock, it dawns upon the therapist that the patient is not only the poor struggling victim but the dragon also, and he realizes to what a degree he himself has been impaled, all along, upon the patient's sadistic effort--usually a genuinely unconscious effort--to drive him crazy with those maddeningly unintelligible utterances. 61

The role of the administrative therapist as a check upon the patient taking control of the therapy via transference techniques with a plethora of contradictory demands, can be seen from this perspective of the therapeutic situation.
The pattern of therapeutic communication in therapy of psychotic patients, generally follows this format:

(1) The therapist refuses the patient's sadism;
(2) The patient recognizes this, argues against it;
(3) This becomes a discussable point; and
(4) The patient later can identify with healthy aspects of the therapist's ego.  

Once this interchange becomes possible, the nature of the therapeutic situation changes greatly, from a deadly serious rescue endeavor to an activity having a healthy playful quality at its root. The therapist can then join the patient: "in mutually enjoyable plays on words, contributions of chaotically nonsensical verbalizations and uninhibited flights of fancy." Searles believes that this playful activity restores what was best and healthiest in the patient's very early relationship with the mother; and it is upon this kind of playful and unfettered interaction, historically traceable to the beginnings of verbal relatedness, in the young child's life, that the patient's gradual development of firm ego boundaries, and the use of more logically organized, adult forms of thought and communication, can be founded. . . . There is a kind of chaos and confusion which is not anxiety-provoking and destructive, but thoroughly pleasurable. . . . there is no need for self-defensive organization.  

Searles appreciates this playful quality of regressed interaction as long as he, as the therapist, can elicit affect in some way. Once some interaction is possible, at whatever level, then Searles finds that the therapeutic
process becomes a mutually interesting exchange. Before such interaction has been achieved, he fears that the patient is drifting dangerously away from human contact. He calls this a life and death situation. It is regression out of control of the therapist. Apparently, such regression cannot be controlled by the patient either.

However, no schizophrenic "manifestations," according to Searles, are without meaning to the patient. Without interaction, however, that meaning can be lost. Because even the most otherworldly, even the most "crazy," manifestations of schizophrenia come to reveal meaningfulness and reality-relatedness not only as transference relatedness to the therapist, but, even beyond this, as delusional identifications with real aspects of the therapist's own personality. 65

Representing the tradition of Sullivan and Fromm-Reichmann, Searles finds that meaning and reality-relatedness are always present, even if the therapist cannot find a toehold or connection to the patient: "not only is he in the human fold . . . he has never really been out of it." 66

As human experiences are unique, so are persons. Although, Searles points out, "We can describe an illness in relatively few words; we cannot describe a person adequately in any space much less than a long novel." 67 Showing respect, for Searles, means recognizing that each person is unique, and that the content of human experiences is as important as the therapeutic formula applied. No specified formula for treating schizophrenics is provided in Searles. Unlike Rosen's cookbook approach, or Sechehaye's lists of symbolic
realizations, Searles provides no recipes for therapeutic success. Understanding the transference process as it is occurring, in its infinite subtle variations, constitutes Searles's therapy of schizophrenia.

Writing about paranoid psychosis, Searles finds that

the paranoid patient's "mission" consists, basically, in a striving to convince the world that his mother's distorted and largely dissociated (or at least poorly integrated) views are valid. This is all part of his effort to protect both her and himself, from the recognition that these views are tragically inappropriate, "crazy."

Mother transference in psychotic patients evolves throughout the therapeutic process. Understanding its manifestations becomes central in importance if the therapist is going to be able to deal with the patient. In the 45th month of therapy with a woman patient of Searles,

there emerged from her almost incredibly intense feelings (though still indirectly expressed and denied by her) of cherishing and adoring me, and simultaneously came a marked shift in her self-regard, from a former self-loathing to a perception of herself as genuinely precious. All this was expressed in bodily terms. She asked, looking at me, "Is that my body you have?" in the intimately possessive way in which a person regards a sexual partner. She went on to express an almost complete conviction that my body had indeed once been hers, and went on to say that "back when I had a [i.e., that] healthy body . . . they could make rubies out of my blood, and amethyst out of my saliva."

Searles appreciates the attention and the visionary capabilities of his patients. Rather than seeking to
neutralize his response to the patient, he suggests instead that since the therapist understands more about the reality-relatedness elements involved in the patient's response, "various manifestations of feeling participation by the therapist which in the past have been regarded as unwanted countertransference will be seen to be inevitable and utterly essential components of the recovery process." The therapist must be willing to be emotionally involved with the patient to effect a successful transference-countertransference process of exchange. The therapist of psychotic patients must be willing to accept

  deep dependency . . . a symbiotic kind of mutual dependency, which he naturally comes to feel towards the patient; his acceptance of a mutual caring which amounts at times to adoration; and his being able to acknowledge the patient's contribution--inevitable in successful therapy--to his own personal integration.

The patient, however, may have trouble having the transference feelings of the therapist. Although a patient responds "with great regularity to the therapist's maternal warmth," she comes to believe that the therapist is homosexual or lesbian. "The younger therapist needs to become quite clear that this is, in actuality, a formidable resistance in the patient against the very kind of loving mother-infant relatedness" necessary in therapy.

Working with schizophrenics, Searles writes that he has come to a great philosophical realization: the inevitableness of death. With schizophrenics, death
constitutes "one of the major sources of anxiety against which the patient is defending himself."\textsuperscript{73} Schizophrenic patients are often childless and have little prospect of marrying and having a family.\textsuperscript{74} Often, Searles finds, the struggle against death anxiety is heightened by the feeling that they are not quite alive, not really living in the world.

In working with schizophrenic patients, one soon comes to realize that many, if not all of them, are unable to experience themselves consistently as being alive.\textsuperscript{75} This repression in toto may serve an additional defensive function: One need not fear death so long as one feels dead anyway; one has subjectively nothing to lose through death.\textsuperscript{76} It is often mentioned that the schizophrenic patient views himself, and other people, as being omnipotent; but we need to remind ourselves that the companion of omnipotence is immortality.

Not being born, being dead, and being immortal are variants on the schizophrenic stance towards life, as Sechehaye's study of Renee and the Joseph Berke and Mary Barnes volume, \textit{Mary Barnes: Two Accounts of a Journey Through Madness}, demonstrate. Searles finds that only with "the strengthening knowledge that one is a whole person . . . able to participate wholly in living"\textsuperscript{77} can a person face death fully. Since the "schizophrenic has not yet fully lived," it is not feasible to expect an understanding stance towards life.\textsuperscript{77} Searles cites Heidegger, Binswanger, Russell, and the novelists James Gould Cozzens and James Jones, in a discussion of "Human Beings in General."\textsuperscript{78} Although
recognizing that the problem of the nature of human experience, and the inevitability of death "forms the ever-present background of the narrative," Searles does not contribute much to answering the question he poses.

The issue of death does lead to the development of his model of regression and rebirth. The major principle of Searles's theory is that the patient's potential capacities for growth are very great. He finds that there is perhaps unlimited energy for growth in the schizophrenic.

Unlike many of his fellow therapists, Searles finds that the process of regression to a nonhuman, inanimate state, analogous to the "relatively stable inanimate objects he perceives in his environment" is a necessary and hopeful stage. Evaluating the psychoanalytic literature on the subject of regression, Searles concludes that

regression always possesses a restitutive facet, and for this reason the phase which Kris applies to certain varieties of regression--"regression in the service of the ego"—is applicable to every instance of regression, as is Hartman's phrase "regressive adaptation."

Regression is an essential restitutive process in schizophrenia. Relatedness at the level of inanimate objects is sometimes a necessary stage of therapy. During therapy with one patient

The greater part of each session he spent, however, in silent apathy; with him I spent a longer time—approximately two years—of almost totally silent sessions than I have ever spent with any other patient. I learned in the course of many arduous
months that placing any sort of pressure on him beyond the inescapable demand presented by my physical presence in the room with him, only made things more difficult for him. I realized eventually, that the only manner in which I could participate usefully with him was by serving for several months, as in effect an inanimate object—silent and rarely in motion—upon which he could project his own thoughts and feelings without interference. 81, 82

The deeply regressed patient has particular needs which therapy should provide to him. "The deeply regressed patient, more than anyone else except for the infant, needs to have a nonhuman environment which is not only stable and relatively uncomplex, but also beautiful." 83

With this call for beauty in the nonhuman environment, Searles is staking out quite new and independent ground in psychiatry.

For the therapist to allow regression to occur, and if needed, for him to serve as a part of the nonhuman environment; is an integral stance in Searles's therapeutic method. Regression is not only to be encouraged, it is to occur in a pleasing environment in order to provide the patient with an opportunity to reformulate his relationship with the nonhuman environment in a proper way. Thereby he will have a good ground upon which he can rebuild his interpersonal world. To provide an aesthetically pleasing and appealing place for therapy, including regression, to occur becomes a constituent part of the therapeutic program designed by Searles. This proposal is
perhaps his most radical and interesting theoretical formulation.

Discussing the psychoanalytic model of childhood, Searles summarizes the need to allow regression to occur. He seems to believe it is an invariable aspect of therapy with schizophrenics. This regression is a re-doing of the patient's earliest phase of human life. "The desire to be nonhuman is a facet, in some instances, of the grandiose conception of oneself as being able to do anything, a conception serving as an unconscious defense against profound feelings of helplessness." Although Searles is unclear on this, it seems that the patient focuses on the nonhuman environment because it is the pre-human condition and state from which he can proceed to re-build his personality. In this process, the characteristic qualities of the nonhuman environment is especially important. It is so significant that the human helpers or associates are categorized into the nonhuman category of environment for ego restorative purposes. New born babies react as if all of the environment were stable and nonhuman. Schizophrenic regression is a retreat— in both symbolic and communicational terms— to the earliest stages of the human pre- and post-natal life.

Laing and his colleagues also advocate the method of regression. It is quite controversial in psychiatry and even in psychoanalysis, however. For example, Theodore Lidz
calls it "dangerous as hell" when discussing Laing's work. Critics apparently feel that if a schizophrenic is allowed to regress—that is, not stopped—he will never progress again back to an adult state. The strength of schizophrenic persons, and their abilities to develop themselves is doubted. If regression constitutes a natural healing process, than those persons under the care of Lidz would not experience significant changes. Regression would be stopped with drugs and other restraints, since it is a state too close to death, the patient acts in a helpless manner, relates to the nonhuman environment rather than to the human, and so forth. For Searles, regression is to be encouraged as long as communication of any sort can be maintained by the therapist. Laing does not find this need to maintain communication to be a precondition or even a therapeutic problem. Perhaps he builds upon and benefits from Searles's experience in this respect.

Searles has written extensively on his ideas about the nonhuman environment and its significance in the therapy of schizophrenics. About the human ego, he suggests that

the earliest rudiments of the human ego may experience existence as being totally inorganic, totally inanimate, including itself, followed by later phases of experiencing itself as something living but not yet human, and only later still experiencing an awareness of oneself as a living, individual human being.\(^{85}\)
Patients who are schizophrenic—who display the symptoms—have had difficult, confusing early lives not only with the human beings around them, but with the nonhuman environment as well. This suggests to Searles that the relatedness of the infant and the young child with, for example, his toys, his clothing, the furniture of the home, the house itself, and so on, has much greater repercussions, for good or ill, in adult life, than has been noted so far in psychoanalytic theory.86

Establishing relatedness with the nonhuman environment provides the child with "a kind of practice-ground in which he can develop capacities which will be useful to him in his interpersonal relationships."87 Maturity, in fact is directly related to the ability of persons to relate to the nonhuman environment in community wide perspectives. For Searles,

Maturity involves a readiness to face the question of what is one's position about this great portion—by far the greatest portion—of one's total environment, rather than fleeing to some pat explanation (such as primitive peoples' regarding the environment in a animistic light, or modern psychiatry's predominately assuming it to be only a frame for psychologically meaningful human living, rather than an . . . integral part of such living. . . .)88

Searles reveals how he came to his new realization of the important role the nonhuman environment played in his own life. One day,

While driving alone, I was turning from the main highway into the housing development where I had been living with my wife and children, for some years now. Suddenly the thought came to me, "What am I doing here? --I belong back in Hancock." The housing development looked drab to me; I compared it, in my mind to the natural beauty of the thinly populated area about my
home village. This realization ... was not an exhilarating one, not a pleasant one. But I immediately felt it to be a valuable discovery: it brought me to the sobering realization of how relatively little libido I was really investing into this housing development and into, by the same token, my whole adult life.89

Searles doesn't generalize from his personal discovery except in a positive way. He urges that this aspect of therapy be made an important consideration. He only discusses his own experiences, and does not expand upon them except to draw obvious conclusions—given his preferences and experiences—that these matters are important. There is little indication that psychiatry has, in fact, pursued his lead. This claim for the importance of a pleasing environment is somewhat ironic given the affluence and beauty surrounding Chestnut Lodge, as compared to the ordinary grimness of public mental hospital wards. As with Fromm-Reichmann, Searles has limited himself to private institutions and, as a consequence, has been able to make some interesting contributions to therapy. Public institutions, however, have situations, resources, and attitudes which make Searles's methodology useless.

He does offer insight and understanding into many of the things patients say or claim which are often dismissed as evidence of organic pathology or deep regression. For example, Searles's theory about the role and importance of the nonhuman environment helps to understand this therapeutic change. The women discussed earlier referred to her
head as an inanimate object, saying "that the whole left side of it is gone . . . caved it. . . ." On another occasion, demanding of a nurse, "why did you take that piece out of my head?"

This woman, for many months after my beginning psychotherapy with her, often glanced at me with an expression on her face of mingled fear, shock, and awe, as if I were a weird monster at which she scarcely dared to gaze for an instant. My discomfort at being so regarded amounted at times to a formidable level of anxiety. . . . I felt toward her, much of the time during that period of therapy, an intensity of hatred and loathing. . . .

I felt additionally threatened in one of the hours when, as I walked into her room, she looked closely at my face and head and asked me in a shocked, awed voice, "How is your head injury?" as if she regarded my head as an inanimate object which had been damaged to an almost unmentionably grievous extent. My knowledge of this as representing a projection on her part, of at-the-moment unconscious feelings about her own head, was not instantly there to comfort me.90

Searles's method and theory of therapy takes much of the mystery and strangeness out of behavior and responses typical of those diagnosed as schizophrenic. With Searles, these patients truly seem to have an asylum where they can repair themselves through regression and growth. Amidst a beautiful environment, among understanding therapists, the issues of forced incarceration, civil commitment, or the dangers of psychiatric diagnosis, and the use of physical and chemical restraints seem quite distant and irrelevant to the issues of treatment and healing. Yet all these concerns constitute important public issues that ought to be
addressed. Any complete understanding of schizophrenia in contemporary culture should be able to respond to the situation in all of its ramifications.

In the work of John Rosen and Theodore Lidz, to be considered next, the advances in therapy posted by Sechehaye and Searles are negated by attempts to serve a particular social order instead of the individual patient. With the chemical and/or genetics causative schools, although antithetical to the work or concerns of Sechehaye and Searles, definite answers and claims to medical scientific hegemony are advanced. Finally, among the therapists favoring the talking cures, Szasz and Laing offer radically different answers to the same public questions about the nature, etiology, and resolution of schizophrenia.
CHAPTER V.

JOHN ROSEN AND

THEODORE LIDZ

1. John Rosen

John Rosen (1902 - ) is the developer of a treatment for schizophrenia, and the Director of the Institute for Direct Analysis at the Temple University Medical Clinic. Direct analysis, Rosen's treatment for schizophrenia, is ostensibly based upon and extends the theories of Freud. Rosen's manner of interpretation, however, is designed not to develop a theoretical perspective capable of analysis and criticism, but is formulated so that his every patient, assistant, or non-specialist observer can understand. As a consequence of some oversimplifications, Rosen's interpretations of Freud serve often to obfuscate rather than clarify the issues being discussed. For example,

As Freud said, a dream is a psychosis. He never would have said a dream is a disease, and the ordinary man would understand this. An ordinary man, observing the grief of a widow, would not say that she had been suddenly attacked by the "disease of depression." Nor would he say that someone in a panic, "crazy with fear" when a theatre catches fire, is suddenly "diseased."1

Psychosis is not a disease, for Rosen. And good ordinary men possessed of their common sense, will know this. But
distinguishing dreams or physical panic states from a state of psychosis—a state of being "crazy," out of one's mind—would certainly be done by ordinary men—perhaps having been well-educated to make these distinctions by psychiatry.

Claiming to update Freud, Rosen asserts that "in direct psychoanalytic theory . . . the psychosis is even more of a royal road" to the unconscious than the dream. Rosen revises the role of the analyst in his direct analysis:

Or, for the Freudian principle that the analyst must remain uninvolved, mirror-like, in treatment, direct psychoanalysis has substituted the principle that the psychiatrist provides the neurotic or psychotic with a new basis for maturity from the resources of the psychiatrist's personality.

The transference phenomenon in psychoanalysis is much more subtle than Rosen admits here. Further, Rosen tells us that the muteness of the catatonic is merely a symptom of the problem.

The goal of direct analysis is to equip the patient to get along in society. Social normality is the aim of this technique. Abnormality, defined as the inability to get along, is therefore the problem of the psychotic.

The "governing principle of direct psychoanalysis is that the psychiatrist shall be, in effect, a foster-parent to the psychotic individual who has regressed to infancy and who must be brought up all over again."
Rosen states this principle somewhat differently in an earlier work:

The governing principle of direct analysis is that the therapist must be a loving, omnipotent protector and provider for the patient. Expressed another way, he must be the idealized mother who now has the responsibility of bringing the patient up all over again.  

Rosen specifies that

Psychotics live immediately under the shadow of the breast. This is able to tell us two things: first, the presenting aspect of their psychologic life is again the earliest infancy and, second, the nature of the breast upon whom they are so dependent threatens their life. . . . In health you eat, the breast eats you, you are warm within it, nothing to fear, you awaken again to its goodness. It will always be there. It has granted you omnipotence and as long as necessary, it continues you that way. With another kind of breast, you daren't eat it. If it eats you, you will be ripped to pieces and destroyed, and how in the world can you possibly sleep? . . . Just as the concept of neurosis as an oedipal problem becomes the cornerstone of analysis, so the concept of psychosis as an oral problem becomes the cornerstone of direct analysis.  

Having established the basic principles and the foundation of direct analysis, Rosen proceeds to sketch in his theoretical points. When the patient comes to Rosen, he is forced into acknowledging Rosen's basic premise: that he had a bad mother. In a psychotic state, the patient will, "when the time comes," recognize the therapist, "among the phantasmagoria" of his condition. The therapist is to address the patient in this manner:

In a determined tone, you announce yourself as the omnipotent figure who has power of
life and death over him but now is determined to wield this power only for life, that is for the protection of his life (governing principle). With the mute catatonic, assuming his mental agony from what he says when he can talk . . . you make the same pronouncement. With this patient, however, after insisting that you are the good omnipotent figure, you force the patient to open his mouth by pressing firmly against his teeth at the tooth line and when his mouth is forced open, you tell him to drink. "The milk is warm and good. Not the poison that your mother fed you."9

The message being that the therapist is good, whereas the mother was bad. The therapist takes command of the situation as if a personal dictator--or behaviorist--who very directly and unabashedly announces his intentions to do good, i.e., save the life of the psychotic.

Direct analysis therapy has a two-part treatment: pre- and post-verbal.

The first part, the direct psychoanalysis, resolves by dealing mostly with the level of mentation which occurs in the pre-verbal period of life and shortly thereafter. The second part is a more orthodox form of psychoanalysis, where the aim is to construct a stable personality and a mature character.10

The heavy handedness of Rosen's therapeutic model is demonstrated again by his concept of the analyst constructing a stable personality for the patient. This is not orthodox analysis in the tradition of Freud, Sullivan, Fromm-Reichmann, or Searles. O. Spurgeon English, in an evaluation of Rosen's work, concludes, "my impression is that there is a minimum of insight gained and that little 'working through' goes on in the patients themselves. In
other words, direct analysis is not a 'condensed psycho-
analysis'. It is a unique treatment procedure of its own.  

The patient "wishes to be schizophrenic because there is something he cannot get from his environment that he can find in his imagination." For Rosen this level of the imagination is an unacceptable level of functioning. Further, although Rosen finds no organic or hereditary causative factors, he believes that with the schizophrenic, "there is ordinarily no waking up unless something positive is done about it." 

As for the therapy, Rosen advances a general ethical principle: "if you cannot do the individual any good, at least do him no harm." Here Rosen rejects various treatments, including insulin, ECT, and lobotomy therapy. He asserts, however, that the therapist is not to "leave a terrified psychotic with fifty or a hundred others like him; don't abandon him." Often drug or ECT treatments are advocated as the only alternative to no treatment--particularly in large state hospitals. Rosen does not discuss this dilemma.

Schizophrenics are treated by Rosen at special centers, much like home environments. Assistants are present at all times. The therapist-mother comes in for therapy sessions. The assistants act as friendly siblings
who are to keep firm control over the patient:

the male assistants may be called upon, for example, to discourage the psychotic from acting upon his impulses to violence. The female assistant may appear to be a mother-figure, in charge of the maternal functions in the operation of a well-ordered home; but during the treatment session she is shown to be an "older sister". . . .16

The reception of the psychotic into the treatment facility illustrates the method of interaction encouraged by the Rosen therapy:

The assistants know how to engage in "psychological small talk." For instance, if a psychotic says, belligerently, "Where are you taking me? I've got to get to Geneva to hold a summit conference," the assistants might answer: "Dr. Rosen is taking all of us to Geneva; he's waiting at the airport now; let's get going." To respond by telling him at this point that he is crazy, runs the risk of needlessly increasing his rage or terror.17

Only later is the "psychotic" told he's crazy and has no credibility.

Rosen lists 59 manifestations of psychosis, complete with definitions, examples, and treatment methods to respond with during analysis. Here is the "wake up" method utilized by Rosen:

When a psychotic is this deeply regressed, the direct psychoanalyst does not deal with his unresponsiveness, or his indifference, or any other single manifestation . . . as a separate entity. Indifference may be challenged by simply shouting, "Wake up," and shaking him in hopes of gaining some tiny spark of response. All the care that one puts into an infant is required for those individuals, and being the good parent is the most important therapeutic principle we know.18

And here is the "I dare you" method of treatment:

After treating "C. V." for six weeks, the psychiatrist took him to a nearby state hospital and
challenged him to break down the thick steel door of a security room. "C. V." was unable to do so, in spite of his great strength and determination. His failure made the first opening in his systematized delusional system. From then on, he had to entertain doubts as to the authenticity of his "divine calling."\footnote{19}

Rosen summarizes the direct analysis process as constituting three phases:

1. Reductio ad absurdum. Reduce the psychotic's assertions to absurdities;
2. Allowing the patient to act out; and
3. Handling the patient's aggression by forbidding it or promising to do so in return: "If you ever again..."\footnote{20}

Recovery starts with the psychotic adopting the view of the therapist, by agreeing that he's crazy, by acknowledging that he can't open the steel door, and so forth. Rosen finds it extremely difficult for his patients to "maintain this form of recovery against everyday stress when the treatment is discontinued." The best advice he has for recovering patients is to rejoin their families, or get married and have children. His theoretical justification for this comes in another of his special interpretations of Freudian principles:

Whatever the basic patterns of family dynamics turn out to be, we can reasonably assume that their nucleus is the raising of children. This is consistent with our belief that each individual has two unconscious tendencies of enormous power: to seek the
"mother" he knew, and to become that "mother" himself. In the usual family situation, both tendencies must have numerous opportunities to be fulfilled.\textsuperscript{21}

Happiness is obtainable for the psychotic, Freud notwithstanding:

In An Outline of Psychoanalysis, Freud said that, "for however long a child is fed at his mother's breast, he will always be left with a conviction after he is weaned that his feeding was too short and too little." We have never found evidence of this conviction in the manifest or latent content of a psychotic.\textsuperscript{22}

Rosen occasionally expresses himself on the nature of normality in ways that cast aspersions on the qualities of his patients. Since normality is defined as the ability to get along with others, the psychotic person is by definition, less than normal. Responding to a formulation attempting to define good mental health, Rosen observes that

In Current Concepts of Positive Mental Health, by Marie Jahoda . . . the position seems to be that "positive" mental health includes creativity, capacity for deep enjoyment, imperturbable self-confidence, and so on--conuring up the picture of some individual, and a former psychotic at that, who combines the best of Thomas Jefferson, Abraham Lincoln, Florence Nightingale, and a galaxy of others.

We would be content with more modest outcomes. . . . The outcome could be a person who is undistinguished for his attributes and accomplishments. . . . Preferably, he would be married and have a family. We do not maintain that we attempt or succeed in producing a splendid personality through psychotherapy. To put it bluntly, we cannot make a silk purse out of a sow's ear.\textsuperscript{23}
Former psychotics are not expected to contribute much to the world, according to Rosen's view of their conditions and situations. Although organic or genetic factors are not important in Rosen's view, the psychotic does have definite limits or disadvantages to his personality as compared to the normal person, or the merely neurotic.

Rosen feels that he has been unduly criticized "for merely achieving the suppression of psychosis, or making the psychotic a conformist." Rosen responds to such charges:

The general idea of these criticisms seems to be that that psychotic is forced or persuaded to act as if he were not psychotic. . . . It would be no small accomplishment to take a psychotic, let's say one who has been in the mute, rigid catatonic phase for ten years—and persuade or force him to conform and to act and talk as if he were normal.

Presumably, Rosen means that a real normal person would be different from a person who was forced into acting normal by direct analysis therapy. Anti-schizophrenic drugs can create at least an illusion of normality. Direct analysis supposedly accomplishes more than chemical treatment. Rosen warns his readers in the 1962 volume that, contrary to his previous understanding, "Direct psychoanalysis, however effective it may be in resolving psychosis, does not offer 'immunity' from psychosis." Using the word immunity creates the impression that psychosis is a medical or organic disease of some kind. Further, Rosen seems to believe that psychotics are not potentially or actually
among the best of men. He finds them to be less than average. This attitude gets displayed clearly in his therapeutic methods. His techniques are very far from those of Sullivan, Fromm-Reichmann, Sechehaye, Searles and Laing in terms of his attitudes and hopes about the patient's human possibilities.

The response to the patient's aggression that Rosen advocates is to threaten the patient in no uncertain terms: "If you ever again . . .."27 Here is an exchange between Rosen and a patient, as reported in the English volume:

Dr: "I don't want to talk to her--I hate her. She was cruel to you and made you crazy."

Dr: "Yeah, because the church is referred to as 'Mother church', and your father wouldn't let you go to 'mother'. The great interferer. I don't know if that is true or not. I just take a guess at that."

These tactics . . . obviously are not analytic or uncovering techniques. For the most part they are suppressive, aiding repression and encouraging regression, conformity and dependency, in relation to Dr. Rosen. . . .28

It may be that regression is a response that could possibly be encouraged in psychotic patients. Calvin F. Settlage, representing a more orthodox position in psychoanalysis, does not believe so. He equates regression with repression. Regression, however, may be the antithesis of repression. As for Rosen, he does seem to want his patients to reject their families and past experiences rather than having them understand earlier situations in a broader context of seeing what was right as well as wrong about early experiences.
Perhaps a better critique by Settlage is his observation that "it is clear that the patient is expected to love Dr. Rosen, but the patient's aggressive and hostile feelings towards the therapist are essentially ignored."\textsuperscript{29}

Thomas Szasz, a student of forensic psychiatry, provides evidence of additional strains in the Rosen approach to schizophrenia. Szasz summarizes the record of a court case brought by the family of one of Rosen's former patients:

It was brought to the attention of the patient's family that the defendant made claims to dramatic success in the treatment of schizophrenic patients. The defendant was sought out, requested to, and did agree to treat the patient. Nurse H. Louise Wong, who attended the patient for 12 days during September, 1948, testified that on two occasions she took the patient to the defendant for treatment. . . . After completion of the treatment on the first occasion, Nurse Wong observed that the patient's body was covered with bruises, and her clothes were torn and disheveled. . . . Apart from the testimony of Nurse Wong, there was ample evidence in the record of the defendant's assaults on the patient on various occasions in the course of his treatments. Mrs. Hammer stated that after the treatments she observed her daughter was "beaten up" and had "blue eyes"; that her daughter returned from treatments "black and blue." Mrs. Hammer also testified to conversations with the defendant wherein he stated that the assaults complained of were part of the treatment.\textsuperscript{30}

Rosen has established an Institute for Direct Analysis in order to treat large numbers of people during the same period of time. Resources, personnel and physical spaces have been utilized in large amounts for this program. Achieving success, having an efficient operation with quick turnover, is undoubtedly a major factor in Rosen's
operation. Spending 12 to 15 years with one schizophrenic patient as Sechehaye had done with Renee, is not an acceptable alternative for most institutions—especially those which operate on public or foundation monies. Perhaps suppression of bad experiences and physical "therapeutic" cures are the requisite costs for a quasi-public institutional psychiatry of schizophrenia. Yet the voluntary nature of this program precludes the kinds of power wielded at larger state hospitals receiving patients committed by state authority. The expensive, private therapeutic alternative is displayed in the work of Fromm-Reichmann and Searles.

Rosen's aggression towards his patients and his stated dislike for many of them, leaves some serious questions about the human qualities of his therapy. Quantitative results seem to be the goal of his program. The quick "cure" of large numbers of persons by psychotherapeutic methods is attempted by Rosen in order to provide an alternative to state mental hospitalization for long periods of time. The qualities of human care, patience and attention, and the attempt to develop the creative potential of patients found in Sullivan, Fromm-Reichmann, Sechehaye, and Searles is absent in Rosen.
2. Theodore Lidz

Theodore Lidz (1910- ) is the Director of the Yale Psychiatric Institute and has written both theoretical and experimental material on the subject of family therapy and the family origins of schizophrenia. He heads a group of psychiatrists, social scientists, and psychotherapists researching the problem of schizophrenia and the developing area of family therapy as a means of dealing with the schizophrenic patient.

Portions of an intensive interview with Theodore Lidz conducted by Robert Boyers and Robert Orrill, published originally in Salmagundi and, subsequently as a book, R. D. Laing and Anti-Psychiatry, will be utilized. Then, the major theoretical basis of Lidz's psychiatric work, a series of lectures entitled, The Family and Human Adaptation, will be consulted to explore Lidz's own ideas on the nature and function of the family system, especially as it relates to the medical disorder (but not illness, to employ the Lidz distinction), of schizophrenia.

Q: Is it your conclusion, then, that schizophrenia is never a disease in one person?

Lidz [hereinafter noted as "L"]: I wouldn't argue with that conclusion--in our experience the family is disturbed, the entire family, and needs attention. But, there is, we must remember, a patient.\textsuperscript{31}

Q: Laing is highly critical of acculturation of the sort you seem to recommend. What do you think of his views on this point?
L: There is a radical difference on this point between his orientation and mine. Laing is in a tradition that now includes Marcuse and Norman O. Brown and others who have misunderstood and over-emphasized Freud's ideas, especially those found in *Civilization and Its Discontents*. Laing's tradition stresses the fact that civilization impedes the development of human potential, and concludes that if we could only get rid of the repression foisted upon us we will all be happy. All we need are conditions that will allow the primitive--innate child--within us to develop without restraint. This is the thing contemporary youth find so appealing in the tradition. But the human being is not able to escape--he is worse without the adaptive techniques required to live in a society. He doesn't have to continue adhering to the mores of his culture, but he cannot fall back on something called an innate quality--this is a fallacious concept of human development.

L: . . . I have relatively little quarrel with *The Divided Self*. While it's a different type of approach than I would use, I think it's a brilliant work and held out the promise of a really great mind in our profession. *The Politics of Experience*, on the other hand, is a wild and whirling commentary that demonstrates little grasp of the reality of human development.33

Q: Laing seems not to be talking only of such people though, of great artists and men of genius, but of his own patients.

L: There are many gifted people--we need not be speaking only of geniuses or great artists. But I would say that how a man sees while he is a schizophrenic is in the nature of illusion, and delusion, and has very little to do with anything real or practical. This much we should be clear about.34

Q: Are these kinds of perceptions at all useful in enhancing the life of patients?

L: I think they can be useful. Insights into other people, what motivates others, can
surely be of use. But I take a very dim view of the things Laing proposes for the schizophrenic experience. He is recommending that people who feel they need it be encouraged to go through psychotic experiences directed by Shaman-figures who are taking drugs and prophe­ sying what is to come. Schizophrenic patients should not be proposed as models for those seeking deeper insights than they can manage on their own. From what I have heard from people who claim to know what Laing is doing, he is currently arguing that schizophrenic patients are helped by taking LSD and being allowed to go back and increase the intensity of their psychotic experience. Most therapists I know would have to feel this is absolutely dangerous as hell.

Q: You seem committed to a process whereby the therapist tries to bring a person back to reality, whereas Laing encourages his patients to move back.

L: He feels there is a more or less spontaneous process in which a psychotic patient can have some vital experience in breakdown, get some enlightenment, and emerge. And I'm sure this is possible for some people. Laing tends also to believe it is hospitalization that often keeps the patient from his happiness. I don't think this is true. . . .35

L: Now we know there isn't a period in the schizophrenic's life that hasn't been extremely disturbed and we've finally learned to ask broader questions: What is the family for, what can it do, what role precisely does language play in the creation of a disturbance. This has affected our therapy quite profoundly.36

L: Laing's philosophy in The Politics of Experience is really a philosophy of despair rather than one of hope. And I cannot help but wonder why I should look at things so differently than he does. I think maybe I didn't have such expectations of human beings as he has, and therefore I've not become quite as disillusioned as he. Laing also says that it is impossible to love—that is a personal problem of his, I think. In fact, one of the terrible things about The Politics of Experience is that Laing generalizes so much from his personal experiences. I can't imagine how else he can see the family as actually antagonistic to human development.37
Q: How do you feel, as a psychiatrist, when you finish a book that concludes: "If I could turn you on, if I could drive you out of your wretched mind, if I could tell you I would let you know."

L: I think Laing, the man who wrote those lines, is in such a despairing state that he shouldn't do therapy. I don't think I could treat patients if I were in such a depression that I felt there was so little joy and creativity in this world. . . .

Laing is represented by Lidz as the corrupter of youth, and as the violator of sound medical and psychiatric practice. All of Laing's discussions or allusions to human potential inherent in the schizophrenic state are glossed over as false and inadequate by Lidz. He concludes that having alternative models of human potential or human possibilities is fallacious since it violates the known scientific facts about the development of specific human beings. Lidz demonstrates a remarkable prejudice against theory and speculation about the theoretical possibilities of human development. He also betrays a low tolerance for Laing's political observations and of the general framework of The Politics of Experience. According to Lidz, the reality of human development is to be found in the work of doctors and scientists in psychiatric research hospitals and on the pages of psychiatric journals. The public has no right, no business, in knowing about the advances of science on the schizophrenic front—for reasons which Lidz does not make clear.
Hospitals and mental health or psychiatric wards are necessary to provide the patients with a sense of security and limits since one of the major difficulties of schizophrenic patients is that they desperately lack, and therefore, require, limits and frameworks established by others for them to follow. Making schizophrenics important, setting them up as models, is something that is thoroughly disapproved of by Lidz. Schizophrenics are sick. Shamanistic analogies, the use of LSD and other such mysterious goings-on Lidz has heard Laing encourages are completely unacceptable within the framework of science and medical psychiatry. Yet, very little is admitted by Lidz about the state or condition of normal psychiatry and normal mental health hospitals. Nothing is said, for example, about the use of drugs, shock therapy or surgical techniques in normal institutional settings. Lidz does not favor the move away from institutionalization of schizophrenic patients because this will not help them get the necessary treatment and allow them to recover. He simply, almost blindly, accepts all that professional psychiatry does as good and useful. All hospitals are as good or advanced as the Yale Psychiatric Institute, Lidz suggests. Extending this professional courtesy deprives Lidz of any grounds for criticism of his profession.

Defending the status quo, Lidz refuses to give Laing much credit for anything. Politics is not an acceptable subject for psychotherapists to discuss. Laing's activities
in London as reported to him are "dangerous as hell." And
Laing has not made much of an original contribution to
psychiatry, apart from his political investigations.

Laing is a pessimist. Therefore, he probably
should not be practicing psychotherapy. Lidz defends
the profession, the psychotic ward, and the mental
hospital against this upstart attack on professional
norms and standards. This role of defender, however,
is not a new one for Lidz. He has written extensively
on the subject of schizophrenia and the family. The
major theoretical work of his career on this subject
is a collection of lectures published in 1963 entitled
The Family and Human Adaptation. All later theoretical
and empirical work in the area of schizophrenia and the
family coming out of the Yale Psychiatric Institute makes
reference to this 1963 volume.

In The Family and Human Adaptation, Lidz feared
for the cultural implications of the expanding nature of
of American society in the early Vietnam era. Foreign
influences were becoming manifest throughout American
culture in the early 1960's. As a consequence of this
foreign infusion, Lidz finds that

a babal of cultural traditions develops; the value
of the inherent traditional ways is doubted and then
ridiculed; the sanctity of parental authority is lost;
the society creates various institutions that take
over many of the original functions of the family;
and then the individual and his own welfare and plea­
sure gain precedence over collective needs of the
family and of the society.39
Lidz establishes the appropriate psychiatric label for people who indulge in activities which tend to weaken or destroy the integrity of the nuclear family and its various cultural and sociological manifestations. He finds that

the decline of a civilization can follow upon the deterioration of its family life and the ensuing blurring of the cultural traditions. . . . Individuals who cannot, when necessary, subjugate impulse and immediate gratification to more enduring objectives and consideration of the needs and regulations of the social system are classified as sociopaths deficient in superego controls. 40

He differentiates between the nuclear family and the traditional extended family involving more than two generations and more than one each male and female parental figure. The modern two generational nuclear family is greatly preferred over the traditional extended family because it can manage to acculturate and socialize its members to the requirements of the technological era. Lidz provides a fascinating sociopsychiatric analysis of the advantages of the nuclear family:

major problems have arisen because of the rapidity of change in adaptive techniques that require a continuing reconstruction of what each new generation must acquire in order to fit into the changing society. The increased use of man's other basic mode of adaptation, his use of his intellect to master nature and plan ahead, lessens the usefulness of the transmission of traditional ways. Tradition hampers readjustment, and cultural lag can set in within a brief span of years—within a generation rather than over centuries. 41

In the technocratic era, the tradition-bound nature of the extended family severely hampers the teaching (training) of
adaptive capacities to new members of the family and the social order. In a technological age, fast changing needs and requirements cannot be taught when children are hampered by tradition.

At the same time, Lidz both attacks the foreign influences threatening the traditional, American cultural ideals of the family system; and praises the non-traditional, nuclear family, because it is not hindered by traditions and is thus able to cope with fast-paced changes required to survive in a modern technological age! The tradition to be defended is the non-traditional, technological, nuclear family. He manages this precarious balancing act by arguing that the role expectations of the various family members are the most important elements allowing it to perform its technological era functions. The Lidz analysis of the nature of the American culture thus seeks a balance between tradition and change by justifying the patterns and role expectations within any nuclear family as vital to the survival of the cultural tradition and to the proper socialization of the children. The content of this socialization—besides the learning of proper role expectations in the nuclear family to allow children to carry on the tradition—can vary greatly and the system can still work, as long as the nuclear family system is maintained. The crux of the Lidz doctrine on the ultimate significance of the nuclear family, therefore, lies in the inextricable connections he
sees between proper nuclear family role teaching and playing, family unity, and the proper formulation of the personality of the children of the family. The adults must act properly so that the children will not develop psychiatric hindrances or illnesses and the culture and society can continue to function in this technological age of change.

A marriage can be satisfactory to the husband and wife with all sorts of role allocations and ways of achieving reciprocity. The customary roles of male and female can be reversed with the wife supporting and the man cooking and housekeeping; they can each remain in their parental homes; one or both may find sexual outlets only outside the marriage either heterosexually or homosexually; one spouse may fill a parental rather than a marital role for the other; it can form a sadomasochistic partnership or a source of masochistic satisfaction to both. The variants are countless and every psychiatrist continues to encounter new permutations. However, when the arrival of children turns a marriage into a nuclear family, the spouse's ways of relating must shift to make room for the children.42

The essentials of proper parental roles are succinctly stated by Lidz. The mother and father must form a coalition as members of the parental generation maintaining their respective gender-linked roles and supporting one another against the children's challenging of these role performances or the coalition itself. The parental generation must be capable of transmitting adaptive techniques, suited to the society in which they live, to the children.

When the marriage is working properly, each parent supports the other's role, increasing the insurance and strength with which it can be carried out. The mother can properly invest energies in the care of the young child when economic support, status and protection are provided by the father. She can also
better limit her cathexis of the child to maternal feelings when her wifely needs are satisfied by her husband.\textsuperscript{43}

In a psychiatrically proper marriage, the wife takes care of the children while the husband goes out into the world and provides the economic and status necessities as well as the wifely needs of the wife-woman in this nuclear family model. Borrowing from the Freudian psychoanalytic system and adjusting it to modern technological requirements, Lidz focuses on the needs of the child:

The child properly requires two parents: a parent of the same sex with whom he identifies and who forms a role model to follow into adulthood, and a parent of the opposite sex who becomes a basic love object and provides the child with a sense of worth.\textsuperscript{44}

The parents provide the exclusive sources of proper learning of sex, parental, and marital roles for the child. Lidz, therefore, demands strict adherence to proper roles and relationships among the parents. The respective roles of men and women, husband and wife, and father and mother are taught by example to the child by his parents in the family system. If the child is not properly taught these roles, he or she will in turn not be able to act them out as parents, and the nuclear family system will not continue. This doctrine about the significance of marriage and family systems is based upon the requisite need to perpetuate the proper pattern in order to save or maintain the whole cultural system during these times of accelerated change and exotic foreign influences.
No other possible sources of learning these—or differing—roles are mentioned. What happens, if, in our fast changing technocracy, one particular generation's model of a nuclear family is found to be inappropriate to the adaptation of the offspring of that family? Might, in fact, the Lidz model be severely threatened by changes in the United States during (for example) the past ten years? Lidz would seemingly dismiss any such changes as corruptions of the culture since a major acknowledged impact of these changes has been the collapse of the nuclear family model postulated (learned?) by Lidz. But Lidz provides no such recognition of possible acceptable alternatives to his model of sex-linked roles in the nuclear family.

The proper completion of the oedipal functions "depends upon having a family in which the parents are primarily reliant upon one another or upon other adults, and can therefore give of themselves to the child." Psychoanalytic concepts are utilized by Lidz to convince the reader of the crucial importance of properly fulfilling the oedipus requirements. "The child's development can be stunted if he must emotionally support the parent he needs for security." And, "A mother who cannot establish clear ego boundaries between herself and the child, as has been noted in many mothers of schizophrenic sons, is also violating the generation boundaries."
Confusions and dissatisfactions concerning sexual identity can contribute to the etiology of many neuroses and character defects as well as perversions. Probably all schizophrenic patients are seriously confused in this area. 48

And:

A child whose father performs the mothering functions both tangibly and emotionally while the mother is preoccupied with her career can easily gain a distorted image of masculinity and femininity. 49

Enacting, and acting out the proper sex and parental roles is an extremely difficult accomplishment. Mothers who want to get or use their educations or pursue careers or work outside the home would all be violating Lidz's rules for proper families. Fathers also would have quite a hard time if they were to seek to establish more nutritive personal relationships with their children. All but the most rigorous mothers and fathers would seem destined to fail. Nevertheless, the nuclear family model is insisted upon by Lidz; no other environment is seen as adequate for proper child rearing.

And:

Children raised in institutions that provide only routine care lag in their speech and intellectual development which may result from the linguistic vacuum in which they are raised as well as from the deprivation of maternal nurturance. 50

As a child completes his primary socialization period, and prepares to emerge into a life with his peers in play and at school, "the erotic quality of his attachment [to the parents] must gradually be frustrated and
the parent-child relationship freed of sexuality. This desexualization of the parent-child attachment is a cardinal task of the family. 51 Presumably these erotic relationships arise naturally from the child and the parents. The family exists to foster and develop such relationships so that the child can properly mature.

With this model of the family, the erotic relationships among its various members, between parent generation and child generation, must be destroyed if the child is to properly mature. The purpose of the family is to nurture and then destroy erotic relationships among its members. It is possible to suggest, as does Laing among others, that erotic relationships inherently exist between human beings. Is it possible to destroy erotic relationships between people, particularly between a mother and a child when the mother has devoted herself exclusively to the child's needs: and when the child has, in return, learned to be exclusively dependent upon and loving towards the mother? The child, of course, goes increasingly out into the world of others; the mother does not in this system. The Lidz model of the ideal family seems to have some extraordinary tensions built into it, and no releases are provided.
Expecting a father and mother to exclusively enact the norms articulated by this model is making a great demand on the adults in this model family. Urging the destruction of any erotic relationships when the child reaches a certain age would seem, in theory, to be making an incredibly difficult demand on each member—particularly on the mother who has urgent strictures applied by Lidz to dedicate herself exclusively to the children's needs in pre-adolescence, and then is instructed to completely drop her emotion and expectations of love in return from the child.

About the possibilities of incestuous tendencies in the family, Lidz asserts that such tendencies are a result of faulty family structure. In failing to provide an environment that precludes the arousal of conscious incestuous interests, the family fails in a fundamental requisite. The progression of the erotically toned child-parent attachment to an incestuous bond threatens the existence of the nuclear family, prevents the child from investing energies in extra-familial socializing channels, and blocks his emergence as an adult.52

Turning to the child to fulfill role expectations that parents expect but are unable to get from one another is a "psychiatrically dangerous situation" for Lidz. According to Laing's theory of the family, the role of children in the family is to fulfill roles in a family system of relationships going back for multiple generations. These expectations may be relatively open-ended, flexible, and even benign. They might, however, severely constrict the opportunities for expression or articulation that children
ought to have in order to develop their human experiential capacities. The control that Lidz argues must be exercised by parents over the family situation is far larger than what Laing sees as necessary or desirable. For Laing, the family is more than the functioning together of its constituent members. The differences between families are great; every family situation is unique and extremely complex. Visible patterns of interaction are like the top of an iceberg. General formulations are of little or no use for Laing.

It does not seem possible to first insist on establishing and maintaining an exclusive pattern—a monopoly—of erotic relationships between mother and child; and to later destroy those relationships. The Lidz nuclear family model assumes that erotic relationships can be turned on and off like a faucet, and that the adult members of the nuclear family must seal themselves off from all possibly damaging outside influences, constraints, etc., so as to preserve the sex-linked familial roles. What happens to the parents, particularly the mother, when the children go outside the happy nuclear family home to seek outside fulfillment? For that matter, what happens to the children when they in turn have children and perhaps find this relationship constraining, frustrating, or unfulfilling? Or what if they are never taught the proper rules of family functioning? Each member of a Lidz model family can
probably find good reasons why such a model relationship limits his human possibilities.

Perhaps rejections of this nuclear family system are to be classified as failures of adaptation in the subject's family of birth. If this is the case, Lidz and his associates should presumably be able to face up to massive failure throughout society in the adaptation and carrying on of the nuclear family as opportunities for the expansion of psychiatry. Teaching of the Lidz orthodoxy will require the urgent expansion of the profession in order to save society from damage.

Lidz borrows freely from the Freudian theoretical system when it serves his purposes. He is also quite able to utilize the threat of improper socialization, mental illness, or even the phenomena of schizophrenia as possible consequences of improper mothering. In retrospect, Lidz seems to have been enshrining and resolutely defending one particular model of the family. He might be understood as something of an apologist for a particular social order and particular orthodoxy about the requirements of proper familial functioning in the technological era. Perhaps he will see things differently now that American society has achieved the post-industrial era? No possibilities for adjusting or changing models or expectations from the Lidz mother-factor reductionist orthodoxy are provided.
Lidz finds Laing's work threatening to his society. Laing does criticize families thought to be properly functioning. In *The Politics of Experience* there is even a negative reference to the Lidz doctrine of proper family structure. Laing does not attack families as much as he tries to explicate a framework to explain what is happening to these human organizations and institutions. He seeks to explicate the criteria to distinguish well functioning families from those which fail to provide the prerequisites for proper human development.

Rosen, Lidz, Sechehaye, and Searles illustrate in their work four types of psychotherapeutic treatments for patients diagnosed as schizophrenic. While none of these methods has attained widespread acceptance within psychiatry, all demonstrate that the dread "disease" or mental ailment called schizophrenia, can be effectively treated and understood utilizing a wide variety of therapeutic methods and theories.

Lidz shows the dangers of reductionism and of replacing theory based on observation with an ideology seeking to provide society with models of health. Sechehaye painstakingly demonstrates the extent of care, attention, time and ingenuity necessary to respond to schizophrenic regression. She fails to appreciate, along with Rosen, the potential for cure in regression. Also, she is unnecessarily
tied to orthodox psychoanalytic models predicated on a biological etiology. Rosen shows the prospects and pitfalls of assembly-line treatment of psychotic patients by cookbook methods of "Do this for that manifestation of the illness." He demonstrates the dangers of losing sight of individual experience and possibility in practice, while he stresses its importance in theory. Searles tells us about how paying attention, seeking to be patient and understanding, can clarify a variety of problems heretofore thought to be symptoms of the pathological, chemical, genetic, or basically non-communicational nature of the disease/illness. Yet Searles shows that therapy for the affluent has limited applicability in a poor world. Most importantly, for Sechehaye and Searles, schizophrenic therapy is predicated on the possibility of hope, rebirth, and the achievement of an integral human wholeness.
CHAPTER VI

GENETIC AND CHEMICAL PERSPECTIVES

1.

Although much progress has been made on psychotherapeutic work with schizophrenics, today the vast majority of medical and scientific resources are devoted to seeking the effective organic and physico-chemical etiology and treatment for schizophrenia. A perusal of the Index Medicus, for example, will provide ample evidence that most research into schizophrenia is committed to the thesis that it has a genetic basis, and can be controlled with the forthcoming identification of its chemical nature.

The pioneering work of Franz Kallman is generally accepted as having established the importance of genetic inheritance in schizophrenia. From the chemical side, the development of chlorpromazine (CPZ) and related schizophrenic-specific drugs has opened a new era of the psychiatry of schizophrenia. Once hailed as the long awaited chemical cure, CPZ is now recognized as a drug which facilitates other therapeutic endeavors; it is not a treatment by itself. The medical and psychiatric professions,
expect to be able to add anti-schizophrenic drug treatments to their medical armamentarium and thus achieve a great victory for medical science.

Theoretical discussions in this field are all connected to advancing a claim of victory in the war on schizophrenia. The theoretical positions advocated by Kallman, Solomon Snyder, Seymour Kety, and so forth, represent attempts to bridge the gap between laboratory research and the larger psychiatric audience and issues of schizophrenic therapy. While no answers have been found, the believers of medical and chemical psychiatry do dominate the field.

Franz J. Kallman (1897– ) published *The Genetics of Schizophrenia*, reporting on 1,087 cases of schizophrenia, in 1938. Today that study is widely regarded as definitive in the field. For example, W. Mayer-Gross, E. Slater, and M. Roth assert in their text, *Clinical Psychiatry* that: "It may now be regarded as established that hereditary factors play a predominant role in the causation of schizophrenic psychoses." This conclusion is based on their evaluation of Kallman's 1938 volume as the definitive study.

Kallman believed himself a pioneer in 1938 as shown by these introductory comments to *The Genetics of Schizophrenia*: 
Despite various advances in recent years, psychiatric research is still battling on many fronts, in America as elsewhere, for general recognition of genetic concepts and for practical realization of biological principles. The key position of this battle seems to be held by the disease group of schizophrenia, which continues to crowd mental hospitals all over the world and affords an unceasing source of maladjusted cranks, asocial eccentrics and the lowest type of criminal offenders. Even the faithful believer in the predominance of individualistic liberty, theoretically opposed to every eugenic measure on behalf of society as a whole, will admit that mankind would be much happier without those numerous adventurers, fanatics and pseudo-saviors of the world who are found to come from the schizophrenic genotype, and with that immoderate and pitiful misery which burdens the families tainted with schizophrenia.  

There are public health dangers that make it imperative to determine exactly those heredito-constitutional elements which are involved in the origin of schizoid abnormalities and to seek reasonable ways of deterring their constant recurrence. We must remember that prevention of several hundred schizophrenic patients and their tainted dependents in every state, would save millions of dollars for cultural purposes and would considerably advance the biological qualities of future generations.  

Prevention of "schizophrenic patients and their tainted dependents" means for Kallman, to forcibly prevent them from having children. If officials and the lay public understood and accepted "the nature of the schizophrenic psychoses . . . the battle against these longstanding prejudices, which still oppose the prompt hospitalization of the insane must be an important point in any system of eugenics."  

Continuous internment of
schizophrenics past their reproductive period is the chief purpose of early diagnosis and hospitalization of schizophrenics in the Kallman model. If those who inherit the genetic taint are stopped from reproducing, the disease will be wiped out.

This institutionalization becomes difficult in practice, however, because

Manifest schizophrenics, eccentric vagabonds and asocial tramps tend to wander incessantly and to free themselves from civil restraints as early as possible. . . . Abnormal descendants of schizophrenics are considerably harder to contact than the healthy individuals who maintain their social status.\(^5\)

The number of tainted individuals "at present" amounted to only 10% of the relatives of schizophrenic cases, but Kallman reported that at least one-third of those "belonging to the hereditary-circle of schizophrenia" have it.\(^6\) And even these figures "might be extended if we had better facilities for diagnosing the psychopathic types."\(^7\) In many cases, Kallman finds that the schizophrenic "tendency remains latent through all direct ancestors."\(^8\) Spending money to search out and institutionalize schizophrenics now will result in large savings in the future in the Kallman model of eugenics. The chief aim of eugenics, however, should be to prevent "the marriages of schizoid psychopaths and eccentric borderline cases with similarly tainted schizoid individuals."\(^9\) The need for
such eugenic action is clearly demonstrated in the Kallman statistics on the probability factors for inheriting schizophrenia:

The probability of schizophrenia in the children of two schizophrenic parents amounts to 68 per cent in our survey; while it is only 9.1 per cent for the offspring of the combination of two heterozygotic parents. The cross-breeding proportion of one schizophrenic and one non-schizophrenic parent yields expectancy figures of 14.8 to 23.9 per cent.\(^{10}\)

Apparently those 9.1 per cent who get schizophrenia even though their parents don't have it inherit it by means of the latent transmission through all direct ancestors. Even this group can be eliminated with multi-generational screening and controls.

Kallman provides his readers with some case studies to demonstrate his diagnostic techniques. Here is the case of Elfriede H., born in 1888. She

is divorced and childless. Has always been a peculiar and intractable person . . . developed a persecution complex and experienced auditory and visual hallucinations. She hears voices in conversation; scolds a great deal, sees visions, talks to herself for hours, and is sure she is being spied on through the walls. Some times she howls like a dog. She does nothing, and can justify her behavior to herself. She has illusions that she is being interfered with and is being oppressed. (Hebephrenia.)\(^{11}\)

If to the non-professional student of Kallman's diagnostic system, Elfriede H. seems to be basically lazy and lonely; the next example, Martha E., nee B., seems to have more difficult problems. Her marriage is not a good one (this case fits well Thomas Szasz's discussion of the
relationship between psychiatry and the oppression of women in Victorian marriages:

Marriage incepted in 1913, was tolerable at first but in the last ten years became "very unhappy." Even as a young girl she was "somewhat high-strung and exaggeratedly pietistic." From her wedding day onward she was preoccupied with "higher problems." She tried especially to investigate "the immortality of the soul." There were repeated sojourns in sanatoria "for pulmonary problems" and "overstimulated nerves." Since 1924 she has been jealous and has developed a definite persecutory trend. She saw visions, and held grievances about "distortion of ideas." Since 1932 she has not only accused her husband of infidelity, but has claimed that he wants to poison her or get rid of her secretly in some way. . . . (Hebephrenia.)

Like the case studies of Kraepelin, what is disturbing about reading these case studies is that we don't know one thing about the experiences of the patient. The record is entirely an institutional record of what happened. What the patient thought is deemed irrelevant.

Kallman summarizes his goal at the end of his 1938 volume: "psychiatry will be able to bring about the cessation of both the manifestation of the predisposition of schizophrenia and of its hereditary transmission, in order to reach the goal of modern medicine: simultaneous prevention and healing." Utilizing and refining his earlier data, Kallman writes in a 1953 published study that

The total expectancy of the direct forms of schizophrenia varies from 7.1 per cent for half sibs, through about 14 per cent for full sibs and two-egg
cotwins, to 86.2 per cent for one-egg twin partners. . . . Grandchildren and nephews and nieces are about five times more likely than the average person to show a recurrence of schizophrenia. . . . Next to one-egg cotwins, the children of two schizophrenic parents have the highest expectancy of the disease (68.1 per cent). 14

Because "It is tragic indeed to be married to a psychotic wife, or to have to send a schizophrenic son to a mental institution," Kallman finds that people want full and frank disclosure about the possibilities of this disease occurring in their family before making decisions about marrying or having children. 15 Unfortunately, however, there are always some people who aren't aware of the dangers involved. For example,

A young man, seeking the advice of a marriage counselor, may be so naive as to appear more perturbed by what he calls his fiancee's "bad family history" (a few strokes, brain tumors, or institutionalized cases of senile dementia in grandparents and the husbands of favorite aunts) than he is by the fact that she had "a nervous breakdown which required only a few months of hospitalization while she was still in school." 16

In line with this genetically ignorant way of reasoning, a potential alcoholic or suspected drug addict is feared more than the case of

a bright young man who--apart from the deforming residues of a mastoid operation or a fairly mild poliomyelitic attack in childhood--comes from a family where the father died of paresis in a mental hospital, and the mother committed suicide after having several stillbirths and a congenitally
blind child. It is not surprising, therefore, that the largest single group of questions asked of a general genetics department (not located in the South) "concerns the inheritance of skin color."17

The genetics counselor must strive to keep schizophrenics from marrying--especially one another--or from having children. The twin studies Kallman presents in his work lead to this general rule of thumb: "the chance of developing a schizophrenic psychosis increases in direct proportion to the degree of blood relationship to a schizophrenic index case."18

In training genetics counselors, Kallman suggests a tactic far from the 1938 blunt urgings for quick hospitalization to save millions for culture. Later, the emphasis is on self-responsibility:

The conscientious and soundly trained counselor will be guided by the general objective of the geneticist to encourage a person's feelings of responsibility for his own self, without negating the all important concept that a well-planned family is indispensable as a biological, social and cultural unit from society's standpoint, and as a source of strength and stability for the individual.19

No tainted persons should be allowed in one's family if it is to remain a good and solid unit meeting individual and societal needs.

As to the medico-scientific foundations of Kallman's research, Laing has written an extensive critique, summarized as follows:
(1) Kallman's sample, drawn from records of state mental hospital admissions, "can by no means have been a representative sample of Berlin schizophrenics." 20

(2) The reliability and validity of his method of diagnosis is not established. No reciprocal blind diagnosis is made. 21

(3) Kallman's principle to establish an authentic case of schizophrenia amounts to: "If schizophrenic, then a priori, hereditary predisposition. If not hereditary predisposition, than, a priori, not schizophrenic. If two blood relatives develop schizophreniform psychoses, this proves that they are suffering from 'endogenous psychoses, genetically determined.'" This form of logic does not conform to the scientific principles of genetics. 22

(4) Kallman demonstrates an "uncritical and naive approach to his data . . . one can place no more confidence in Kallman's assessments of 'concordance' of 'environment' than in those of life history and diagnosis." 23 In his twin studies, the case histories are inadequate and naive as to the impact of environment. Biologists would not "regard the data on twins as affording a controlled experiment." 24
(5) "While adult experience and behavior is several steps away from primary gene action, genetical diseases can be taken to be, in the present state of knowledge, metabolic defects. No metabolic defects have been found specific to schizophrenia, nor have any been correlated to schizophrenia. Nor, in our view, is any single unit of behavior or experience specific to schizophrenia." 25

(6) "The conclusion and the moral are the same: You cannot make a statistical silk purse out of a clinical sow's ear." 26

A fascinating aspect of Laing's critique of Kallman is the assurance with which Laing writes about good, or less than adequate diagnoses of schizophrenia—as if the disease actually existed and could be independently varied among psychiatric researchers. For another example, he gives this critique of the work of Eliot Slater, another genetics and schizophrenia enthusiast: "Not purely clinical considerations move him to concur with another psychiatrist's diagnosis when he himself finds no present signs of past schizophrenic defect, or to reverse a diagnosis of schizophrenia when clinical evidence seems to support it." 27 Functioning as a psychiatric critic, Laing assumes that a good clinical diagnosis of schizophrenia can be made — i.e., that schizophrenia does exist.
Why the profession accepts Kallman's work on the genetic causation of schizophrenia as definitive and conclusive is very unclear. Kallman's political and personal attitudes, and his moralizing statements are not demonstrations of scientific neutrality or understanding. And the validity and reliability of his work is open to serious challenge. What is clear is that this line of reasoning suggests strongly that any therapy of schizophrenia is a losing proposition. Genetic control is therefore the only alternative. In this respect, Kallman's work is certainly at variance from therapists such as Fromm-Reichmann, Searles, Laing, and even Szasz. The disjunction between these points of view will become even more apparent as the contemporary advocates of the genetics and chemical approach are discussed.

The genetics perspective can perhaps be better appreciated by looking at the work of Jon Karlsson. In The Biological Basis of Schizophrenia, he charges that the environmental theory advocates have not proven their case scientifically. And Kallman's 1953 study does support the claims for genetic etiology: "No specific studies have been done by the adherents of the environmental theory to provide basic data on the extent to which the environment in fact influences the development of schizophrenia."
Karlsson claims to have demonstrated, in a multi-generational study in Iceland, that "the distribution" of schizophrenia "in the relatives follows mathematical rules which can be accounted for by the Mendelian laws of heredity." For example, in one family history, Karlsson claims to have discovered "the long term transmission pattern of chronic psychosis in a kindred whose history is known for seven generations." Therefore:

On the basis of the family data it may be concluded that the chronic psychosis develops only in individuals with the appropriate genotype. The evidence does not support the view that faulty environment is responsible for the origin of schizophrenia, but rather such stress seems to bring out or aggravate the symptoms in persons with a schizophrenic constitution.

How clinical diagnoses of persons long dead can be achieved is never discussed or explained by Karlsson. The scientific acceptability of his study is probably lower than Kallman's work. However, Karlsson views schizophrenia from quite a different perspective than does Kallman. Karlsson's basic hypothesis is that schizophrenia results from an incompatibility of two relatively harmless or possibly beneficial physiologic states. The one of these that by itself seems to be involved in a determination of thought patterns is of particular interest, as it appears that 6 per cent of the population that should possess this characteristic perhaps includes individuals who are cultural and political leaders in human societies.

Karlsson found that schizophrenia often developed in individuals "who had exhibited outstanding intellectual
performance prior to the onset of the overt disease," as demonstrated in their outstanding science and mathematics abilities in school! Persons who developed schizophrenia were the same ones likely to "lead society toward further progress" in medicine and the quantitative sciences.\textsuperscript{34} Karlsson finds that the 5 per cent he labels gifted are also tension ridden; and the one per cent labeled genius are listed as schizophrenic. If this hypothesis is true, Karlsson finds, "it can explain why a race of superior mentality has not arisen. . . . Schizophrenia can then be looked upon as the price which the human race must pay for its superior members."\textsuperscript{35}

All is not lost, however, since Karlsson concludes that "Hopes for its conquest rest with the determination of the underlying chemical disturbance."\textsuperscript{36} The aim of this research is to restore schizophrenics to normal functioning through chemical means. And, Karlsson tells us, "This has been partly achieved by the advent of the phenothiazine drugs."\textsuperscript{37}

2.

To comprehend the chemico-genetic approach, it is important to examine some of the claims made on behalf of the chemical treatments for schizophrenia. Especially important in contemporary psychiatry is the discovery and
widespread application of the phenothiazine or anti-schizophrenic drugs to hospitalized patients diagnosed as schizophrenic.

Although hundreds of articles and monographs are published annually advocating or assuming the chemical treatment point of view, few researchers are able or willing to explain or defend the basic premises of their research. Solomon Snyder assumes that schizophrenia is an inherited trait, for example. With the advent of the drug CPZ, according to Snyder, "some patients responded dramatically, and it was clear that what they had in common was the disease schizophrenia." Snyder continues his study with the assertion that CPZ

both calms hyperactive patients and activates the withdrawn ones . . . the drug is not by any means a mere sedative, but must be doing something that is specifically anti-schizophrenic.

Snyder points out that the effect of widespread use of this drug has resulted in a 50 per cent decline in the projected population of schizophrenics in mental hospitals. At the same time--between 1955 and 1971--the number of admissions to hospitals with the diagnosis of schizophrenia was doubling. With CPZ being extensively utilized, the turn over was greatly accelerated since schizophrenics could return to their homes, under medication, and the hospitals could take in new schizophrenics and train them under the new drug regimen for quick release.
Even with CPZ, however, the chemical and organic nature of schizophrenia presents some difficulties, as Snyder admits:

There is abundant genetic and clinical evidence that the disease entity of schizophrenia, as well as other psychotic disturbances, is genuine. The difficulty of the psychiatric community stems from the lack of a simple physical indicator of the disease.41

No physical indicator or test for this supposed medical disease exists. The notion that a physical indicator can be developed is based on the assumption, first articulated by Bleuler and here advocated by Snyder, that hallucinations, delusions, and catatonic behaviors are merely "accessory" symptoms. A psychological diagnosis is a notoriously inaccurate way of determining the existence of schizophrenia. And since schizophrenia exists as a medical disease, a physical test can be developed to allow accurate diagnosis--irregardless of the psychological symptoms. If this assumption is made or accepted, "our net for the population of people who may be suffering from schizophrenia widens tremendously . . . untold numbers of individuals, generally thought to be 'all right' although rather shy, lonely, and perhaps a little peculiar, are very much schizophrenic but have simply not yet developed the more bizarre and recognizable stamps of the disease."42
Or perhaps they never will develop the full panoply of symptoms, but nevertheless do need psychiatric assistance. Expanding the field in this manner serves notice on the psychotherapists that there is more work to be done than can be accomplished with talk therapies. And:

Despite many heroic efforts by some of the leading psychoanalysts of this century, the best controlled research studies have all concluded that a simple prescription of chlorpromazine in adequate doses is far more useful for the schizophrenic patient than endless hours of love, trust and understanding on the part of the psychoanalytic therapist. 43

The answer and cure lies in increased laboratory research. Unfortunately, however, CPZ and other phenothiazines, "do not 'cure' schizophrenia, but only facilitate remissions of the disease . . . once a schizophrenic, always a schizophrenic." 44 If CPZ doesn't cure schizophrenia, additional research will lead to the chemical solution. We already have some good clues, Snyder reports. For example:

we still feel heartened that the blockage of dopamine receptors is indeed the most meaningful action of the phenothiazines as far is schizophrenia is concerned. Moreover, research related to the mechanism of action of amphetamines further bolsters the hypothesis that dopamine and schizophrenia have something important to do with each other.45

Therefore one should leave it to the scientific researchers to make that great discovery indicating what connection dopamine and schizophrenia have to one another. And give up on psychotherapy in favor of CPZ in the interregnum.
Judith P. Swazey, a medical historian, has written a thorough study of the impact of CPZ, Chlorpromazine in Psychiatry: A Study of Therapeutic Innovation. This volume was sponsored by the Committee on Brain Sciences, Division of Medical Sciences, National Research Council.

Swazey traces the laboratory isolation and identification of CPZ and its derivatives, and thoroughly surveys the psychiatric profession to assess the impact of CPZ on the practice of psychiatry with schizophrenics both in and out of the mental hospital. All of her evidence comes from interviews with practicing psychiatrists.

Lehmann and Hanrahan establish the impact of CPZ in psychiatry:

The psychiatrist is surprised to find his manic patients amenable to reason. . . . The drug is of unique value in the symptomatic control of any kind of severe excitement. This includes catatonic schizophrenia, schizo-affective conditions, epileptic clouded states, agitation occurring in lobotomized patients . . . and organic toxic confusional states.46

Unlike shock or sedation by other drugs, CPZ permits "sustained psychotherapeutic rapport" between patient and psychiatrist.47 Even therapists who practice psychoanalytical approaches can utilize CPZ to enhance their efforts by insuring through chemical means that the patient is quiet and attentive. All of psychiatry can benefit.
Lehmann and Hanrahan describe the effects of CPZ on the central nervous system of the recipients. CPZ has a pronounced inhibitory effect on certain functions of the central nervous system. Patients receiving the drug become lethargic. Manic patients often will not object to bed rest, and patients who present management problems become tractable. Assaultive and interfering behavior ceases almost entirely. The patients under treatment display a lack of spontaneous interest in their environment, yet are easily accessible and respond as a rule immediately and relevantly to questions even if awakened from sleep . . . . Perhaps the greatest advantage of this drug lies in its power to quiet severely excited patients without rendering them confused or otherwise inaccessible. CPZ makes patients accessible to authorities whether or not they want to be accessible. It can become a therapy by itself, or the sine qua non of any therapy requiring the cooperation of the patient. Apparently, there are other effects on the patient as well: "Like previous investigators, Anton-Stephens found that the most striking psychiatric response to CPZ were 'somnolence' and 'psychiatric indifference,' beginning 2 to 3 days after the onset of treatment." Instead of using ECT, or restraining him physically or chemically, this drug quickly and cleanly makes the patient accessible to anyone. The patient has no control over his own availability with CPZ. The perspective of the patient, of course, is not the subject of the Swazey study and is never considered.
Dr. Harry Brill recalls that the introduction of CPZ was attended by an enormous amount of controversy, especially from people who had emotional commitments to the psychological type of treatments. These were practitioners who defended psychoanalysis and psychotherapies, and psychodynamic procedures of one type or another—the talking kind of treatment. They were very unhappy and weren't able to believe what was taking place. It took a lot of demonstrating. But it is also interesting that in spite of the controversy, the use of drugs spread so rapidly that this type of treatment became almost universal. Only a few diehards refused to use them at all. And so the revolution was victorious. Brill describes the new dayroom in the CPZ era: "The most memorable experience I remember was walking into the dayroom and seeing this small group of patients dressed, quiet, cooperative and in surprisingly good contact—with their psychiatric symptoms wiped away." Dr. Martin Fleishman describes what happened at his institution:

We consented to use phenothiazines, erroneously pushed them to toxicity—and found that they worked anyway. Patients became quieter, wards became quieter and psychiatric aides became quieter. . . . Patients became people, and even more important, they became identified as people by the people who took care of them.

In contrast, Dr. Sidney Cohen describes a hospital before the CPZ era:

The seclusion rooms. A mattress thrown on a bare floor, no furniture to smash, no toilet to plug with clothes and flush till a flood cascades down the stairs. Peep through the small barred hole in the door. A creature in rags or nude, paces like a caged animal, glaring, shouting, tearing at the plaster.
Peace, quiet, cleanliness, and order were all made possible by CPZ.

The marketing of CPZ in the United States as Thorazine, by Smith, Kline & French, opened up a new era in merchandising drugs. As an official of the company reported to Swazey, a salesman could make no inroads at a single hospital. We had to work with the whole system, from the legislature in a state through its entire public mental hospital system and [with] civic groups.

The work of the Task Force with state legislatures and at mental hospitals was not lobbying per se. It was a true educative effort... We set up a speakers' training bureau to work with psychiatric administrators on effectively presenting their treatment program proposals. An official of the drug company helped to found the National Association for Mental Health on the principles of CPZ therapy, and became the president of the group. Other company personnel worked closely with state mental health groups to spread the learning about tranquilizers for schizophrenics. The impact of these CPZ drugs on psychiatry can be appreciated by perusing the advertising pages of any psychiatric journal.

It was learned that CPZ "may have to be maintained indefinitely afterwards" once it was given to a patient. The impetus for establishing decentralized community mental health centers was the new CPZ treatment technology. The old policy of isolating schizophrenics in mental hospital wards had to be replaced: "As
long as available treatments required specialized settings and highly trained personnel, a fully public health approach to schizophrenia could never be developed." With CPZ, medication could be dispensed from local clinics or private doctors. The schizophrenic could function in the community in his tranquilized condition indefinitely. And mental hospitals would not have to be expanded, even though the number of diagnosed schizophrenics was going up.

The development of CPZ marked the arrival of psychopharmacology as an important profession supporting research and therapy in psychiatry. Swazey relates that although psychopharmacology's history dates back to antiquity, its explosive growth during the 1950's marked the beginning of a new era. Triggered in large measure by the advent of CPZ, psychopharmacology emerged as a distinct professional field, whose institutionalization can be seen in the formation of specialized journals, of national and international societies, and of such agencies as the Psychopharmacology Service Center.

Swazey gives as an example of the importance of this burgeoning field the fact that today there are more than 850 psychotropic compounds available to psychiatrists.

Research psychiatry and drug therapy today occupies the center of national consciousness. The search for chemical causation and curative agents absorbs the vast majority of research funding in psychiatry. And answers or cures are expected anytime in the war on schizophrenia.
The cost of mental illness is a concern to the research scientist seeking governmental and private funding for increased research. Although the costs of mental illness are difficult to measure, Swazey reports,

Two categories that can be determined with some precision—treatment and prevention, and loss of productive capacity—were estimated to have cost "just slightly less than $21 billion" in 1968 [after the widespread application of CPZ!]

Two other mental illness cost categories studied by the N.I.M.H. Biometry Branch are equally important, but harder to phrase in dollars and cents:

The cost of illegal and other undesirable behavior which involves crime, unnecessary accidents, disrupted family relations, offensive behavior, etc.

The tangible costs which refer to the insecurity, bewilderment, frustration, embitterment, and occasional hostility which often results from mental disorder.

The search for a cure to schizophrenia and other disabling mental illnesses, is an important national economic priority.

CPZ and its relatives are tranquilizers which work well on patients diagnosed as schizophrenic. The result is that "working through," regression, or natural healing processes are stopped or simply not allowed to begin. The advantage of this is that patients are sent out of the hospital and back into their pre-schizophrenic roles. Economically this makes good sense. And with ever-increasing numbers of diagnosed schizophrenics, CPZ provides for community-centered treatment, the provision of maintenance dosages of the drugs, instead of hospitalization. CPZ
took over when there was a crisis of too many patients, too few beds, and a lack of qualified therapists. While the patients on CPZ await for advancing science to provide the answers—a cure for schizophrenia—the psychiatrists keep them tranquilized, with or without additional therapy. Psychotherapy probably cannot work effectively with CPZ since the drug does not allow for emotional explorations of the patient's past or present.

3.

Abram Hoffer, Humphry Osmond, J. R. Smythies and Miriam Siegler constitute a team of psychiatrists who work with schizophrenics and advocate the chemical, organic approach to the phenomenon of schizophrenia. They have provided a fascinating and articulate model of the chemical and medical perspectives on schizophrenia. They advocate a particular model of madness, and also extensively criticize competing models.

The models explored by Hoffer, Osmond, Smythies and Siegler include: continuous models, the technological change model, the social reform model, the romantic-psychedelic model, the conspiratorial model, the witch hunting model, and the medical model. They espouse the medical model.

People who advocate various types of continuous models are serious, gloomy and fundamentally religious.
They believe that the sins of the fathers are visited on the children from generation unto generation; determinism rather than free will, prevails. Since blame has to be widely distributed, those who use these models soon get into the habit of attempting to make almost everyone feel guilty, including, of course, themselves. . . . Although everyone is guilty, including past generations and doubtless those still to come, relatively few people are actually available for censure, and blame tends to fall unevenly upon those scapegoats, such as mothers of schizophrenic children.

Scientific medicine is advanced in its thinking and forward-looking as compared to the quasi-religious moralistic kinds of therapy which seek to assign blame. Hoffer and Osmond, in *How to Live with Schizophrenia*, reject psychotherapy outright, primarily because it has been found wanting in scientific rigor:

Psychotherapy of a deep and interpretive kind has not been shown to bring about an improvement in this illness, and many in fact consider that it disrupts the patient and may impede recovery. Blame can and must be attached directly to the disease where it belongs; it is enough for the patient to have to struggle with a grave disability without adding a further burden of guilt and hatred with dubious interpretations of an old-fashion, psycho-analytic kind.

A technological change model is unacceptable because it suggests that mental diseases are expanding as technology accelerates its pace of change:

The notions that civilization favors the development of madness and that social change inevitably increases the numbers of mentally ill people have been advanced for millenia. Although these ideas have changed little, each time they appear newly minted they carry the same quality of inevitable doom which they had hundreds or even thousands of years ago.
As for the social reform model, these researchers and theorists assert simply that people do not want it. "People suffering from major diseases rarely have much energy left for undertaking social reforms, however politically active they might be if well." People who are ill want exactly what they should want: "competent medical advice, preferably in a clear-cut, familiar doctor-patient relationship." People who are sick want to get well. Why would they want to go out and advocate one or more kinds of political change, anyway?

The next model of madness, the romantic and psychedelic model, includes Laing's work. We are told that Laing more than anyone else today, has sought to romanticize schizophrenia by confusing it with the natural rebelliousness of young people and their desire for a new and exciting world. As young schizophrenics are more likely than their normal peers to feel keenly their desire to escape parental norms and values while still needing parental protection, they are especially susceptible to Laing's view that schizophrenia is a form of enlightenment not available to the "squares" of the normal generation.

The logic of this argument is not obvious. It sounds very much like the perspective taken by the Kallman arguments about ridding the world of schizophrenics if only they could be found and hospitalized in time.

Our authors are historically minded, of course, and have seen such romanticism before. After the French Revolution, there was a tremendous interest in the romantic aspect of madness. Tuberculosis also became a very popular disease
among young romantics and artists. As with Laing's view of schizophrenia today, tuberculosis in earlier times was an ideal illness:

An absolutely clearcut illness known to be limited to a small and definite population, which can be diagnosed quickly and accurately with a few laboratory tests would not be nearly so satisfactory from a literary point of view. The lines have been sufficiently unclear so that the hero's or heroine's character, personal choices, and fate can be seen as contributing to the final inevitable outcome. In short, there must be that mixture of free will and inevitability which marks any great tragedy.67

According to Siegler and Osmond, however, Laing's followers are sadly mistaken--and are playing dangerously with their own health to boot. Remember that "The tubercle bacillus and its cure were discovered."68 Laing and other non-believers in scientific progress notwithstanding: "Techniques are being developed to measure the illness chemically, electrophysiologically, and perceptually. Measurement deflates the romantic balloon as nothing else does. Many laboratories are now engaged in identifying the biochemical lesion or lesions central to the schizophrenic process."69 The future outlook for Laing and his followers is not good. When science triumphs over the nay sayers, such dangerous fooling around with illness will go out of fashion. The dangers of such a romantic view will then become very clear.

Erving Goffman is the chief theorist and advocate of the conspiratorial model of schizophrenia. Goffman writes about the "discrediting" of hospitalized mental patients, but he "does not explain why people initially
commit deviant acts, [he] deals mainly with secondary processes that may not always be of crucial importance."⁷⁰

According to the logic of Siegler and Osmond, the reason for committing deviant acts is that these persons are sick with the disease of schizophrenia.

Siegler and Osmond report the results of a question put to the heretical psychiatrist, Thomas Szasz:

Szasz was asked whether, if he himself suffered a temporary suicidal depression, he would wish to be rescued from it against his will by psychiatrists and whether he would be grateful afterward. There was nothing he could say to this.⁷¹

Szasz, according to this critique, was rendered speechless because he was caught between his philosophical principles and his doctor's desire to save a life. Szasz does not believe that mental illness is a disease, so presumably this challenging question meant little to him. He also believes that a person should have the right to take his or her own life. Siegler and Osmond castigate Szasz for not believing in the legal plea "not guilty by reason of insanity" in the Sirhan Sirhan trial since the defendant was obviously mentally ill when he committed the crime. Persons who are mentally ill should not be held legally responsible for their acts, according to Siegler and Osmond. Finally they reject Szasz's view of the world in no uncertain terms. Although witch-hunting is

a deplorable human proclivity which erupts from time to time, we believe that far more and far
greater damage has been and is being done by ascribing schizophrenia to human malice, whether conscious or unconscious, individual or collective.72

The plaintive claim is again made: these people are sick and require competent medical help—not talk or theories, social science, religion or psychotherapy.

Beyond critiquing the models of others, Siegler and Osmond do offer us their theoretical views on the nature of a proper psychiatric order to give care to schizophrenics. Their principle of order is centered on the concept of aesculapian authority. This term is taken from Management Theory by T. T. Peterson. Aesculapian authority is the authority designated by a society to its doctors ("or 'witchdoctors'") in order "to persuade certain people that they are 'sick' and must submit to treatment and curtail their normal activities."73 Further, no one is blamed for their illness. The doctor's authority "must be stronger than any other existing authority—at least for that particular moment and in that particular context."74 This authority is very powerful, our authors tell us, and, "the oddest thing about it is our failure to notice it."75 By power, apparently, they mean that people readily accept this authority, and that it takes precedence over all other authority claims. Not noticing may be a consequence of good social order prevailing.
Aesculapian authority is composed of three major ingredients:

1. sapiential authority, which is claimed by reason of knowledge and expertness;
2. moral authority, as constituted by the Hippocratic Oath. This makes it socially right as well as individually good; and
3. charismatic authority, or "the right to control and direct by reason of God-given grace . . . [It] reflects the original unity of medicine and religion which still exists in many parts of the world."  

Siegler and Osmond find again that, "This is an unbeatable combination. There is no other profession that matches this."  

It is not a completely rational authority, we are informed, because life and death are not rational matters.

The doctor role could not exist without the sick role. Therefore, the sick role is more important than the doctor role. Because the doctor is more likely to misuse his authority without the patient than the patient would without the doctor, the sick role is more important. The sick role exempts a person from "some or all of his normal social responsibilities." The sick person "cannot help being ill and cannot get well by an act of decision or will . . . [and] is expected to get well as soon as possible."  

Finally, the sick person should seek help, and
follow the advice given to him. This articulation of the sick role is credited to Talcott Parsons.

Within medicine itself, there are three models: the clinical model, the public health model, and the scientific medicine model. In the public health model, some role problems exist since "the central roles in this model are not doctor and patient, but public health official and citizen." And "Community mental health has no model," according to the authors. Given a choice, "It is unclear whether the public would be willing to pay for nonmedical health centers . . . however admirable they might be." Indeed, it has become so much a part of the conventional wisdom that there is a community ever willing and anxious to assist in resocializing the mentally ill that it is almost heretical to question this assumption. Dr. Henry R. Rollin has observed that "community care to me is one of the most seductive and yet one of the most treacherous catch-phrases ever devised for the very simple reason that in my experience of a catchment area largely concerned with Metropolitan London there is very little evidence that the community gives a tupenny damn." Another alternative explanation is that the public does not believe aeusculapian authority applicable because mental illness is not thought to be a real, organic illness. The third model, the scientific, is concerned with future, hypothetical patients.
The problem of authority in the hospital occupies a good deal of the authors' attention. Since hospitals are run by doctors, all treatments given therein are assumed to be legitimated by the medical authority possessed by the doctors. Any suggestion that mental illness is other than medical at root is heretical to the proper ordering of the psychiatric hospital.

When proponents of the various models are gathered together under one psychiatric roof, several kinds of difficulties arise. Those psychologists and social workers who use nonmedical models will see no reason why they should be underpaid, under-valued, and exploited by the psychiatrists, especially if they believe themselves more skilled in psychotherapy than their medical colleagues.83

In the experience of the authors at the Saskatchewan Hospital, Weyburn, "doctors were delighted to be rid of an authority which they had never particularly wanted, did not understand, and did not use very adroitly."84

In this case, as in the experiments conducted and reported by Rebenstein and Lasswell in The Sharing of Power in a Psychiatric Hospital, authority over the structure and organization of the wards was transferred to the nurses. This is a big mistake, according to Siegler and Osmond. Doctors should not relinquish their authority. They should understand it and use it to further their medical aims and purposes.
Teaching the doctor role ought to become an integral part of a medical education. Siegler and Osmond find that

There are very good reasons why this skill should be taught by physicians to up-and-coming physicians rather than delegated to a variety of social scientists, however able these may be. It is unlikely that descriptions and discussions of Aesculapian authority by those who do not possess it and are never going to possess it will have much effect upon neophyte doctors. Nor are they likely to be helped by inspirational talks by distinguished physicians, for lacking suitable language for discussing the social basis of medicine, these talks are often vague and even mystical. We believe that our work, combined with that of T. T. Peterson, provides a foundation on which problems of Aesculapian authority can be discussed and examined in an intellectually respectable manner. This seems to us a more satisfactory approach than those extensive exercises in the social sciences which have recently been suggested by T. Lidz and others.85

Psychiatrists would do well to make increased claims on their heritage of aesculapian authority. It is usually the case, however, that the medical model is the choice of patients. Therefore psychiatrists gain the confidence of their patients by using the medical model since, "most human beings are remarkably conservative in preferring the medical model . . . one can only hope that psychiatry . . . will have the good sense to seize this convenient opportunity to return to the medical model."86

The opportunism reflected in this rational is balanced by another professional assertion of authority: Schizophrenics are twenty times more likely to attempt suicide, and therefore, "schizophrenia is a killer and . . . only the medical
profession is equipped to handle death.\textsuperscript{87} Death, as a human phenomenon, is a constituent part of every human life. Siegler and Osmond seem unable to recognize this fact, perhaps because their purpose is to subdivide the world of human experience into professional categories.

Psychiatry needs schizophrenia: "psychiatry has access to the mountain ranges of unconquered and little-understood diseases, and the massif of schizophrenia is the Everest of psychiatry."\textsuperscript{88} Medicine is concerned with life and death matters, and should therefore have authority over schizophrenic treatment, research, and hospitals where schizophrenics are held.

As there are three kinds of medicine, so are there three kinds of psychiatry in the Siegler-Osmond system:

1. medical, aiming to "restore health to someone who has been ill and to reduce pain and suffering";
2. educational psychotherapy, "aimed at promoting social psychological skills in people who are not ill and do not occupy the sick role"; and
3. enlightenment psychotherapy, which "can be practiced only by the enlightened. Its practitioners ought to admit that they have moved beyond their medical authority as doctors."\textsuperscript{89}
Only the first kind of psychiatry is considered a legitimate exercise of aesculapian authority. Educational therapy, including psychoanalysis, and enlightenment are not considered to be honest applications of authority. These therapists are not scientific enough since they do not do experiments or epidemiological studies. But, "there is no theoretical reason why enlightenment could not be demonstrated, provided of course that it could be defined," in a properly rigorous scientific manner.90

Discussing psychotherapy in more detail, Hoffer and Osmond, in The Chemical Basis of Clinical Psychiatry, conclude that psychoanalysis doesn't pay attention to the patient's experiences. Here is their report on a patient:

One of us recently talked to a schizophrenic girl who was at that time ill in a mental hospital and had been under psychiatric care for at least seven years. She told her doctor that she did not want to do recreational therapy because it made her feel unreal. When she was asked what she meant by "feeling unreal" she described how the room became brighter, how the faces of those around her changed while she watched them and how her sense of time was distorted. . . . When asked why she had not described these happenings before she said that no one had ever inquired about them. Perhaps the current preoccupation with dynamic explanations of various sorts has blunted our interest in what our patients actually experience.91

This seems an incredible charge given the therapies of Sullivan, Fromm-Reichmann, Searles, and Laing reported in this paper—and surely available to Hoffer and Osmond.

In How to Live with Schizophrenia, a unique how-to-do-it handbook and guide for schizophrenics and their
relatives, Hoffer and Osmond simplify the problems of understanding schizophrenia to the level of simple mindedness:

So you have schizophrenia. Or you have a relative who has it. Schizophrenia is a long name for a disease which attacks many people all over the world. Babies may be born with it. Small children may get it. Adults in all walks of life and of all ages may have it.

You may have heard of schizophrenia as a frightful mental illness with mysterious effects which must be spoken about in whispers. In fact, years ago schizophrenia was such a bad word that psychiatrists preferred to diagnose a schizophrenic as an immature personality, a depressive or a neurotic to spare the family the terrors it evoked.

Don't despair, however, because:

Schizophrenia actually is a very common disease which affects the whole body, and the only mystery is that many people are still unable to recognize it as such.

It is a disease like any other disease, with causes and treatment. When you have certain symptoms, you go to a doctor expecting that he will examine you and make a diagnosis on the basis of his findings. It is the same with schizophrenia.

When you have schizophrenia you are actually physically ill, but the symptoms are both physical and mental for the disease has a specific effect on the brain.

Hoffer and Osmond dwell for a long time on the need for doctors to admit to patients they have schizophrenia, and to begin a treatment program. Patients suffer guilt and frustration if they aren't told the truth about their disease, because "almost anything is better than an unknown and unnamed ailment."

Rather than old fashioned, guilt producing and inefficient psychotherapy, Hoffer and Osmond outline a
rigorous medical program. In phase one, "at home treatment"\textsuperscript{95} is prescribed. If this does not bring results, phase two treatment will be introduced: "In the hospital you will continue to take one of these vitamins as before but, in addition, you will receive a short series of electroconvulsive therapy, ECT, for short."\textsuperscript{96} If phase two doesn't lead to improvements, phase three of the medical treatment is introduced. It consists of

\begin{quote}
\begin{itemize}
\item two grams of penicillamine a day for ten days, or until you develop a skin rash and a fever of 104° F.
\item The fever may occur any time during the ten days and if it does, we will stop the penicillamine. Usually the temperature will be normal next day.\textsuperscript{97}
\end{itemize}
\end{quote}

If the patient doesn't improve under this regimen, he is categorized as chronic and told to expect a long period of treatment at hospital or home.\textsuperscript{98} Exactly what connection this vitamin, shock and fever-inducing therapy has to schizophrenia is never discussed by our authors. Perhaps these questions are considered to be part of medical therapy and, as such, not to be explicated to the public. (Solomon Snyder offers Hoffer as an example of psychiatrists who proclaim a particular vitamin or chemical cure which is simply wrong.)\textsuperscript{99}

The case of Brenda Gallagher demonstrates how this medical treatment system is applied:

Her psychiatrist was well-known to us as one dedicated to the idea that all schizophrenics are ill because their mothers or fathers brought them up the wrong way. . . .
She received psychotherapy, a "talking out" treatment, for many months, when she was encouraged to speak freely against her parents, and to talk about any problems she could bring to mind. For six months more in hospital, she was treated with permissive psychotherapy. Instead of getting better, she got worse. Her behavior, which before was merely bad, was now intolerable. She was transferred to our care as a last resort before committing her.

In our first interview, we informed her for the first time that she was ill, that she had schizophrenia and that she would be treated with nicotine acid plus ECT. She spoke angrily about her parents whom she blamed for her difficulties. We told her that they were in no way responsible for her illness.

She was treated for some months in this way, and began making great improvement. When she was discharged, her relations with her parents were good and she no longer voiced her delusional hostility against them. She has remained well for nearly six years without requiring further treatment. And she gets along well with her parents.¹⁰⁰

This therapy seems to be more related to establishing moral attitudes in the patient than to providing medical treatment. The permissiveness of this patient's previous therapy has been rooted out and replaced by a new kind of therapeutic explanation which stressed getting along with one's parents and taking one's treatment and medicine. Standards of conduct displayed before and after therapy are the focal point of the Hoffer and Osmond chemical-clinical psychiatry. This example, of course, shows that "cures" are possible even without the chemical cause of the illness being known. How a cure with vitamins, ECT and moralizing about appreciating one's parents is possible if schizophrenia is a medical disease of unknown etiology is not discussed by our authors.
In the latest volume published by members of the group, Humphry Osmond's *Understanding Understanding*, some fascinating theoretical projections are made. Osmond now proffers a "psychedelic" theory of schizophrenic etiology of his own in which psychedelic drugs were seen as related to substances that occur naturally in the body and whose metabolism may be involved in the production of the "psychedelic like experiences" that schizophrenics endure in their distorted perceptual worlds.

This psychedelic model seeks to take perspectives credited to Laing and his colleagues and employ them for more authoritative uses.

Most authorities who are medically or psychiatrically qualified believe that between 15 and 25 percent of all hard drug users are, in fact, schizophrenics who are trying to heal themselves. Thus at least 1,000 of New Jersey's 7,000 narcotics addicts are probably schizophrenic, but there are probably more. It would seem, then that a substantial part of the state's narcotics addiction problem is really not so much socio-medico-legal-economic as it is medico-psychiatric. Schizophrenia!

Our studies have shown, in fact, that about one third of all alcoholics are schizoid, many of them resorting to alcohol as a kind of tranquilizer to lessen the impact of their mental illness.

Hence the need for more research into schizophrenia!

No etiological facts are known. No physical or chemical test can establish the existence of schizophrenia. No chemical curative agent or drug is known. All of these assertions are simply attempts to magnify the importance of schizophrenia and to make drug "addiction" and alcoholism
into medical problems awaiting schizophrenic research and care by proper authorities—i.e., those with aesculapian powers.

Schizophrenics Anonymous is an organization for schizophrenics which "reinforces the idea that they have a severe illness about which they must learn if they are to be responsible patients rather than mere victims of misfortunes." This organization advocates the Hoffer-Osmond-Smythies-Siegler ideological teaching on schizophrenia. According to an article on Schizophrenics Anonymous International in the October 10, 1966 issue of The National Observer:

Any individual who has been diagnosed as a schizophrenic by a mental health specialist [not limited to medical diagnosis!] is invited to attend. Members recite the 12-step plan of "permanent hope," which includes a pledge of faith in God and a promise to follow prescribed medicine.

Finally, Osmond provides data on the Hoffer-Osmond Diagnostic test for schizophrenia, hereafter known as the HOD test. HOD is a self-administered psychological test consisting of true-or-false card sorting. Sample questions include the following:

I feel as if I am turned to stone.
Time seems to have changed for me.
Time seems to have stopped.
I think I'm someone else.
All colors look very brilliant.
My head seems bigger than before.
I think I've got someone else's body.
I think my body is changing.
When I look in the mirror, I see someone else.
I am worthless, of no importance at all.
Other people look like puppets, like paper cut outs, like animals, etc.
The HOD test and a companion Experimental Word Inventory are used to probe the inner depths of the schizophrenic psychosis. How this is any improvement over personal psychotherapy or psychoanalysis is not clear. We are assured, however, that no attempt is made to relate the "society, family, or early sexual experiences to a sick person's mental state." How it is possible to probe a person's experiences without addressing these points is very unclear. Osmond tells us that HOD and EWI "penetrate the person's own umwelt, revealing in simple terms how he perceives the world, other people, himself, and relationships among them all." These tests are "remarkably effective in doing what they were designed to do: measure mental illness." Nothing beyond the measure—the yes or no answer—is wanted by these researchers. Since the manifestations, but not the cause or etiology, are social or psychological, the social and psychological are merely symptoms to be controlled. Medical treatment and research hold the keys to the triumph over schizophrenia, drug addiction, alcoholism, and so forth. Self-diagnosis and attempts at self-cure are not welcome, however. Alcoholics and drug addicts have among them many mis-diagnosed schizophrenics. The believers and hangers-on of the Laingian movement, the "bright young schizophrenics," Siegler and Osmond write about, ought no try to cure themselves. Self-cures are dangerous.
The "subpsychiatries"—perhaps called this because they are lower in status than the pure medical research psychiatry, since their advocates do not vociferously invoke their aesculapian authority—of Laing, Szasz, and Eric Berne even mislead doctors by confusing "personal fulfillment, civil rights, and game playing with the assessment of grave and sometimes fatal illnesses and so make it harder for inexperienced young psychiatrists . . . to take a cool, detached look at their patients."¹⁰⁹ These persons ought to realize that they are sick and require medical help, not civil rights or personal liberation. The extent to which this insistence on medical treatment is simply a weak ideology, rather than science or medicine, can be appreciated by an examination of the work of Szasz and Laing.

The nature of aesculapian or medical authority is a fascinating question which pertains to schizophrenia and its treatment; and opens the question of chemico-genetic causation to specifically political questions of authority. All the insisting and asserting done by Hoffer, Osmond, Smythies, and Siegler can perhaps lead one to imagine that their medical authority to treat schizophrenics is being challenged within psychiatry, and medicine. Generally this is not the case. There are, however, a small but growing number of critics of
psychiatric and even of medical authority. Ivan Illich, one of these critics, writes in his *Medical Nemesis: The Expropriation of Health*, that the medical establishment is out of control. His thesis is that

A professional and physician-based health care system which has grown beyond tolerable bounds is sickening for three reasons: it must produce clinical damages which outweigh its potential benefits; it cannot help but obscure the political conditions which render society unhealthy; and it tends to expropriate the power of the individual to heal himself and to shape his or her environment. . . . [This is] a glaring example of the political misuse of scientific achievements to strengthen industrial rather than personal growth.110

Critics like Illich are questioning the authority of the medical profession to treat organic illnesses. As for the authority of the psychiatrist and the psychotherapist to treat mental illness, J. H. Van Den Berg, in his *Divided Existence and Complex Society*, finds that the failure of contemporary psychiatry is based upon a breakdown in the authority and belief system of patients and doctors.

Van Den Berg reports that Liebeault and Mesmer cured by touching their patients and putting them to sleep by hypnosis, because the patients believed in and accepted the authority of the doctor:

. . . Liebeault's demeanor appertains to a society divided into classes, or at least a society which respects and protects the disparities between its members (disparity of birth, disparity of talent, disparity of training). The current society does not protect the disparity between its members, on the contrary, it shows a tendency to remove
disparities even where they occur quite naturally. This is, so it seems to me, the cause of Liebeault's success: he belongs to a period with disparities, he is a doctor, and therefore, unlike his patients. That being so, he can act as an authority. And as an authority, he can cure by the method of authority.\textsuperscript{111} Van Den Berg finds that the founders of psychoanalysis, with their clearly defined words, to be therapists "who knew what was wrong and who fearlessly said what they knew, at the right moment without flinching"; far different than Carl Rogers's client-centered therapy, wherein the "true counselor never says anything to his client, even if the counseling takes years."\textsuperscript{112} Van Den Berg does not consider the possibility that psychiatry has misused its authority.

With psychiatry suffering from such authority problems, it seems quite doubtful that Hoffer, Osmond, Smythies, and Siegler will manage to rekindle necessary belief systems, no matter how many classes in aesculapian authority are offered in medical school, or how many schizophrenic patients can be found who willingly take their prescribed medication.

The political scientist Sabastian DeGrazia, writing in 1952, frames this issue of therapeutic authority extraordinarily well. He asks "By what authority?" the psychotherapist heals. DeGrazia finds that

As a doctor of medicine or a scientist he has no right. He has no special knowledge of morality. Mental disease is a moral disorder. Moreover if he must make moral decisions and give moral guidance in his work, he is not a scientist in the present-day conception of the term. . . . But then by what
right does he set himself up to give moral direction? At one time he could say that his methods of curing were successful and that success entitled him to his healing authority. But under examination his success could not be demonstrated, and now that this claim is weakened, that authority, too, will begin to slip.113

DeGrazia finds modern psychotherapy ignorant of its own nature.114 For the therapists like Szasz and Laing, who conspicuously introduce politics into their considerations, the points DeGrazia raises about the sources of authority become issues of primary importance. In evaluating their therapies, one is of necessity making explicitly political judgements.
CHAPTER VII

THOMAS SZASZ

1.

Thomas Szasz (1927— ) is a contemporary psychiatrist and author who has written extensive criticisms of the psychiatric profession. He has considered at length the phenomenon of witchcraft in The Manufacture of Madness, the concept of hysteria in The Myth of Mental Illness, and the theories of schizophrenia in Schizophrenia: The Sacred Symbol of Psychiatry. He has published 13 volumes on psychiatric subjects, including one work for which he served as editor, and innumerable commentaries on political issues of the day.

Szasz is perhaps best known for his campaign against involuntary hospitalization of mental patients. His theory of the proper role and function of therapy contains, as does all of his writing, a particular model of what constitutes appropriate economic and political relationships. Szasz, more explicitly than anyone else in contemporary psychiatry, has taken a consistent political stance and
has urged the infusion of political issues into psychiatry and mental health decision-making.

He rejects the language of psychiatry because it de-ethicizes and de-politicizes human relations and personal conduct. In much of my work I have sought to undo this by restoring ethics and politics to their rightful places in matters of so-called mental health and mental illness. In short, I have tried to re-ethicize and re-politicize the language of psychiatry.¹

Szasz views politics as the arena in which the ruled are oppressed by the rulers who successfully establish a particular ideological justification or rationale for their exploitation and power over the ruled. He believes that rulers have always conspired against their subjects and sought to keep them in bondage; and to achieve their aims, they have always relied on force and fraud. Indeed, when the justificatory rhetoric with which the oppressor conceals and misrepresents his true aims and methods is most effective . . . the oppressor succeeds not only in subduing his victim, but also in robbing him of a vocabulary for articulating his victimization, thus making him a captive deprived of all means of escape.

The ideology of insanity has achieved precisely this result in our day. It has succeeded in depriving vast numbers of people . . . of a vocabulary of their own in which to frame their predicament without paying homage to a psychiatric perspective that diminishes man as a person and oppresses him as a citizen.²

The rhetoric of mental illness is, for Szasz, a language to oppress some people, and to allow others—disguised as helpers—to take power over them. Any time a psychiatrist or psychologist pronounces a diagnosis of mental illness, along with the admonition that his job is to help the
patient, the person so diagnosed is not only being oppressed and ruled against his will, but is also deprived of the ability to act in response since he does not have the language. He does not know what is happening to him. His oppressor is calling himself a helper. Questions of ethics and politics are replaced by pseudo-medical discussions of mental health and illness.

Szasz assumes that all politics is the oppression of the people by their governors. In this first formulation he misses the realization that politics can mean more than oppression. Further, Szasz articulates a model of the state and politics representing only one variety of power politics, laissez-faire capitalism and classic liberalism. He rejects the entire panoply of modern psychiatric care extended to citizens by state, federal, and private institutions. His model of psychiatry is severely constrained from the beginning by the extraordinarily limited conception of politics that he articulates.

Witchcraft, according to Zilboorg in his *History of Psychiatry*, was really a medical problem of mental illness for psychiatrists to solve. For Szasz, however, "The fusion of insanity, witchcraft, and heresy into one concept, and the exclusion of even the suspicion that the
problem is a medical one are now complete."³ Szasz responds further that he cannot see where the medical problem is in Zilboorg's analysis: "in suggesting that the problem of witchcraft was medical, Zilboorg not only ignores . . . historical evidence (it is a religious and legal problem) but also denies the role of discrimination and scapegoating in the witch-hunts."⁴ For Szasz, the witch trials demonstrate that

Typically we confirm our loyalty to our group by asserting the disloyalty of others (in or outside the group) to it; we thus purchase membership in the community by excluding others from it. This appears to be one of the invariant rules of social behavior. Because of this, the scapegoat is the indispensable victim of non-cannibalistic societies.⁵

The universal and invariant applicability of the principle is demonstrated in his review of the history of scapegoating. He points out, in an example chosen to debunk the official version of psychiatric history, that Pinel strongly advocated the coercion and repression of mental patients, even though he opposed the use of physical restraints. Pinel states that "If [the madman] is met, however, by a force evidently and convincingly superior, he submits without opposition to violence. This is a great and invaluable secret in the management of well-regulated hospitals."⁶
Szasz draws from Hannah Arendt this account of the Nazi utilization of the scapegoat principle during the 1940's:

1941. The gassing of mental patients in Germany stops and the systematic gassing of Jews in the East starts. The men in charge of this program come either from "Hitler's Chancellory or from the Reich Health Department . . . " The murder factories at Auschwitz, Chelmno, Majdanek, Belzak, Treblinka, and Sobibor are officially named "Charitable Foundations for Institutional Care."7

Any and all forms of coercion (except the coercive forces of the free marketplace) are rejected by Szasz. Coercion constitutes scapegoating for him. He culls a sequence of events and positions which unites Pinel, the revered humanist of psychiatry, with the organizers of Hitler's death camps. Szasz argues that the scapegoating principle inexorably operates in the world. He finds also that psychiatrists have sacrificed the principles of the Hippocratic Oath by serving the state. Rather than serving the suffering individual as specified in the Oath, the physician-psychiatrist "assumes instead the role of civil servant protecting the health of the bureaucratic state."8 Giving up the Hippocratic mandate is the major step in a "fateful transformation of the physician's role from individual entrepreneur to bureaucratic employee."9

The lesson of professional complicity in the inquisition is "that man must forever choose between
liberty and such competing values as health, security or welfare." The physician of the inquisition was expected to diagnose "mental illness if he cannot diagnose organic illness." But if witchcraft was a legal and religious problem, what significance does it have for psychiatry? Physician-psychiatrists failed their citizen—not their professional—functions in the Szasz formulation.

The argument Szasz advances by utilizing these historical analyses is that mental illness no more exists than witchcraft did in the days of the inquisition. Persons incarcerated against their will for mental illness are oppressed. Today, "twice as many Americans lose their freedom on account of mental illness as opposed to crime." For Szasz, authoritative psychiatry is, and always has been, for the purpose of oppressing people. To regain the possibility of freedom, medicine must be separated from the state. Szasz suggests an amendment to the U. S. Constitution.

He continues his historical analysis with a study of the advent of psychoanalysis. J. M. Charcot, and later his student, Freud, started the practice of refusing to diagnose hysteric as malingerers. That is, for Charcot and Freud, hysteric were really sick, and not pretending to be sick. Szasz states that under this new rule
Persons disabled by phenomena which only look like illnesses of the body (i.e., hysteria) should also be classified as ill. We shall henceforth consider them mentally ill and treat them accordingly, i.e., by the rules applicable to persons who are bodily ill.¹⁴

Persons previously not treated by psychiatrists were accepted for treatment by Charcot and Freud.¹⁵ The classification system for mental illness was thereby altered by the authority of Charcot and Freud. This change from "malingering" to "hysteria" (and "mental illness") was, "a linguistic change of action-orientation in the listener."¹⁶

Specifically, the new orientation was away from a moral-condemnatory, and towards a solicitous, benevolent attitude toward the persons so categorized.¹⁷ While some might consider this a positive step—expanding treatment opportunities—Szasz objects that values of health and welfare are taking over a type of moral distinction he wants to make. As a social scientist, however, Szasz would not want to enforce one kind of morals over other kinds.

Szasz advocates a games theory perspective to better explain mental illnesses in society. Quoting R. S. Peters that "Man in society is like a chessplayer writ large," Szasz suggests that Freud's achievement was to extend the rule-following, model behavior to
Szasz concludes that Freud only deals with games at a child's level, and not with the fully socialized adult human being. For him the dignity and self-responsibility of adulthood is to be attained "only by honestly subscribing to a democratic (egalitarian) ethic." Mental illness games are less than fully adult and egalitarian since they deprive one of the players in the game of equality, that is, of the right to make contracts, since he is classified by the other as less than fully capable--i.e., mentally ill.

Malingering never has been an acceptable game move for Szasz. Personal problems in living are not acceptable whereas bodily or organic illnesses are acceptable. "What constitutes correct sickness depends, of course, on the rules of the particular illness game." Malingering and hysteria can be understood as particular instances of impersonation. Psychosis also can be defined in game terms as "the label that is pinned on those who stubbornly cling to, and loudly proclaim publicly unsupported role definitions." People seeking therapy are not ill, but are in need of educational assistance to expand their (communicational) role-playing abilities. Their aim ought to be to acquire certain skills and knowledge to enable them to maintain acceptable role definitions. Ideally persons ought not to play at
the games of society, but "become truly engaged in one's role-playing in a real game." What constitutes real as opposed to less than real games for Szasz is left unclear. Real games, however, are associated with real work.

2.

Szasz rejects the medical model of mental illness in his study of the origin of the concept of hysteria and asserts that the search for physical, organic etiologies of mental illness "may be motivated more by the prestige need of the investigators than by a quest for scientific clarity." The psychiatrist thereby seeks to share in the social status of the physician. Readers and critics of Szasz often contrast him to Laing by pointing out that Szasz deals with neurosis whereas Laing works with psychosis.

In Schizophrenia, Szasz takes on psychosis with predictable, though perhaps troublesome, results. Three models of schizophrenia are presented by Szasz: the psychiatric model, the anti-psychiatric model, and the Szasz alternative.

Schizophrenia is a disease not based on any "medical discovery," but merely on the assertion of a "medical authority, that it was, in other words, the
result not of empirical or scientific work, but of ethical and political decision-making." Psychiatric authority, therefore, is of a political and ethical nature. Schizophrenia is based on the syphilitic model of organic brain disease, developed around 1900, and "solved" with a discovery of medicine. Szasz states that "with the development of clearcut anatomical, histological, biochemical, immunological, and clinical criteria for syphilis, it was possible to establish, with a great deal of accuracy, not only that certain persons hitherto unsuspected of this disease were in fact syphilitics, but that others, suspected of it, were not." Syphilis in advanced stages does--or did--lead to brain damage or paresis. Linking syphilis to paresis was a brilliant scientific discovery, Szasz explains to his readers. It showed "that persons whose brains are abnormal are likely to exhibit behavior commonly judged abnormal." Psychiatry adopted paresis as its paradigm. Therefore psychiatry became the diagnosis, study and treatment of "mental disease"--that is, of abnormal biological processes within the patient's head manifested by the psychological and social "symptoms" of his illness. Psychiatry--whether organic or not, as Freud and his followers have subscribed to this model, as slavishly as their organic opponents--thus became fatefully tied to medicine and its core concepts of illness and treatment.

Neurosyphilis is the model of twentieth century psychiatry. Szasz writes that until the advent of penicillin in the
1940's, "a large proportion of patients admitted to mental institutions throughout the world suffered from general paresis." For Szasz, however, this model must be rejected either because it is wrong, or because it violates his basic premise of therapy by allowing psychiatrists to commit patients against their will. His evaluations of Bleuler and Freud are based exclusively on this judgement. Szasz rejects Bleuler's work because he practiced forcible suicide prevention on the orders of the society. This is the highest form of cruelty since it deprives the patient of free choice, and "no one--especially in Switzerland--is forced to be cruel to anyone else." As for Freud, his "official silence on commitment . . . seems to me decisive evidence of his views on this matter. After all, he expressed himself on every other subject in psychiatry, and on countless subjects outside of it." 

Schizophrenia is only a medically authoritative word. It has no real scientific discovery behind it to back it up. Szasz believes that schizophrenic diagnosis and treatment constitutes a scientific scandal, and not a legitimate medical-psychiatric syndrome. The purpose of a diagnosis of schizophrenia is to deprive persons of their liberty without due course of law, in violation of their constitutional rights. The psychiatric treatment of schizophrenia is completely fake medicine. It
completes the conquest of real (organic) medicine by fake (psychiatric) medicine: in the old days physicians diagnosed diseases which they could not treat; now they treat diseases [schizophrenia] which they cannot diagnose. 37

Schizophrenia cannot be diagnosed because it does not exist. With arguments and theories of Szasz, we come full circle: from an organic etiology having grim prognosis, with Kraepelin, Bleuler, and Jung; to a treatable-by-therapy mental illness, with Sullivan and Fromm-Reichmann; to a non-existent disease and scheme designed to improperly deprive citizens of their rights, with Szasz.

He saves him most harsh judgments, however, for Laing and the anti-psychiatric movement. He first takes credit for initiating the movement, however: "one of the developments since the publication of The Myth of Mental Illness, and attributable in no small part to its influence, is the so-called anti-psychiatry movement." 38

Apparently the movement went wrong after its beginnings, since the results today are very disturbing to Szasz. The anti-psychiatrists are all self-declared socialists, communists, or at least anti-capitalists and collectivists. As the communists seek to raise the poor above the rich, so the anti-psychiatrists seek to raise the "insane" above the "sane"; as the communists justify their aims and methods by claiming that the poor are virtuous, while the rich are wicked, so the anti-psychiatrists justify theirs by claiming that the "insane" are authentic, while the "sane" are in-authentic. 39
Is this an evaluation of a psychiatric movement? Or is Szasz simply delivering a series of *ad hominem* attacks? Given Szasz's view of the world, this is probably his professional critique. It is difficult to evaluate this kind of criticism because he does not write—as do other psychiatrists, including Laing—about helping persons. He presents no research findings or case studies for support or scrutiny. He dismisses all institutional psychiatry—i.e., all psychiatry with psychotics—as a fraud.

The evidence Szasz provides for his charges that Laing is a socialist, communist, or collectivist, is that "the cost of the care of the residents in the Laingian asylums is mainly borne by the British taxpayer; and the British taxpayer has no more of a direct vote on whether or not he wants his hard-earned money spent that way than did the American taxpayer on paying for the war in Vietnam." Szasz concludes that while Laing criticizes contemporary British society, he takes public monies to run his asylums. He makes no distinction between voluntary asylums and enforced commitment. Any use of public monies is unacceptable.

Szasz rejects anti-psychiatry for using rhetoric instead of logic, especially in Laing's "The Bird of Paradise," and in David Cooper's writings. Cooper states, in discussing the non-organic origins of schizophrenia and
the scapegoating often connected with psychiatric
diagnosis and commitment, that schizophrenia "is nothing
less than the predicament of each one of us." Szasz
responds that

People do deprive others of their possessions. But
how can everyone be the victim of plunder, which
is Cooper's penultimate view of the world. The
question is, of course, rhetorical. In the imagery
that Laing and Cooper are promoting, we are both
victims and victimizers. Who, which and when is
not for us to ask. They will let us know when
they are ready.

Szasz wants the winners clearly identified and rewarded.
No loser's talk is acceptable in his model society.

Laing imposes "nonreciprocal economic relation-
ships" on the psychotic patient. Laingian asylums "reek
of the odor of therapeutic sanctimoniousness which the
'conceit of philanthropy' inevitably exudes," Szasz
reports.

Yet Szasz provides no evidence that he's ever
been inside of a Laingian asylum, or even carefully read
about them. His conclusion results logically from Laing's
rejection of (actually, his lack of attention to) the
principles for contracting services between therapist and
patient. A second conclusion follows from this lack of
attention on Laing's part: "What Laing and Cooper oppose
is not so much coercion as contract." It isn't that
Szasz found people that Laing has lied to, or acted unpro-
professionally towards. It's simply that Laing is a collect-
ivist, socialist, or worse; and he cannot by definition
practice the principles of contract among equals. He must, therefore, be all these things Szasz calls him. This follows quite logically given Szasz's world view.

Further examples of this logical system at work are provided in Szasz's analysis of the Mary Barnes case. Few, if any, facts of the case are examined by Szasz. Yet this does not prevent analyzing and concluding. He tells us that Mary Barnes's recovery from schizophrenia depended, it seems to me, not on her being 'guided through a journey through madness,' but rather on her ability to manipulate her therapists--and their willingness to be manipulated by her; and on her eagerness to play the role of special patient, saved at Kingsley Hall--and her therapists' desire to cast and commercialize her in that role. In all these ways Mary Barnes was reinflated, and inflated herself, with self-esteem.45

Providing or gaining this self-esteem is some sort of trick since she really isn't that good an artist in Szasz's appraisal and understanding of schizophrenics.

When Mary Barnes entered Kingsley Hall she was an undistinguished, unknown, unhappy nurse. When she left, five years later, she was a woman miraculously cured of madness, a gifted painter, a celebrity well on her way toward fame. As a goddess in the Church of Anti-Psychiatry. It does not surprise me that she felt better. As the characteristic operations of institutional psychiatry diminish the mental patient's self-esteem by means of repetitive 'degradation ceremonies,' so the characteristic operations of anti-psychiatry increase his or her self-esteem by means of repetitive 'promotion ceremonies.' It surely implies no endorsement of the former to be skeptical about the latter... Suffice it to say that there is legitimate reason to doubt that Mary Barnes really learned to paint at Kingsley Hall.
In other words, there is legitimate reason to believe that she was not discovered to be a 'gifted painter,' but merely was declared to be one.46

And:

Is every Mary Barnes really the Mary Cassatt her Pygmalions claim her to be? Is every young man and woman who is bored and boring, unadored and unadmirable--or just ordinary--the victim of 'plunder'? Has each of them really been robbed of his or her authenticity and sanity, like slaves of their labor and colonized people of their riches? The anti-psychiatrists answer each of these questions with a resounding 'yes.' But the correct answer, I submit, is 'no'.47

For Szasz the case of Mary Barnes is an example of over-inflating someone's ego and proclaiming her to be someone she isn't and could never be. Presumably she has not learned to be a real game player, or is still fooling around with less than adequate games. Or perhaps, as a former diagnosed schizophrenic, she isn't intelligent or creative enough to be a real talented painter, and this claim to talent advanced on her behalf is merely a hype of the anti-psychiatrists to sell their therapy. The "promotion ceremonies" Szasz dismisses as not real do, however, seem legitimate, effective, and educational in the ways Szasz wants therapy to be. Apparently it cannot work here because it is not based on a contract among equals. How many cases like that of Mary Barnes, in which a person progresses through a sequence of regression episodes, and comes out functioning well as a fully consenting adult able to support herself by her painting and
writing, have there been in psychiatry? At the begin-
ning of her therapy with Laing and Joseph Berke, Barnes
specifically sought out this therapeutic relationship as
one that she believed would meet her needs. Szasz, however,
dismisses the whole thing since she did not have an indepen-
dent source of income and probably paid for her therapy
and room and board with state monies. Additional reasons
for Szasz's hostility to Barnes are not specified.

Szasz is disturbed because anti-psychiatry seems
to reward and praise the weak or downtrodden and seeks
to make a case for them. He asserts that

Psychiatry is a wrong, intellectually--because it
interprets disagreement as a disease, and morally
--because it justifies confinement as cure. Anti­
psychiatry is a wrong, intellectually--because it
interprets anomie as authenticity; and morally--
because by selectively condemning the behavior of
our own parents, physicians, and politicians, it
justifies the behavior of those, within and outside
of our society, who would deprive us of liberty,
dignity and property because they despise us for
their own personal or political reasons.48

Anti-psychiatry upsets the good order of society
by praising and upgrading those seemingly at the bottom
of the social ladder. Although not mentally ill, they
properly belong there for good reasons. Their criticisms
and lack of adjustment to the social order ought not to
be credible since the leadership of the social order is
thereby brought into question. Szasz has the right to
criticize his professional colleagues and the political
order which supports psychiatry without mercy, but to recognize the criticism of a schizophrenic is to give his views credence. Doing so upsets the good order of society because it allows the most humble, lowly members to address and effectively criticize the leadership and challenge the good order which any functioning society possesses.

Narrowing himself somewhat, Szasz continues with his analogies. He finds that

in the psychiatric view of schizophrenia, sanity is synonymous with a biologically healthy brain . . . insanity results from damage to their treasured possession, to which everyone has a sort of "biological right." In the anti-psychiatric view, sanity is synonymous with an authentic or true self . . . insanity results from damage to or loss of this treasured possession to which everyone has a sort of "political right." 49

For Szasz both of these views are unacceptable. The psychiatric view has not been, and never will be, proven scientifically. It is the result of a wrong analogy: schizophrenia with syphilis. The anti-psychiatric view is politically dangerous since it upsets the organization of society.

Medical research will make everyone sane in the orthodox psychiatric view. The anti-psychiatric position, "allows incompetent, destructive, and self-destructive persons to wallow in their self-contempt and [the] contempt of others will suffice to guide them safely through their journey in the Alps of alienation, after which all will
arrive in the neat and clean Swiss village and live happily ever after. Hoping for peace and tranquility is wrong because these misfits will always be that and nothing better. Or Laing is a naive utopian seeking happiness for people who are destined to be the dregs of the social order.

The Szasz view of schizophrenia is based on the doctrine of consent:

The role of consent, especially for the history and epistemology of psychiatry, is so overreaching in importance that it is impossible to exaggerate it. . . . it is consent and consent alone that justifies cure and treatment (as opposed to control and torture).

For those who protest that schizophrenics are not in any position to consent as equals with a therapist, Szasz responds that "if psychiatry is abolished, schizophrenics disappear . . . there assuredly remain persons who are incompetent, or self-absorbed, or who reject their 'real' roles, or who offend others in some other ways." It is the diagnosis process which would disappear if public psychiatry were abolished. The elimination of coercion from therapist-patient relationships is the goal of Szasz's therapy. He sees the model of marriage in Victorian times --a situation which provided for no alternatives or outs, especially for the woman--as related to the rise of institutional, i.e., coercive, psychiatry.

This need to enforce intolerable marriage situations provided the impetus for the organization of institutional psychiatry. The therapeutic relationship must fail if one
of the parties is coerced or forced into it. Neither Victorian-style marriages, nor psychiatric institutionalization provides an out for either party; "insofar as human, especially paired relationships are coerced rather than contracted, there will always be a need to justify both the coercion and the claim that it is abused. . . ."53

Eliminating the coercion does not provide those released with all the answers. Although the abolition of slavery frees the slave, it does not make him educated, self-sufficient, attractive, employable, or physically healthy; it only sets him free from his master. Similarly, the abolition of psychiatry would only free the schizophrenic. It would not make him competent, self-sufficient, attractive, employable, or "mentally healthy."54

Are schizophrenics on the wrong side of all these desirable human attributes and traits according to Szasz? From his critique of Laing, we can assume that he finds them to be not very desirable people. Schizophrenics don't fit well into his model society. Yet in the classic laissez-faire social order that Szasz postulates as necessary, there is a place for all somewhere in the hierarchy. He believes that both psychiatrists and schizophrenic patients are guilty of abusing and dehumanizing language by pursuing their special roles. He finds that

The language of madness is thus one kind of jargon, and that of psychiatry another kind. In other words, some (though emphatically not all!) of the people who are called crazy abuse language; and so do many of the people who categorize and treat them psychiatrically. The result—whether it be schizophrenic claim called 'symptom' or psychiatric counterclaim called 'diagnosis'—is debased and dehumanized language.55
And:

Each language is debased by systematic fraudulence, by the overwhelming effort on the part of the protagonist to impose his own image of the world on the other, and by justifying any means used to achieve this end.  

The changing nature of language, and the possibilities for breaking out of existing language molds are not discussed by Szasz. Change in society is not a matter of concern to him.

To those psychiatrists who claim that with the advent of phenothiazine (anti-schizophrenic) drugs, the problem of institutionalization of schizophrenics has been solved, Szasz replies that drugs have nothing to do with the problem or the solution.

It seems clear that psychiatric pairings between psychotics and psychiatrists, just as matrimonial pairings between wives and husbands, are profoundly affected, indeed, regulated by the economic, legal, and social contexts in which they occur that it would be as foolish to attribute increased rates of discharge from mental hospitals to Thorazine as it would be to attribute increased rates of divorce to Valium.

As evidence, Szasz points out that while there has been a 50% or more decrease in the number of hospital beds assigned to schizophrenics between 1954 and 1972 in the United States, there has been an increase from 4 to 25 beds per 10,000 population in Japan during the same period.

In *Heresies*, Szasz suggests that we treat psychotic utterances as if they belonged to a religious rather than to a medical framework. We non-psychotics could thereby pay our respect to their miraculous powers, "to
do or to suffer . . . or we could declare our disbelief in their mendacious claims . . . and could sever further relations with them.\textsuperscript{59} Szasz suggests elsewhere that he finds religious considerations misplaced in the analysis of societal questions.\textsuperscript{60}

Comparing schizophrenia to a real disease like multiple sclerosis, Szasz finds schizophrenia lacking. "Why should there be special laws justifying the involuntary diagnosis, confinement, and treatment of schizophrenics, but not of multiple sclerotics?\textsuperscript{61} He observes that

"Hypocrisy," said La Rochefoucauld, "is the homage vice pays to virtue." Just so schizophrenia is the homage egalitarianism and the classless society pay to inequality among individuals and to the social stratification which it generates.\textsuperscript{62}

Mental health and classes of mental illness become the new stratification ordering principles. Doing away with psychiatric diagnoses would require recognizing a class social order based upon principles other than psychiatric coercion.

3.

Szasz categorizes psychiatrists as being either in the housing and real estate business of institutionalizing persons; the drug business--including general psychiatrists who offer advice regarding life management as well, the brain damage business, or the conversation business. Classifying Laing and his colleagues into the real estate business, he describes them as "operators of flophouses
and cheap hotels for the poor and unimportant." He considers himself to be in the conversation business.

Analysis is defined by Szasz as "the process of buying and selling." According to his autonomous psychotherapeutic method of analysis, "most of the restrictions are placed on the analyst; the patient has great freedom of action. For example, he is under no obligation to be punctual for his appointments with the therapist. He must be punctual only in paying his bill." Since no institutional or personal intermediaries are allowed (not even insurance companies) no diagnosis is made of the patient in autonomous therapy.

The basis for accepting a patient is that "only if the client and therapist are free to decide what they wish and are willing to do can they negotiate the conditions for therapeutic collaboration. This informed negotiation is the basis of the analytic contract." Szasz is against all forms of institutional intervention. He does not practice in hospitals, and is opposed to the traditional psychoanalytic institute training analysis.

As for the cost of analysis, Szasz states that, "I do not accept clients for whom the cost of analysis is a significant hardship." Any and all forms of extranalytic help provided by the analyst make the analysis "a noxious rather than therapeutic" influence on the
patient. Analysts are physicians only by historical accident, Szasz realizes. Because it might interfere, no medical help is to be provided in this conversation business. Given the enormous strains incurred in functioning as a "secular-spiritual advisor or guide," Szasz finds being a therapist an activity "so laden with moral burdens that it could not form the basis of a regular, daily occupation."

The general principle of autonomous therapy is that the therapist, as the patient's agent, "must not resort to social or legal force to prevent the patient from putting his beliefs into action." Unlike Bleuler, Szasz would not forcibly stop a client of his from committing suicide. Perhaps he would try talking him out of it, but no coercion is allowable in autonomous therapy. The organizing theme here is that in exchange for a given sum of money, a conversationalist called a therapist listens and talks to a person who desires such assistance in order to expand that person's ability to function with other persons. The analyst owes no allegiance to any outside agencies or persons, and is paid to function precisely according to contract specifications. Analysis is a service available for purchase in the marketplace. Informed consent and agreement between buyer and seller is the basis of the agreement. And the patient is replaced by the client.
4.

Szasz is completely opposed to civil commitment of persons found to be mentally incompetent and to the imprisonment of persons charged with a crime without a trial because they are alleged to be mentally incompetent to stand trial. In the realm of civil rights and forensic psychiatry, Szasz has most impressively established his credentials within the psychiatric and legal professions.

The dilemma of contemporary forensic psychiatry is that

Either we regard offenders as sane, and punish them; or we regard them as insane, and though excusing them of crimes officially, punish them by treating them as beings who are less than human. . . . By treating offenders as responsible human beings, we offer them the only chance, as I see it, to remain human. 73

To incarcerate persons without trial by one's peers in public, and thereby to deprive them of the right to go to jail for the prescribed punishment, is to treat them as less than human. The alternative to the criminal justice system is to subject them to "unwanted psychiatric treatments." 74 Persons incarcerated in mental hospital-prison institutions serve until it is determined by psychiatrists that they are fit to stand trial, however long a time it may take for them to become mentally healthy.

As to the right of habeas corpus guaranteed to all citizens of the United States, Szasz asserts that
it was not designed to protect persons with mental illness from being locked-up for indeterminate periods of time.\textsuperscript{75}

Szasz portrays the forensic psychiatrist as normally serving the interests of the established order of society, rather than the civil rights of his patients. Examples of court hearings show these psychiatrists as apologists for those who want to avoid causing disturbances in the social order that might result from public trials. The rationale provided by psychiatrists often sound quite absurd. For example, Szasz provides this passage from a court transcript:

\begin{quote}
Q. Doctor, can you give me a single example from the records, from your interview with Mr. Perroni [the subject of a habeas corpus hearing who is seeking release from a psychiatric prison and the right to stand trial]--a single example of any illogical thinking processes?

A. When it was explained to Mr. Perroni the desirability of his cooperating fully for the examinations... his comment was, "What good is that--how is that going to help me?"

Q. Is that the only remark, Doctor, in the entire proceedings?

A. This is the one that I can clearly recall. There were others.

Q. I see. And can you think of one other, Doctor--just a single one?

A. I cannot recall another one that I am sure of.\textsuperscript{76}
\end{quote}
The lack of enthusiasm, despair, or even denial of guilt are seen as reasons to deny a person the right to stand trial due to mental incompetence, or "insanity." Szasz points out that "there are comments made by doctors in Mettewan [a New York state correctional institution] in which they say that this patient still denies or keeps repeating his denial of having committed the crime and he still insists upon his innocence." Admitting guilt becomes the criteria for being allowed to stand trial.

Discussing the attempt of the federal government to detain General Edwin Walker for psychiatric examination, following his arrest during the University of Mississippi integration crisis in 1962, and the Fact magazine poll of psychiatrists about the mental caliber of presidential candidate Barry Goldwater in 1964, Szasz finds that in both cases psychiatric intervention serves the same strategic purpose: to prevent the subject from playing a particular role. In the case of General Walker, the aim was to prevent him from assuming the role of the accused; in that of Senator Goldwater, the role of President. Never has the art of slander been developed to greater perfection.

All these uses of psychiatry are antithetical to the Szasz version of therapy, and repugnant to his political beliefs as a citizen. For Szasz, each system of psychiatry is closely connected with an economic and
political system. And

there are two radically different types of economic and political systems—one capitalist and free, the other communist and unfree; and as there are two radically different types of medical intervention, both called "treatment"—one voluntary and the other involuntary; so there are also two concepts of disease, each assuming that the patient suffers from whatever physicians believe constitutes a disease—one viewing disease as something over which the community (the state) is sovereign. 79

In another place, Szasz calls psychiatry "fake medicine" which helps "fake physicians (psychiatrists) to influence or control fake patients (the mentally sick)." 80 Voluntary psychiatry, with no claims to medical expertise, based on a contract which totally excludes state sanctions or outside authoritative interventions constitutes good psychiatry for Szasz.

Persons charged with crimes should stand trial if they can participate in their own defense. 81 Not guilty by reason of insanity would be expunged from the legal codes as a possible plea or verdict. Commitment to psychiatry institutions would be abolished. As for the poor, the beneficiaries of state-funded psychiatric services, Szasz argues that

Poor people, by definition, have no money and hence cannot pay in real currency for what they want. They therefore pay for it in the only currency they have, namely, pain, suffering, and the willingness to submit to medical and psychiatric authorities. And what is it they want and so obtain? Personal attention disguised as medical and psychiatric care; sedatives and stimulants disguised as treatments; and finally room and board disguised as hospitalization. 82
The poor are those at the bottom of the economic and social hierarchy. They cannot afford Szasz therapy and must turn to institutionalized psychiatry (or anti-psychiatric institutions) for help. But the schizophrenic patient is as guilty as the coercive psychiatrist for abusing language. Szasz is doing his civic duty, noblesse oblige; reminding us of the economic facts of life and urging that the poor shape up, stop abusing language, and demanding attention. They must earn enough money to hire a good therapist who will teach them the skills they need to make it in this hard tough world. And the state which governs—interferes and coerces—least is best.

On the subject of commitment to state mental hospitals, Szasz finds that patients are discharged as well as admitted against their wills. "The result is that while the prison function of the mental hospital remains unchanged; the asylum function is progressively eroded."

Nowhere else in his writings can I find any additional, positive references to an asylum function performed by mental hospitals. This notion of the hospital as a retreat or asylum is what Laing seeks to establish in his institutional experiments. Szasz rejects any institutional or psychiatric models of asylum in his system.
4.

In 1900, Szasz informs us, "The scientific study of ethical behavior was completely impossible." Apparently this was because human culture had not evolved far enough to permit such study. The development of moral capability was a slow and painful process as Szasz tells it:

Until the Civil War, many Americans could not clearly confront the essential moral problem of involuntary servitude--namely: What, if anything, justifies slavery? Similarly, Bleuler and most of his contemporaries could not, and most people today cannot, clearly confront the essential moral problem of institutional psychiatry--namely: What, if anything, justifies involuntary hospitalization, and other compulsory psychiatric interventions. This is why even men like Jefferson extolled freedom and practiced slavery, and why even men like Bleuler extolled psychiatric toleration but practiced psychiatric tyranny.

Szasz finds that there are two kinds of freedom: individualistic (Jefferson and Voltaire) and collectivist (Rousseau, Saint-Simon, Marx and the early communists, Lincoln and the abolitionists). Collectivistic freedom is negative, desirable and necessary since it creates the foundation for positive, individualistic freedom. Negative connotes based on government in some way. Positive means free of community or government control.

Classic liberalism constitutes the basis of Szasz's economic and political beliefs. He cites Ludwg von Mises's Human Action and Milton Friedman's Capitalism and Freedom.
as the cornerstones of his political and social perspective. Classical liberalism is the basis for his interpretations of psychiatry as well. Szasz is not a modern liberal who tolerates state intervention to shore up the marketplace. He teaches that

Modern liberalism—in reality a type of statism— allied with scientism, has met the need for a fresh defense of oppression and has supplied a new battle cry: Health!

In this therapeutic-merliorist view of society, the ill form a special class of "victims" who must, both for their own good and for the interests of the community, be "helped"—coercively and against their will if necessary—by the healthy, and especially by physicians who are "scientifically" qualified to be their masters.

Szasz has sought to establish a model of classic liberal psychiatry. He sees this society, as Karl Popper, as the most free, most open society possible—given the imperfections of man:

The vision of the perfect society, governed by a wise philosopher-king, is as fresh today as the day Plato first dreamed of it. I reject this dream—of the self-restrained, virtuous leader—as a nightmare. Instead, I cast my vote with the English and American political tradition which places its trust in the checks and balances of a constitutional, representative government.

Giving up the possibility of striving for an ideal political society in favor of existing liberal societies, Szasz completely rejects these same societies in terms of their conception of health and psychiatry. Szasz rejects the possibility of seeking a better society in political terms; yet seems to demand an ideal liberal, non-coercive, and
non-statist model of psychiatry. He is a conventional moderate in politics; but an absolutist in his laissez-faire psychiatry. Szasz is not clear or consistent when it comes to categorizing theorists within his political realm.

He articulates a romanticized vision of liberal economics as seen in his view of psychoanalysis by contract among equals. Under the category of ethics, Szasz sounds very much like Ayn Rand. Responding to the Proudhorn assertion, "Property is theft," Szasz counters:

But suppose that a man goes into the mountain, brings back a piece of marble, and carves a beautiful statue out of it. He will have created property: he will "own" the statue and there will be others who will desire it for themselves. From whom has he stolen it? Truly, the anti-capitalist mentality is more fanatical in its disregard of facts than all of the revealed religions had been. 

"Real work" (related perhaps to the "real games" of The Myth of Mental Illness) is that work "which results in a salable product or service." In the mental hospital, both the patient and psychiatrist are "alienated from real work. . . . Deprived of the reward of having been useful to someone, both patient and psychiatrist seek their reward in power." Those who exercise or seek power are considered bad examples by Szasz. This follows from his rejection of state or institutional interference in psychiatry or medicine--or in any aspect of life. The community should interfere with the rights of the individual as little as
possible. The existing structure of coercive power of the state is rejected. Representative liberal government is embraced as the best of all possible governments. And potential models of community different from those existing are rejected by Szasz when, for example, he lumps together the concepts of state and community, making no differentiations between them.

Szasz finds fault in the logic of those who try to involve the power of the state in prohibiting "therapies" such as lobotomy.

some critics of psychiatric brutalities seek the remedy in the enemy--the state--for example, by advocating the prohibition of lobotomy. However, since they cannot advocate prohibiting therapeutic procedure, they . . . must first rename what they want to remove: they say that lobotomy is not medicine but mutilation.

But who defines "mutilation? . . . contract and consent suffice to protect those who want to be protected. Any attempt to extend protection beyond this limit makes the "reformers" indistinguishable from the therapeutic totalitarians they oppose.93

The Szasz model of state power relating to mental health affairs is completely naive and not practicable. He asserts that he is a good liberal democrat, but rejects all devices and institutions created in the contemporary liberal democracy to equalize the relationships among citizens. More importantly, Szasz completely negates the possibility of community. All institutional incursions into private, i.e., economic, relationships are rejected. Politics,
the governing of the community, is reduced to the coercive use of power in the Szasz outlook. Politics and community are to be avoided by good economic men.

Szasz labels power as control and concludes that there are three basic ways of controlling human beings. And

as these institutions become oppressive, each is opposed by an ideology or institution intended to protect the victim, each protection becoming in turn, a fresh source of danger: force is opposed by pacifism, leaving men unprotected against anarchy; religion is opposed by atheism, leaving men unprotected against anomie; and the free market is opposed by communism, leaving men unprotected against the state. 94

Power, politics and control are synonymous evils in the Szasz view. All institutions, the state most of all, ought to be eliminated in favor of the free market—a concept drawn from economic theory and applied to any human situation involving institutions. Authority means control for Szasz. Legitimate power is an impossibility. Szasz replaces psychiatry, mental institutions and facilities, and all political possibilities of community, with the economic model of the marketplace of classic laissez-faire liberalism. This reductionism should be unacceptable to the student of politics, community, and human experiential possibility.

Surprisingly, Szasz approves of the writings and criticisms of Jean-Paul Sartre and Karl Kraus, an Austrian contemporary and critic of Freud. Analyzing Sartre's
rejection of the Nobel prize, Szasz suggests that Sartre rejected the award because he did not want to be typecast in any particular role. Praising what he understands to be Sartre's science of man, Szasz observes that if it is to remain a "morally dignified enterprise,"

Instead of aiming to control the object of its investigations, it must seek to set it free. To achieve this requires methods unlike those of the physical sciences.95

Sartre, long a devotee of Marxism, is portrayed as an intellectual hero of our time by Szasz. Laing and his colleagues in the anti-psychiatric movement, who rely on Sartre's theories for their philosophical base, are denigrated and rejected by Szasz. Laing differs from Sartre in attempting to create institutional situations where the working through of psychotic experiences can be attempted. This difference between Sartre and Laing is enough to send Szasz on an intellectual tirade against Laing.

Karl Kraus is lavishly praised by Szasz as the upholder of the dignity and honesty of language and intellectual life in early twentieth century Vienna. Kraus is the noble rhetorician in contrast to Freud, portrayed as the base rhetorician grasping for institutional power, prestige, and followers.

Szasz, echoing Kraus, rejects Freud's analysis of Leonardo DaVinci (and all artists) because he introduced
denigrating and superfluous analytical material in exploring the sources of DaVinci's creativity. In explicating Ludwig Wittgenstein's point, in *Tractatus Logico-Philosophicus*, that "Ethics and aesthetics are one and the same," Szasz argues that this idea is derived from Kraus. Szasz reports that Kraus's method of analysis of works of art

takes the person's product—in this particular case, language—and pronounces judgment on it supported by the evidence which that very work displays. This approach is diametrically opposed to that of the Freudian "pathography" or of the modern "psycho-history," in which the critic uses information unrelated to the work of art, or even manufactured by him, in order to defame and discredit its creator.

In praising Kraus the critic and ethical student of language, Szasz has nothing good to say about Freud and psychoanalysis. The closes he comes to praise of Freud is his point that Freud was better—more creative, ethical, and honest—than any of his followers. But this is faint praise indeed. Defending Kraus against analytical interpretations made of him, Szasz employs the views of Karl Popper and Eric Voegelin. In *The Logic of Scientific Discovery*, Popper asserts about a scientific theory that:

> its logical form shall be such that it can be singled out by means of empirical tests, in a negative sense: it must be possible for an empirical scientific system to be refuted by experience.

The nature of human experience, as opposed to the nature of materials and objects in natural science experimentation,
should focus any debate on the acceptability of Freud's or Popper's assertions. No such discussion is to be found in Szasz. Szasz uses Popper against Laing as well, claiming Laing's theories are rhetorical (presumably base, like Freud's; not noble like those of Kraus) and not subject to rational proof. But the nature of proof changes between the realms of natural and human sciences. All of Laing's attention to experience and discussions about human experiences—for example, about the Freudian system, about Sartre's work, and so forth—do not budge Szasz from rejecting him out of hand as a theorist of base rhetoric, a communist, socialist, or collectivist. Szasz reports that Voegelin "classifies psychoanalysis—with Marxism, Communism, and National Socialism—as a form of gnosticism, a term he uses in juxtaposition to philosophy. Philosophy is the love of knowledge or truth, its aim is personal salvation. Gnosticism is the claim to having knowledge or truth; its aim is not personal salvation, but domination over others." And therefore, Szasz concludes, the psychoanalytic movement, and Laing's school are gnostic, not philosophic.

As to politics, Szasz finds that Kraus was wise and knowing about the dire consequences of destroying language, whereas Freud was naive about the rise of Hitler and the reasons for the destruction of Austrian and European democracy. Szasz doesn't invoke Voegelin in
attacking Laing; but he does, along with Popper, reject Plato as the enemy of the open society. Voegelin, as do all political philosophers, finds Plato to be the fountainhead of all Western philosophy, and of a political science infused with moral and ethical concerns.100

Venturing into political philosophy to justify his praise for Kraus, or to attack Freud or Laing, Szasz displays ignorance or confusion about the basic parameters of politics and philosophy. Liberating mental patients incarcerated against their wills is an admirable extension of personal liberties to persons heretofore deprived. Constructing a political order or a model of psychiatry with no understanding of the basic concepts of politics, state, order, authority, community, and human experience is naive. It is an unacceptable reductionism to enforce the concepts of a radical laissez-faire economic liberalism onto a theory of psychotherapy. Although Szasz represents a substantial advance over most psychiatrists in his recognition of the significance of political concerns to psychiatry, his ideological posturing leads the social scientist to question his intent. Why is it necessary to proclaim such an elaborate framework in order to make a claim for freedom from psychiatric harassment and involuntary institutionalization or control?

His politics is conventional American-style liberalism, while his psychiatric theoretical stance is laissez-
faire capitalist in origin. If he were to square his model of psychiatry with his politics, he would not have a position from which to criticize the profession. Perhaps his liberal politics prevents him from asking the right questions in the psychiatric domain--i.e., questions about the human experiential possibilities. His polemics contribute little to the social sciences or psychiatry beyond a startling recognition that most psychiatry is infused with significant political questions. Szasz has made contributions to forensic psychiatry, and to the exploration of the relationship between politics and medicine. These contributions do not move beyond a simple recognition of the human experiential problem because Szasz severely limits his conception of politics to institutional and ideological "issues" removed from considerations of the role of human experience in schizophrenia.
CHAPTER VIII

R. D. LAING: EXPERIENCE, NORMALITY
AND SCHIZOPHRENIA

"Billions of Realities," by Jean Dubuffet

New York is at an extraordinary point in history, and in its history. Perhaps at some time back in ancient China there may have been a similar high point of creativity, of inventiveness, of intelligence. It is fantastic! In fact, there is something on this continent to stimulate people to insanity. . . . For me, insanity is supersanity. . . . The normal is psychotic--a collective psychosis. Normal means lack of imagination, lack of creativity.

Some people say, 'Dubuffet, when you attempt a new reality, you are expressing the ultimate nihilism, the ultimate desperate nihilism.' That's not my view of it. Instead of one reality, we have billions of realities. Each person can legitimate his own reality. Is this not enriching for the human mind, is this not the negation of a surface approach to life, is this not very positive. The New Yorker, June 16, 1973

Reality is socially constructed . . . society exists only as individuals are conscious of it . . . individual consciousness is socially determined.

It takes severe biographical shocks to disintegrate the massive reality internalized in early childhood; much less to destroy realities internalized later. Peter Berger and Thomas Luckmann, The Social Construction of Reality
1. Experience and Operations on Experience

Persons cannot have an experience that they are not conscious of according to Laing's critical analysis of Melanie Klein's concept of phantasy. Unconscious experiences, or fantasy experiences are not acceptable theoretical concepts for Laing. Considering phantasy as unconscious creates a theoretical dualism which results in "two opposed clusters of terms,"¹ or a dualistic conception of the human being. Persons usually do make a distinction between inner and outer realities; but this is not useful if one is attempting to achieve a full and complete understanding of human experience, in Laing's perspective.

Psychiatry utilizes a wide variety of explanatory concepts to express what occurs in human experience. However,

concepts like conversion, projection or introjection, do not describe what is actually going on in anyone's experience. As 'mechanisms' intended as 'explanations' of experience, it is impossible to tell what experiences they are intended to 'explain'.²

These mechanisms become extremely difficult to relate to experience since they function as a "shuttle service between inner and outer realities."³ Utilizing these mechanistic explanatory devices results in a situation where psychiatrists become unable or unwilling to relate to the experiences of their patients. Therefore psychiatry becomes the study of behavior, and not of experience. Yet
Laing finds that you cannot study persons if you don't know them. And you must know their experiences to know them as persons.  

Phantasy is an insidious and fascinating psychological process in Laing's formulation of psychiatry. The problem is that "What I take to be my most public reality turns out to be what others take to be my most private phantasy. And what I suppose is my most private 'inner' world, turns out to be what I have most in common with other human beings." The "social phantasy system" we live in simultaneously constitutes a shared and a "false sense of reality" that persons normally take to be reality. "The normal state of affairs is to be so immersed in one's immersion in social phantasy systems that one takes them to be real."  

For Laing every group operates by means of phantasy. A group will reject any experience demonstrated or articulated by one of its members which is outside the pale of reality for that group. Having an identity, a personality, or a role is "to be in a tenable position in phantasy systems of a nexus. . . . We never realize we are in it. We never even dream of extricating ourselves. We tolerate, punish or treat as harmless, bad or mad those who try to extricate themselves, and tell us that we should also." A group that strives to constrain the possible experiences of its members, and thus substitutes a phantasy situation
for reality--i.e., one mode of experience for another--thereby limits a person's experience. Laing's model man is capable of more types of experience than are obtainable from any particular group or family situation which operates as a relatively closed enxus. But what does Laing mean by reality?

He responds to an observation by Anna Freud that a child in A. A. Milne's *When We Were Very Young*, is "just a little boy" in reality. The boy acts as if he were an explorer, a ship's captain, a lion, and so forth; but he really is a little boy according to Freud. Laing observes:

My impression is that most three-year-olds helped on by their parents, helped on by authorities such as Anna Freud, are well on the way to successfully pretending to be just little boys and girls. Just about this time the child abdicates his ecstasy, and forgets that he is pretending to be just a little boy. He becomes just a little boy. 'Just a little boy' is just what many authorities on children think a three-year-old human being is. And sixty years later,

suddenly he begins to remember that it had all been a game. He had played at being a little boy, and at being a big man, and now is well into playing at being an 'old man'. His wife and children begin to get very worried. A psychoanalyst friend of the family explains that. . . . 9

Accepting or being assigned these proper acting roles is greatly constraining. If one is only pretending, one can try a new pretense. Groups such as families, with strong patterns of expected role reciprocations, often
don't tolerate pretending as Laing sees it. The normal person takes his reality as a substantial given. He does not reflect much on the basic elements of his human experience. "Schizoids," Laing tells us, often do not take these reality elements seriously enough. But sticking close to a presumed-to-be reality can and does result in the constriction of chances for pretense and ecstasy.

Elusion "counterfeits truth by a double pretense," Laing tells us. Being in a state of elusion is not a good experience in Laing's formulation, since one does not know that one is pretending, phantasizing, or doing whatever one is doing. Further, one doesn't know that one doesn't know. Raskolnikov, in Dostoevsky's Crime and Punishment, participates simultaneously in multiple realms of experience: dreams, phantasies, imagination, memory, and reality. The genius of Dostoevsky for Laing is demonstrated in his command of a full range of experiential modes. Normal limits are shown by Dostoevsky to be needlessly constraining on alternative, possible experiential events. A variety of modes of experience are available expressive outlets for man. To constrict, channel, or ignore these can enhance or limit other realities in turn. The creation of one or more "false self systems" can lead to losing contact with reality--the world of others. Elusion, collusion, and so forth, are techniques of avoidance.
Generally, attributions and injunctions can communicate a wide range of meanings. Laing offers his theory of context to make this point:

The same arrangement of words, grunts or groans, smiles, frowns, or gestures can function in many possible ways according to context. But who 'defines' the context? The same form of words can be used as a plain statement of fact, as an accusation, as an injunction, as an attribution, a joke, a threat. The same communication can serve either to foster and encourage experience and involvement with the other, or it can seek to constrain and deny it. Only by carefully observing the interpersonal relationship can we get even a hint of the meanings intended.

Projection "refers to a mode of experiencing the other in which one experiences one's outer world in terms of one's inner world . . . one experiences the perceptual world in terms of one's phantasy system, without realizing that one is doing this." A spiral of reciprocal perspectives is created between persons. To the extent to which self is projecting onto the other, the truth of the experience of the other is not communicated to the self. An observer can measure the amount of interpersonal disjunction in a relationship by asking each party to the spiral what he thinks about the other person, what he thinks other thinks about him, and what he thinks about what the other thinks about him.
It is possible that self and other can appreciate one another's position:

Jack and Jill . . . are much more in touch with each other than is usually the case. On the level of direct perspective that each has of self and other, they are in disagreement. However, each realizes how the other feels. That is, each person's metaperspective is in play and correct. Furthermore, each realizes that he or she is understood . . . no disjunction is postulated between direct and meta, or between meta-meta and metalevels of experience. 14

In spite of the complex nature of interpersonal perception, it is possible for a person to explain himself or herself to the other. . . . If bitterness and revenge (I am going to hurt you for the hurt you have done to me) have not intensified too much, it may still be relatively simple for each to satisfy the other's expectations according to their idiosyncratic value systems. . . . Once a history has been developed of pain and misery, the matter becomes correspondently more complex and difficult to reorient. 15

In Interpersonal Perception, Laing, H. Phillipson, and A. R. Lee, seek to show that this spiral of perspectives between persons can be quantified and understood by participants and observers to the spiral. Laing claims that in spite of the difficulties involved, communication is possible between persons. It is also possible for the professional to help persons communicate by demonstrating the existence of a situation of reciprocal perspectives.

In Laing and Cooper's survey of Sartre's philosophy between 1950 and 1960, Reason and Violence, Sartre's understanding that all evil is projection from self to other is explicated in a discussion of his Saint Genet:
The wicked man is an invention of the good man, the incarnation of his otherness to what he is, his own negative moment. All evil, for Sartre, is projection. The honest people are able to hate in Genet that part of themselves which they have denied and projected into him. As an analogy, Sartre describes the industry which used to flourish in Bohemia in which honest people took little children, split their lips, compressed their skulls, and imprisoned them day and night in boxes to prevent growth. They thus produced monsters which they were able profitably to exhibit. Similarly, but by more subtle means, people transformed Genet into a monster for reasons of social utility.

As a child Genet had no defense available against this technique practiced against him by the adults who surrounded him.\(^{16}\)

Cooper, however, suggests that we can appreciate projection as well as resent it: "far from being pure error, what has been called projection is a groping deflected way of arriving at a new and difficult truth. Projection is a human experimentation that takes a risk."\(^{17}\) He defines projection as the activity "of turning a non-existent coat inside out so that the inner lining of oneself shows itself to the world . . . a world of extreme vulnerability, a form of nakedness or exposure."\(^{18}\)

These two perspectives on projection, both written by Cooper, can be reconciled if we assume that not only the child Genet didn't understand what was happening to him, but the adult villagers didn't know what they were doing either. Under conditions of awareness, self would be aware that he is projecting a part of himself so that other will see it in him and respond knowledgeably about what is being
projected. This would constitute a therapeutic situation, or meeting, between self and other. Without knowledge of these interpersonal spirals, persons can and do quickly adjust to the projections made onto them as reality.

Genet is for Sartre (Cooper and Laing) a heroic individual because he figures out what has happened to him, and he eventually liberates himself from the projected evil of others with an extraordinary performance of phantasy. Laing and Cooper find that Genet might have lived the rest of his life like most of us, with his phantasies buried 'inside' him, although perhaps manifesting themselves as 'symptoms' and inaccessible to his reflective consciousness, had he not been placed in a position where the others attempted to establish their presence in him and henceforth to control him 'from the inside', in a manner which constituted a total threat to his identity, a threat of total alienation which would have left nothing of him for himself. They acted out his most terrible phantasies of the other, and this situation first brought his phantasies from the level of pre-reflective awareness, which is unconscious phantasy so far as this is experience, to the level of imagination, which entails a reflective awareness. This transformation of phantasy (pre-reflective) into imaginative (reflective) awareness is the central issue. Genet's phantasies became the images of his myths. He might have become a psychotic 'victim' of his phantasies, but instead he mastered the phantasies through the imagination of his rituals and his writings. 9

Human freedom is the activity of a "translucent consciousness" which strives to articulate experiences in a variety of modes, and thereby, to avoid the ever-threatening "grotesque or monstrous apperception of the practico-inert, the interior inhumanity of the human." 20
Normal everyday human reality is designed to protect self from emptiness, deceit, evil, and the unreality of the unknown or misunderstood. Laing discusses these defense mechanisms, or operations on experience, in the second part of his *The Politics of the Family.* These operations are usually utilized in order to avoid dealing with realms of experience beyond the expected normal societal and family interactions. Evil is projected onto those others; we here are the possessors of goodness and virtue. "Given our distinctions and our rules, we have to work to normalize our experience," Laing observes.21

These operations on experience include denial, splitting, displacement, projection, introjection, rationalization, repression, regression, identification, mystification, and reversal. "The definitive work remains to be written on this subject. The present list is not well classified, because some of these 'defenses' are simple, and others are made up of two or more simple operations."22 The study of these operations constitutes the field of psychoanalysis and, in part, psychiatry. Laing finds these operations going on in and out of the clinic, everywhere among normal men in society. This operational activity on experience is not restricted to those seeking psychiatric services.
Laing finds that in many persons "there is an operation, or class of operations that operates on our experience of our operations, to cancel them from our experience."\textsuperscript{23}

To widespread expectations among those who seek the services of a psychiatrist that the latter ought to serve effectively to enforce the normal, as opposed to the unknown or evil (other to be avoided), Laing responds:

\begin{quote}
I can think of no way of generating a 'normal' product from the stuff of our original selves except in some such way: once we arrive at our matrix of distinctions, we have rules for combining and partitioning them into sets and subsets. The 'normal' product requires that these operations themselves are denied. We like the food served up elegantly before us: we do not want to know about the animal factories, the slaughterhouses, and what goes on in the kitchen.\textsuperscript{24}
\end{quote}

This combining of psychiatric and organic (food) language is a standard Laing analytical technique. It serves to expand discussions to allow considerations of moral and ethical questions. This style is particularly disturbing to Laing's critics within the psychiatric profession, since they believe it exemplifies Laing's adoption of the very language of his schizophrenic patients. No where is this analytical style more prevalent than in his "The Bird of Paradise." The style, however, is an inextricable part of all of Laing's work.

The activity of assigning attributions to others in order to provide an ongoing continuity within a group is called mapping by Laing. In a family system, the newest
member, the newborn infant, is the final common range—
until the next new member comes along—onto whom attribu-
tions are mapped by other members of the group. Most of
us, Laing writes, clearly prefer to have our place within
the group defined. As Laing sees us,

We are prepared to be happy or unhappy, satisfied
or frustrated, hopeful or despairing, good or evil.
As long as we know where we are: as long as we
feel oriented. We think we know where, what, when,
who, even how and why we are.
We would rather be anywhere, as long as we are
somewhere. We would rather be anyone, as long as we
are someone.25

Although Laing is concerned with what is going on
in the slaughterhouse and the kitchen, he finds that most
people don't want to know. Laing disapproves of this
urgent yearning for security, and of the desire for persons
to be good members whatever the cost in psychological
activity or content.

The schizoid person is actually trying to emulate
the model of normal existence as that person learned it.
However, this attempt increasingly fails since the
schizoid self needs to operate covertly. He must hide
his experiences—his self—from others. He creates a two-
self or multiple-self experiential system as a consequence
of this effort. In schizoid behavior, further developed and
moving towards the psychotic (and Laing doesn't hesitate to
utilize these terms in The Divided Self),

The observable behavior that is the expression of
the false self is often perfectly normal. We see
a model child, an ideal husband, an industrious
clerk. This facade, however, usually becomes more and more stereotyped, and in the stereotype bizarre characteristics develop. There is a tendency for the false self to assume more and more of the characteristics of the person or persons upon whom its compliance is based. This assumption of the other person's characteristics may come to amount to an almost total impersonation of the other. The hatred of the impersonation becomes evident when the impersonation begins to turn into caricature. 26

The schizophrenic (the label for persons having moved into the psychotic stage) cannot manage to keep himself together. His self splits into a real, true self carefully hidden to prevent exposure; and a false, public self designed to keep others away from the true self.

Studying the experience of the schizophrenic teaches Laing much about the nature of experience and the failure of the self-other system in the family or group context. From the normal operations of ostensibly healthy persons to the two-self system of the schizophrenic, the various operations on experience are carried out in attempts to achieve contentment. With the schizophrenic, we can see fully how these operations come to constrain options and deny security. The attribution and mapping operations halt the person, stop him from functioning.

Clearly, Laing does not admire the normal system of attributions, injunctions and operations on experience since they fail to make moral distinctions between good and bad, and because potential realms of experience are blocked, denied, introjected, etc., and are thereby unavailable to
the person. Psychiatric description, diagnosis, and explanation does not satisfy Laing. He insists on making moral and ethical distinctions.

2. Normality

Laing's radical critique of normality is the focus for a major portion of the attention he has received from within and outside the profession. He finds the way persons and groups orient themselves vis-a-vis outsiders (others) to be dangerous and threatening to developing experiential possibilities. In *The Politics of Experience*, Laing demonstrates an us-and-them analytical framework illustrating the operation of the group as a closed system—a nexus:

> It is still a type of unification imposed on a multiplicity, but this time those who invent the unification do not themselves compose it. . . . The Them comes into view as a sort of social mirage. The Reds, the Whites, the Blacks, the Jews. In the human scene, however, such mirages can be self-actualizing. The inventions of Them creates Us, and We may need to invent Them to reinvent Ourselves.27

An Us situation seems in this analysis invariably to require a Them as other, scapegoat or enemy (here he is in agreement with Szasz).

> The brotherhood of man is evoked by particular men according to their circumstances. But it seldom extends to all men. In the name of our freedom and our brotherhood we are prepared to blow up the other half of mankind, and to be blown up in turn.28

For Laing, however, (but not for Szasz) the variety and variations of groups provide social man with release
from an all-encompassing Us and Them confrontation. The multiplicity of roles men in contemporary society are required to play is so wide that social life itself can become difficult.

It is just as well that man is a social animal, since the sheer complexity and contradiction of the social field in which he has to live is so formidable. . . . Consider the metamorphosis that one man may go through in one day as he moves from one mode of sociality to another—family man, speck of crowd dust, functionary in the organization, friend. These are not simply different roles: each is a whole past and present and future, offering different options and constraints, different degrees of change or inertia, different kinds of closeness and distance, different sets of rights and obligations, different pledges and promises.

I know of no theory of the individual that fully recognizes this.29

And each group requires the person in it to undergo "more or less radical," internal transformations. Normality, or normal operations, can be difficult to maintain in the best of situations.

The 'family' system, the internalized model of the family that persons in that family share, constitutes a model of the way group can affect person. One's family of origin is "transformed by internalization, partitioning and other operations, into the 'family' and mapped back onto the family and elsewhere."30 This 'family' system operates within the space and time of the consciousness of its members. It is not a social object, nor an objective set of relations. "It exists in each of the elements in it and
nowhere else."\textsuperscript{31} It is the reciprocal internalization by each of other's (and others') internalization. It is "not an introjected object, but an introjected set of relations."\textsuperscript{32} This 'family' realm is akin to mythic space and time. The system is internalized by persons, transformed by them, and externalized (projected) out into other worlds, sets of group experiences, by the members of this 'family'. Psychoanalysis is inadequate to "assess the extent of these internal operations and transformations. . . . studies of families in conjunction with studies of 'families' are required."\textsuperscript{33} Finding patterns of relationships between the two is the aim of Laing's family and 'family' analysis.

The re-projection of the 'family' is not simply a matter of projecting an 'internal' object onto an external person. It is superimposition of one set of relations onto another: the two sets may match more or less. Only if they mis-match sufficiently in the eyes of others, is the operation regarded as psychotic.\textsuperscript{34}

Laing tells us that in investigating these relationships, "One should always look for a sequence of events in which more elements than one have their parts to play."\textsuperscript{35} The researcher in this realm, however, must be able to account for his own experiences. "Until one can see the 'family' in oneself, one can see neither oneself nor any family clearly."\textsuperscript{36}

The 'family' as phantasy may be 'unconscious'."\textsuperscript{37} Laing relates the story of Jane, diagnosed as a schizophrenic, at least in part because she persisted in explaining
herself as a tennis ball. Investigating the family situation, Laing found Jane's phantasy to be an imaginative and powerful explanatory metaphor.

The family set-up, under one roof, consisted of father and mother, mother's father and father's mother, ranged against each other, father and his mother against mother and her father: mixed doubles. She was the ball in their game. To give one instance of the accuracy of this metaphor: the two sides would break off direct communication with each other, for weeks at a time, while communication was maintained through Jane. At table they would not speak to each other directly. Mother would turn to Jane and say, "Tell your father to pass the salt." Jane would say to her father, "Mum wants you to pass her the salt." He would say to Jane, "Tell her to get it herself." Jane would say to her mother, "Dad says to get it yourself." 38

Intervention into interpersonal situations has as its major object the attempt to control scapegoating of one member of the family or group by others. Often Laing finds that "no one in the situation knows what the situation is." 39 Education, counseling and psychotherapy are potentially workable techniques for controlling scapegoating activity in social situations. Laing finds that psychotherapy constitutes "a form of violence under certain circumstances only more subtle than bringing in the police." 40 It becomes critical to distinguish between a medical and social diagnosis when involved in social intervention situations.

Medically, our diagnosis does not affect the fact that the person has tuberculosis. We do not change the illness by our diagnosis. You do not convert a case of tuberculosis into a cardiac failure. But suppose our diagnosis of a situation is: This is a social crisis due to the fact
that this boy has 'got' schizophrenia. We must treat the 'schizophrenia' in the boy, and the social workers must help the relatives to cope with the terrible tragedy of having a mental illness in the family and so forth. This is not a medical diagnosis. It is a social prescription. 41 Whether or not schizophrenia is a medical ailment, the promulgation of such a diagnosis changes radically the social situation. This time, however, it is the psychiatrist making the diagnosis who is assigning attributes to one member, or confirming attributions already made and changing the situation to a medical disease situation.

Laing finds that the attribution process and corresponding professional intervention to be scandalous from a theoretical perspective since this intervention is a scapegoating or blaming process.

The scandal is not in the simple existence of the other, but in the violence undergone or threatened in each person's perception of the other as one-too-many through interiorized scarcity, the rationality of the praxis of each is the rationality of the praxis of violence. Here, violence is not a simple, naive ferocity of man, but the comprehensible reinteriorization of each of the contingent facts of scarcity.42

Laing's "tentative outline of some components of a perspecti
tive systemztic theory"43 of the family centers around the thesis that the concerted strategem of most normal families is to keep all involved in the dark--that is, mystified--as to what is happening and why. "We would know more of what is going on if we were not forbidden to do so, and forbidden to realize that we are forbidden to do so."44
Normal experience between self and other, and within family groups, is rejected by Laing as woefully failing to provide for the expression of a variety of human experiential modes. Laing sees the role of the intervener in social milieus as having the task of expanding the options available to members of the group by making them aware of the scapegoating activities on one or more of their members. Groups and families needing such intervention are those whose options have been increasingly narrowed. In the outbreak or diagnosis of schizophrenia, Laing finds the evidence of failure in human situations, and the frame for his model of social theory.

Laing's theories are based primarily on his concept of schizophrenia. What has heretofore been the scourge of twentieth century medical psychiatry becomes the central metaphor, and model for the examined life. Rather than seeking to cure schizophrenia, or simply rejecting it as not existing as does Szasz, Laing tries to learn from it. He creates a model for contemporary psychiatry based on this vision of human opportunities. This model seeks to encourage the good, and discourage the bad--to make moral distinctions and act on them. Everyday normal reality is not a good enough basis for Laing to construct a politically and ethically infused psychiatry.
3. Schizophrenia

Psychiatrists may know the disease of schizophrenia, yet they fail to understand the schizophrenic as a person, observes Laing. The schizophrenic experience cannot be understood without knowing despair. Those psychiatrists who persist in making the distinction sane/insane, (such as the creators of the HOD test) have no comprehension of schizophrenia as a human experience.

The schizophrenic lacks security about his being (ego) within the interpersonal world. Either from the experience of engulfment, whereby autonomy or identity are lost; implosion, where reality impinges onto the self and the self escapes like a gas into a vacuum; or petrification, when all personal contacts are depersonalized, the schizophrenic loses confidence. His self can no longer operate in the social world. Ontological autonomy is the general human state induced by a schizophrenic from his situation.

As a consequence of this rise in ontological insecurity, a series of splits within the personality system of the person occurs. As Laing explains in the case of David,

The central split is between what David called his 'own' self and what he called his 'personality'. This dichotomy is encountered again and again. What the individual variously terms his 'own', 'true', 'real', self is experienced as divorced from all activity that is observable by another, what David called his 'personality'. One may conveniently call this 'personality' the individual's 'false self' or a 'false-self' system.... One is evidently witness not to a single false self but a number of only partially elaborated fragments of what might constitute a personality, if any single one had full sway.
The individual who sees himself as separate from his personality may well be "cultivating his lack of spontaneity and thus aggravating his sense of futility. He says he is not real and is outside of reality and not properly alive. Existentially he is quite right. The self is extremely aware of itself, and observes the false self, usually highly critically." The person feels that he is in his real self. His body is under the domination of his false self or personality. Further elaboration of this predicament may include the splitting of the secure inner self.

Since self and personality are split,

It can readily be understood why the schizoid individual so abhors action as characterized by Hegel. The act is 'simple, determinate, universal. . . .' But his self wishes to be complex, indeterminate, and unique. The act is 'what can be said of it.' But he must never be what can be said of him. He must remain always ungraspable, elusive, transcendent. The act is 'such and such . . . it is this, and the individual human being is what the act is'. But he must at all costs never be what his act is. If he were what his act was then he would be helpless and at the mercy of any passer-by.

The advantage of such a false self system is that the schizophrenic imagines that he thereby maintains an "inner honesty, freedom, omnipotence, and creativity." A "tortured sense of self-duplicity, of the lack of any real freedom, of utter impotence and sterility," however, cancels any gains to be had from this complicated set of strategems. Laing points out that "deterioration and disintegration are only one outcome of the initial schizoid organization. Quite clearly, authentic versions of freedom, power, and
creativity can be achieved and lived out."\textsuperscript{53} No examples of this creative version of schizophrenia are provided by Laing in \textit{The Divided Self}. Laing maintains that generally such creative states cannot be achieved or sustained and deterioration of the self continues. "The self of the schizoid has to be understood, therefore, as an attempt to achieve secondary security from the primary dangers facing him in his original ontological insecurity."\textsuperscript{54} The schizoid gives the appearance of a stereotyped normality whose behavior is a patchwork of other people's peculiarities made even more strange by the context in which they are presented.\textsuperscript{55} Since he depersonalizes himself and others, he fears the others will reciprocate.

Laing provides this example of Peter, a young man referred to psychiatrists since he claimed a pervasive smell was coming from his body which could not be confirmed by regular medical doctors. Note the phenomenological style of this analysis:

He had in fact, two entirely antithetical and opposed sources of guilt; one urged him to life, the other urged him to death. One was constructive, the other destructive. The feelings that they induced were different but both were intensely painful. If he did things that were an expression of self-affirmation, of being a worthwhile valuable person, real and alive, he would be told 'this is a sham, a pretense. You are worthless.' However, if he persisted and refused to endorse this false counsel of conscience, he did not feel so futile, unreal, or dead, and he did not smell so badly. On the other hand, if he resolutely tried to be nothing, he still felt he was a pretense or a sham; he still experienced
anxiety; and he was just as compulsively aware of his body as an object of other people's perception.

The worst effect of all efforts to be nothing was the deadness that settled over his whole existence. This deadness permeated his experience of his 'uncoupled self', his experience of his body, and his perception of the 'disconnected' world. Everything began to come to a stop. The world came to lose what reality it had for him and he had difficulty in imagining that he had any existence-for-others. Worst of all, he began to feel 'dead'. From his subsequent description of this feeling . . . it was possible to see that it involved a loss of the feeling of realness and aliveness of his body. The core of this feeling was the absence of the experience of his body as a real object-for-others. . . .

It seems probable that in all this he was contending with a primary gap in the two-dimensional experience of himself of which his parents' handling, or rather failure to handle him, had deprived him. His compulsive preoccupation with being touchable, smellable, etc., to others was a desperate attempt to retain that very dimension of a living body: that it has a being-for-others. But he had to 'pump up' a sense of this dimension to his body in a secondary, artificial and compulsive way.56

And:

Peter tried to uncouple himself from anything of him that he could be perceived by anyone else. In addition to his effort to repudiate the whole constellation of attitudes, ambitions, actions, etc., which had grown up in compliance with the world, and which he now tried to uncouple from his inner self, he set about trying to reduce his whole being to non-being. . . . he was driven by a terrible sense of honesty to be nothing.

. . . Peter's guilt, as he later expressed it, was not simply that he masturbated and had sadistic phantasies but that he did not have the courage to do with others what he imagined himself in phantasy doing with them; and when he tried and to some extent succeeded in curbing, if not repressing, his phantasies, his guilt became not only that he had these phantasies but that he was repressing them. . . .

He felt guilty, that is, not so much at his desires, or impulses in themselves, but because he had not the courage to become a real person by doing real things with real people in reality.
. . . His sense of futility arose from the fact that his wishes were fulfilled only in phantasy and not in reality. . . .

What one might call Peter's authentic guilt was that he had capitulated to his inauthentic guilt, and was making it the aim of his life not to be himself.57

According to Laing, the schizoid self cuts itself off from direct relatedness with others. The normal psychiatric history is, from Laing's perspective, in fact the history of the false-self system. The enlargement of the false-self system can lead to psychotic developments, and to full-fledged schizophrenia. Often persons, for one reason or another, decide to pretend that they are real or sane, although they do not actually feel they are real. Laing discusses one of his patients who was pursuing a psychotic course which "happily was apparently arrested, or, it would be more correct to say, she arrested it before she had led herself into a psychotic state from which return would have been difficult."58

Laing concludes The Divided Self with the admonition that "The task in therapy then becomes to be able to make contact with the 'original self' of the individual which, or who, we must believe is still a possibility, if not an actuality, and can still be nursed back to a feasible life."59

In The Divided Self, there is no political or professional criticism of fellow psychiatrists. Even family members are simply reported, not investigated or criticized
as to their role in the schizophrenia of a fellow family member. Phenomenological analysis of the individual schizoid situation—explaining things from the perspective of the patient—is the purpose of this first study. In *Sanity, Madness and the Family*, Laing and Aaron Esterson, however, take vigorous exception to the psychiatric establishment's position (including the phenomenological position) on the diagnosis, prognosis, and etiology of schizophrenia.

First, Laing and Esterson proclaim that the diagnosis of schizophrenia is not a fact, medical or psychological.

We do not accept 'schizophrenia' as being a biochemical, neurophysiological, psychological fact, and we regard it as palpable error, in the present state of the evidence, to take it to be a fact. Nor do we assume its existence. Nor do we adopt it as a hypothesis. We propose no model of it.60

Second, they are studying diagnosed schizophrenics and their families in order to demonstrate that the experience and behavior most "psychiatrists take as symptoms and signs of schizophrenia [are] more socially intelligible than has come to be supposed."61 Investigating from the perspective of the original family context of these diagnosed schizophrenics, Laing and Esterson find that the supposedly schizoid, rationally and objectively inexplicable behavior of the patient, is completely understandable. The authors say that they have tried this kind of social intelligibility analysis over 200 times and have been successful in each instance.
Generalizing from the eleven families, they report that, "this is the sort of thing we have found every time we have taken the trouble to do so. . . . Those psychiatrists who are not prepared to get to know for themselves what goes on outside their clinics and hospitals simply do not know what goes on. . . ." 62

Third, they assert that no one else has done this kind of analysis before or since the first publication of this study. And:

What is the social intelligibility of the fact that not one study has been published, so far as we know, of a comparable kind before and since this one?
Surely, if we are wrong, it would be easy to show it by studying a few families and revealing that schizophrenics really are talking a lot of nonsense after all. 63

Utilizing the techniques of phenomenological analysis and interpretation applied to all members of subject families, Laing and Esterson insist that they are not positing the existence of a "family pathology" to replace the individual pathology of normal psychology. The concept of a family pathology is a confused one because it extends the unintelligibility of individual behavior to the unintelligibility of the group. It is the biological analogy applied now not just to one person, but to a multiplicity of persons. . . . Not the individual but the family [therefore becomes] . . . the unit of illness: not the individual, but the family, therefore, needs the clinician's services to 'cure' it: the family (or even society at large) is now a sort of hyperorganism, with a physiology and pathology, that can be well or ill. One arrives at a pan clinicism, so to say, that is more a system of values than an instrument of knowledge. 64
Members of the subject families are interviewed both alone and in various combinations. A phenomenological explanation, rather than a standard psychoanalytical or psychiatric diagnosis-explanation is presented for each family studied. Psychoanalytic explanations are avoided because the investigators were not prepared "to attribute to the agents involved fantasies of which they are themselves unconscious."

The accounts center on seeking to understand the person diagnosed as schizophrenic. They do not delve any deeper than is necessary to demonstrate a particular family system functioning. It is difficult to evaluate the evidence presented since only samples of the interview material are presented.

Finally, Laing and Esterson claim an historical importance for this social intelligibility phenomenological analysis method: "We believe that the shift of point of view that these descriptions both embody and demand has a historical significance no less radical than the shift from a demonological to a clinical viewpoint three hundred years ago." 66

Esterson, in his The Leaves of Spring, takes one of the family systems presented in Sanity, Madness and the Family and greatly expands the analysis. He presents a psychoanalytical-phenomenological explanation for the unconscious fantasy systems operating in the Danzig 'family', as well as the communication pattern of this family system.
Mrs. Danzig, the mother of the hospitalized schizophrenic Sarah Danzig, has a major complaint that her daughter is lazy:

I do get cross, I lose my temper. I mean one's only human. I mean she knows she has to go to school and she has to walk to the bus stop and has to have something to eat before she goes. I think it's only right, considering we've paid the fees for the month. And also, when she knows that she has to go she should know that her responsibility towards herself--not towards me--but towards herself as an adult--she's got to face life and get up. It's not asking much of her. It's a normal thing. Everybody else does it. If everybody said, 'I don't want to go to work', there'd be no hospitals, no shops--everything would be closed. We'd all be in bed. I mean look at it that way.67

Mrs. Danzig claims that she despairs of all the days, "from nine till five," that her daughter has wasted when she could have lived a normal life of doing, "something. No matter what it is you do--something!"68 Compared to the model of regularity established for her parents (by their parents) "Sarah was implicitly experienced as an infant gut, which was implicitly required to ingest and excrete strictly to a time-schedule regulated according to the convenience of a food-giving other."69

The Danzigs were, in phantasy, still concerned with gaining and keeping control of their marginally controlled infant bowels, in anxious anticipation of a response of a regulating phantasy other, who disapproved of failure to control. For reasons we have yet to discover, when Sarah stepped out of her serial familial role of filial compliance, there was invoked in them a threat of imminent incontinence. Since in phantasy they had already unwillingly projected their infant gut into her,
they experienced this phantasy threat in her. And we may infer that in requiring her to behave regularly and routinely they were, in phantasy, requiring her to embody and control on their behalf their projected marginally controlled bowel. 70

As Esterson evaluated the family situation, Sarah performed a group of vital functions for the family system as a whole, and for each individual member of the family as well. Mr. Danzig, Esterson reports, had always sought to "screen" Sarah's male friends, ostensibly to insure that she dated only proper persons. As Esterson see his motives, however,

Mr. Danzig was consumed with unacknowledged curiosity to see what was happening between Sarah and her young men. We may infer that in phantasy, he was preoccupied with desire to witness a primal scene wherein he participated orgastically in the excitement of Sarah, with whom he was identified through his bowels. We may infer it was in the woman's excitement he wished to participate, because he did not put pressure on John to bring home his girlfriends so that he could watch John. This was expressed in his compulsive attempts to control, in phantasy, what he experienced to be happening between Sarah and her young men. Encouraging Sarah to enjoy herself with boy-friends while he watched was thus the expression both of his desire to become orgastically incontinent, and the defense against its fulfillment. 71

Sarah's function in the Danzig family was to represent the public model of order and rectitude that her parents and brother feared they were not achieving. Esterson found that Sarah was

Required in phantasy by her parents to embody and control on their behalf their projected personal disorder, she was expected to live the ideals of respectability they did not. She was to be the living public proof of their success and solidarity as a family. She was to be, 'an untarnished daughter of Israel,' a talisman against evil repute, to be discarded if she did not fulfill her function. 72
Mr. Danzig lost his sexual outlet in phantasy when Sarah stopped dating as a consequence of his interference. Mrs. Danzig "reassured" Sarah that she shouldn't get too concerned about her image with boys because she was not sexually attractive at all. Then, Esterson reports,

Not surprisingly, Sarah stopped seeking her mother's help. However, Mrs. Danzig was extremely surprised. And Sarah lost all interest in social activities, as we have described, her mother found it unintelligible. Could it be laziness? Mrs. Danzig decided it was. What else could it be? She and her husband then redoubled their efforts to 'encourage' her, the more she did not. For while they complained of the inconvenience she caused them, they took food to her room and provided meals any time she demanded. Sarah was not doing things necessary to sustain her parents' reputation as normal members of the community because she was not "meeting people outside the family and having relationships with boys." Sarah's expulsion came following her running out of the family home because an interior decorator would not do her bedroom the way she wanted and her mother did not support her in the confrontation with the decorator which ensued. She returned the following morning saying defiantly that she had slept with a boy.

This desperate attempt to open-up the issue of her existential growth was completely misunderstood. For her parents, threatened in phantasy by loss of control of their bowels before the disciplining phantasy other, panicked. Sarah, their ideal child, had gone over the public brink. She was out of control.

She was committed to a mental hospital, "one of those places made to receive the malformed products of society, rejected because having no commodity value they
disrupt the smooth business-like functioning of the system." Esterson argues that Sarah merely scandalized her own family members. She was not mad. Sarah was only being labeled mad for not properly fitting into their (and her?) 'family'. But "This is not an argument, of course, against recognizing that some people are mad. It is an argument for recognizing who the mad one's are, and an argument against the assumption that psychiatric training fits psychiatrists to do the recognizing." Esterson does favor some types of classification in psychiatry:

Nor is it an argument against all forms of classifying mad persons. Classification is necessary as the analytic moment of the dialectic, but it should be on the basis of understanding their existential problems, not on the basis of assuming they are suffering from a clinical one.

Categories, labels, and psychiatry itself, in Esterson's view, can be good or bad, depending on the uses to which these tools are put. Helping people is a good use. Constraining them by proclaiming their behavior and experience to be invalid is bad; and is an improper use of psychiatry as a human science. Who distinguishes between the good and bad in Esterson's system? This concern becomes minimized in Laing's later works because he seeks to appreciate and utilize the insights of the schizophrenic state, and not to assign blame for its creation or existence.
How does one distinguish between a true madness and a false madness? Esterson might say that the mad are out of touch with social reality—they do not know when they are experiencing reality. Sarah was mystified by her parents and her brother; but she did know what they were really doing (opening her mail, listening-in on her phone calls, and lying about these activities when confronted by her) in spite of what they told her they were doing. She knew they were lying, but didn't know why. Therefore her mystification had a reasonable basis—i.e., the actions of her family towards her, and their seeking to alter reality to mystify her.

In *The Divided Self*, Laing declares that the true schizophrenic state is to be avoided whenever possible. In *Sanity, Madness and the Family*, and in *The Leaves of Spring*, Laing and Esterson demonstrate the ways in which a person's behavior and experience are invalidated. Social intelligibility is shown to exist in every family studied. The various schizophrenic symptoms are explicated in terms of the operations on the experience of the selected scapegoated member. In this middle period of Laing's theorizing to date, schizophrenia as a disease is irrevocable to the situation. It is not even discussed as a medical or psychological problem. Even here, however,
Laing and Esterson do not conclude, with Szasz, that the schizophrenic is at fault for not fighting back, for abusing the language, or for various other forms of corruption of the normal. Laing and Esterson do not characterize schizophrenics as stupid and inferior persons, as does Rosen. They call for psychiatrists to help the situation by making it socially intelligible, and advancing the person and her family's consciousness about the operations they do on their own and other's experience. The psychiatrist represents "translucent consciousness" in order to articulate the interpersonal situation(s).

But what about the schizoid and the schizophrenic discussed in *The Divided Self*? What about the real psychotics not considered in these later volumes? Apparently such psychotic episodes are also to be attributed to the family situation of the patient. Social intelligibility analysis replaces the theoretical discussions about etiology and prognosis in *The Divided Self*. The phenomenological discussions of the first Laing volume, however, remain as definitive statements. These descriptions are not surpassed in their perceptiveness of the schizophrenic experience. Societal and political levels of analysis are added on to the first experiential level --and found to be the determining factors. Laing's understanding of the potential dangers of the
schizophrenic condition does change from *The Divided Self* to *Sanity, Madness and the Family*; and again from *Sanity* to *The Politics of Experience*. Each of these studies focuses upon a distinctive perspective: the personal, the familial-interpersonal, and the political.
CHAPTER IX

R. D. LAING: NATURAL HEALING EXPERIENCES

"The Hollow Tree" by Mary Barnes

There was once a tree in the forest who felt very sad and lonely for her trunk was hollow and her head was lost in the mist. Sometimes, the mist seemed so thick that her head felt divided from her trunk. To the other trees, she appeared quite strong but rather aloof, for no wind ever bent her branches to them. She felt if she bent she would break yet she grew so tired of standing straight. So it was with relief that in a mighty storm, she was thrown to the ground. The tree was split, her branches scattered, her roots torn up and her bark charred and blackened.

She felt stunned and though her head was clear of the mist she felt her sap dry as she felt her deadness revealed when the hollow of her trunk was open to the sky. The other trees looked down and gasped and didn't know whether to turn their branches politely away or whether to try and cover her emptiness and blackness with their green and brown. The tree moaned for her own life and feared to be suffocated by theirs. She felt she wanted to lay bare, and open, to the wind and rain and the sun, and that in time she would grow up again, full and brown from the ground. So it was
that with the wetness of the rain, she put down new roots and by the warmth of the sun she stretched forth new wood.

In the wind her branches bent to other trees and as their leaves rustled and whispered, in the dark and in the light, the tree felt loved and laughed with life. Mary Barnes and Joseph Berke, Mary Barnes

4. Natural Healing Experiences

In The Politics of Experience, Laing finds that schizophrenia is not only a destructive psychological activity, it can be a reconstructive activity leading to a natural healing process as well. The concern with the truly psychotic or schizophrenic found in The Divided Self is not found in The Politics of Experience. And the social intelligibility analysis found in Sanity is bypassed in favor of a focus upon the potentialities of the schizophrenic experience. Defining schizophrenia as a natural healing process which should be allowed to occur represents the basic understanding of this phenomena for Laing and his colleagues. The Politics of Experience has been an enormously controversial book within the psychiatric profession. Two differences between The Politics of Experience and The Divided Self can help to account for the widely varied reactions. First, in The Divided Self no criticism of other psychiatric professionals is to be found. Second, whereas normal social life is taken for granted as a given in
the first book, it is criticized, debunked, and rejected by Laing in favor of the authenticity of the schizophrenic natural healing process in *The Politics of Experience*. We are told that schizophrenia is an attempt to overcome normal alienation and the concomitant failure of normal experiential possibilities. This reversing of schizophrenia from a dreaded organic disease into a means of overcoming normal alienation and scapegoating by means of a natural healing process, amounts to a basic challenge to the chief paradigm of normal medical and psychological psychiatry. Not only does Laing dismiss the model of schizophrenia-as-organic-pathology, but he makes schizophrenia the central focus of a devastating critique of normal contemporary society. Laing portrays this natural healing process outcome as the alternative to normal alienation. Portraying the schizophrenic as hero, Laing is criticized by the chemical therapists such as Hoffer, Osmond, Smythies, and Siegler; by the conservative politically oriented practitioners such as Szasz; and by the middle-of-the-road professionals like Arieti. He differs also from Sechehaye and Rosen by finding potential for creativity in the schizophrenic state, rather than seeking to eliminate it as quickly as possible. Laing goes beyond the work of Fromm-Reichmann, Sechehaye, and Searles by explicitly bringing politics and political
questions into the titles and content of his writings, interviews, and public statements. Laing presents a radically new model of a politically infused psychiatry centered on a distinctive interpretation of schizophrenia as natural healing process.

The diagnosis of schizophrenia is a psychiatric ceremony of putting a label on someone. Laing states that

In using the term schizophrenia, I am not referring to any condition that I suppose to be mental rather than physical, or an illness, like pneumonia, but to a label that some people pin on other people under certain social circumstances. The "cause" of "schizophrenia" is to be found by the examination, not of the prospective diagnosee alone, but of the whole social context in which the psychiatric ceremonial is being conducted.¹

Crediting Harold Garfinkel, Harry Stack Sullivan, Thomas Szasz, Erving Goffman, and Gregory Bateson, Laing develops his concept of schizophrenia as a potentially invaluable human experience. Agreeing with a comment of Sullivan, Laing finds that schizophrenics "have more to teach psychiatrists about the inner world than psychiatrists their patients."² Bateson, in his introduction to Perceval's Narrative: A Patient's Account of his Psychosis, is credited by Laing with first advancing the idea that schizophrenia is the beginning of a natural healing process. Bateson states that the schizophrenic "is, as it were, embarked upon a voyage of discovery which is only completed by his return to the normal world, to which he comes back with insights different from those of the inhabitants who never embarked
upon such a voyage."³ The schizophrenic episode, again quoting from Bateson, "would appear to have a definite a course as an initiation ceremony—a death and rebirth—into which the novice may have been precipitated by his family life or adventitious circumstances, but which in its course is largely steered by endogenous processes."⁴ Given this thesis, spontaneous remission—the mysterious recovery that was so closely examined by Bleuler—is clearly to be expected. Bateson continues that the problem is to explain the failure of many who embark on this voyage to return from it: "Do these encounter circumstances either in family life or in institutional care so grossly maladaptive that even the richest and best organized hallucinatory experience cannot save them?"⁵ (Bateson does, however, blame Perceval for not avoiding the psychiatric imprisonment he suffered.)

As to the concerns of Kallman and the psychiatric geneticists, Laing cites the work of Pekka Tienari, in Psychiatric Illness in Identical Twins, which brings into question all of these research findings. Laing contributes by questioning the sanity of normality, revered as the ideal in psychiatry.

The perfectly adjusted bomber pilot may be a greater threat to species survival than the hospitalized schizophrenic deluded that the bomb is inside him. Our society may itself have become biologically dysfunctional, and some forms of schizophrenic alienation from the alienation of society may have a socio-biological function that we have not recognized. This holds even if a genetic factor predisposes to some kinds of schizophrenic behavior.⁶
Schizophrenics may relate to a sane reality more appropriately than normal persons. Therefore, Laing continues, perhaps the treatment craze organized and led by psychiatrists is misguided.

We defend ourselves violently even from the full range of our egoically limited experience. How much more are we likely to react with terror, confusion and "defenses" against ego-loss experience. There is nothing intrinsically pathological in the experience of ego-loss, but it may be very difficult to find a living context for the journey one may be embarked upon.

A basic premise of psychiatry, including most phenomenological psychiatry, is that only egoic experience is acceptable. With Laing, Fromm-Reichmann and perhaps Searles, non-egoic experience is considered a human potentiality. Laing outlines the component phases of such a non-egoic voyage of self-discovery.

What is entailed then is:
- (i) a voyage from outer to inner,
- (ii) from life to a kind of death,
- (iii) from going forward to going back,
- (iv) from temporary movement to temporal standstill,
- (v) from mundane time to eonic time,
- (vi) from outside (post-birth) back into the womb of all things (pre-birth),

and then subsequently a return voyage from
- (1) inner to outer,
- (2) from death to life,
- (3) from movement back to a movement once more forward,
- (4) from immortality back to mortality,
- (5) from eternity back to time,
- (6) from self back to a new ego,
- (7) from a cosmic fetalization to an existential rebirth.

Laing reports on the "Ten-Day Voyage" of Jesse Watkins (born 1899) a seaman who had a "psychotic" experience in 1937
which lasted ten days. Watkins decided during his experience that he was conscious of time back to the origin of the world. He believes, as a result of his episode that there are three levels or realms of reality. Laing observes that such an experience can be extremely confusing and may end disastrously. There are no guarantees. Jesse experienced three planes of reality instead of the usual one. Apart from going through the Stations of the Cross, he did not link up with any ideology. He had no map . . .

But he trusted his experience of having entered into a state of more, not less, reality, of hypersanity, not subsanity. To others, these two possibilities may be no more distinguishable from each other than chalk from cheese. He had to be careful.

Watkins decided that at the end of it everybody had to take on the job at the top. And it was this business that made it such a devastating thing to contemplate, that at some period in the existence of oneself one had to take on this job, even for only a momentary period, because you had arrived then at awareness of everything. What was beyond that I don't know. At the time I felt--um--that God himself was a madman . . . because he's got this enormous load of having to be aware and governing and running things--um--and that all of us had to come up and finally get to the point where we had to experience that ourselves . . .

. . . Everything below him or everything below that got to the point where he got--er--had to treat him like that because he was the one that was taking it all at that moment--and that the--the journey is there and every single one of us has got to go through it, and--um--everything--you can't dodge it . . . the purpose of everything and the whole existence is--er--to equip you to take another step, and another step, and another step, and so on . . . "

Jesse Watkins decided after ten days that he would "come back" at least in part because he did not want to be locked up at night in a cell. Laing believes that mental
hospitals, especially those which insist on a treatment regimen to cure persons such as Watkins from having such a voyage, are bad places to have such a breakdown--or break through. He suggests that a "true physician-priest" would be able to properly handle experiences like those described by Watkins.

The true physician-priest would enable people to have such experiences before they are driven to extremities. Does one have to be dying of malnutrition before one is allowed a meal? Jesse Watkins was, however, luckier than many patients would now be, in that he appears to have been sedated comparatively lightly and was not given any "treatment" in the form of electro-shocks, deep-freezing, etc.

Laing's quest for a place where the whole of the schizophrenic experience--as opposed to the merely disintegrative phase--can be lived through, guided by a physician-priest who knows what is happening and can help, resulted in the establishment of Kingsley Hall in London. And the chief recorded accomplishment of Kingsley Hall is the going-down and coming-up of Mary Barnes. Mary Barnes, by Barnes and Joseph Berke, constitutes a documentation of the Laingian concept of schizophrenia as a natural healing process.

"Kingsley Hall-the 'down years'" covers the major trials and errors involved in allowing Mary to "go down" into herself while still maintaining her physical health and the minimal standing in the community of Kingsley Hall that was required of her.
During the early months of her treatment, Mary was very dependent on Berke—her personal therapist cum mother replacement. She describes one example of this extraordinary relationship:

Joe tears down the stairs. I'm panting behind. Joe takes me across the Games Room, into the kitchen. Joe sits me down. There are other people there. Getting used to the room, I'm exploring a little with tiny looks. Joe is moving about. He goes to the fridge.

'Like some nice soup?'
'Mm mm', nodding.
Joe heats it in a pan. Puts some in a bowl.
'Come here.'
Joe puts me up to the table. The soup smells good. It's safe. I feel all nice and beautiful, everything is so wonderful today.
'Mary, I'm going out today.'
A bomb had fallen. I'm shattered. Everything has gone. I'm away, stuck, can't move. Joe takes my hands, across the table, I've no words. It's silent. We sit. Joe looks very intense right at me.

. . .
No movement. Stone still, like a dead body in a chair, cut off from all life. The barrier was as a mist, of the density of steel.

And:

So I sat all day, exactly as Joe left me, my eyes shut. In the evening Raymond came. I screamed and screamed and screamed. . . .
Joe returned. He sat on the other end of the table. Raymond put me to bed. The next morning Joe brought me food, in bed. He plays with me.
'Tickle, tickle.' I laugh and laugh. He covers me: 'Oh, where is Mary Barnes? She's gone away—she's all gone.' 13
Her attitudes about punishment suggest those of a child developing a self—or ego—concept. Barnes's account of her therapy resembles that of Renee's with Sechehaye.

It was ingrained in me that my badness must be punished. So great was the badness that Joe also must punish himself on account of it. To see Joe suffer so on my account, caused me to get stuck, to go dead.

'Joe, Joe?'
'What, what's the matter, Mary?'
'Joe, what, what have I done?'
'What do you mean, what have you done?'
'Joe, Joe, all that salt. All right, I know you have to do it. But, but?'
'Look, Mary, this is my dinner. I like a lot of salt.'
'But, but?'
Everything is wrong. It won't come right.

Joe chews loud. Puts on more salt. Oh God, what have I done? Why does Joe so have to punish himself?

Looking at Joe's hands. He remarked,
'Doctors shouldn't have dirty fingernails.'
'Oh, Joe, Joe.'
'What's the matter?'
'Why, why am I so bad?'
'I haven't not cleaned my nails because of you.'

Taking food from the kitchen, Mary felt she was stealing and therefore would or should be punished. It got to be wrong to eat any food. Her nutritional condition was the cause of considerable consternation at Kingsley Hall. As a part of her therapy, she wanted to stop eating and to be fed intravenously, if necessary.

Mary began painting as a therapeutic way of dealing with her destructive feelings, on the advice of Berke. As she relates the origins of her painting efforts:
I came to realize that there were two things, the shattering of the anger and the shame of the destruct-uctions. I felt my anger, not only killing me, but everyone and everything around me. Then I punished myself.

Anger, torn to bits, deadness, not fit to live. My cry towards Joe was, 'I'm nothing, nothing, you are everything to me. I'm nothing to you.' Joe told me, 'Paint the Crucifixion.'

I did, again and again. From crucifixion to resurrection. Going down and in, coming up and out. Being re-created, being re-formed. Joe did it: he was able to because I trusted him. Now, in the spring of 1966, IT, my anger, seemed thereafter to submerge and drown me. No human activity, nothing seemed able to take, to consume, IT. Slowly, for brief spells, I was coming towards the possibility of lying with IT, to a state of 'being', without 'doing'.

Thinking of Joe as a refuge, a safe breast, Mary became very greedy while being extremely fearful of meeting or even seeing other persons, or of being seen by them:

When I got an idea of the breast, a safe breast, Joe's breast, somewhere I could suck, yet not be stolen from myself, there was no holding me. I was out to suck Joe. To suck him dry. My greed was enormous. Also it was terrifying. Joe conveyed two things to me. My most terrific greed would not eat him up. He would still be there. Love was safe. You can love. I love you. You still have yourself. You are not destroyed. You are not possessed.

These demands and fears are traced by Mary to her unful-filled, inadequate baby and childhood experiences. She felt that her therapy constituted a going back to her earliest human experiential levels and getting her fill of all her (i.e., what she believed to be) unsatisfied needs. She theorized that

Therapy treatment, then, was coming to know what I wanted. Through the food, with Noel and Paul, I
seemed to realize this. The 'right' thing had always been what someone else had wanted of me. Or to get what I wanted: 'Joe doesn't really mean me to eat.' Not simply--'I don't want it.' Not separate, my desire had to go through someone else. As if I was a tiny baby, I could only be satisfied through a 'Mother' gauging my needs. In the womb, the food of blood from her, to me. The trouble with me had been that my real Mother hadn't really wanted me to have it, food. She had never had any milk in her breasts. She couldn't, she hated me. Yet told me she loved me, and wanted me to eat.17

Getting all the attention she wanted from Joe, Mary Barnes gradually learned to function on her own, without taking everything that happened around her to heart as her fault. Gradually able to deal with others on a more or less "adult" level, she continued her painting and writing, had fewer failures and down periods. She began to come out into the social realms of Kingsley Hall with a powerful demonstration of her creative powers expressed in her paintings. She reports that

In a particular way, Joe recreated, reformed me. I was able to let him because I trusted him. This trust had been rewarded. Since the spring of '67, I have grown up. To an increasing extent I have become much more involved with people both at Kingsley Hall and in the outside world. Also I have had two successful exhibitions of my paintings. Sometimes I have felt like going down again, but never so strongly as before.18

Living alone today in London, Mary Barnes supports herself by her writing and painting.

Berke provides a different perspective on Mary's going down experiences at Kingsley Hall. In his view
Mary wanted to go far down into herself, return to a period before she was born, when she was a foetus. And she wanted everyone at the hall to help her do so. She had the idea of being fed by a stomach tube, with additional tubes in her bladder and rectum to remove liquid and solid excrement.

This situation had precipitated a monumental crisis of which Mary was generally unaware. Some residents insisted that she be sent to mental hospital as soon as possible. Others, including Ronnie and myself, thought that what she wanted to do was not unreasonable, that it would be interesting to see if someone could regress so far, and that it might be possible to tube-feed her.

For some days this matter was battered about while everyone tried to coax Mary to drink some milk, or at least some water. We were all afraid she might die. Mary wasn't.

She was finally told that the available doctors decided it was not in their capacity to tube-feed her. About Mary's abilities to act as if she were a young child and at the same time function more or less at an adult level in making demands about her therapy, Berke observes that

... Mary manifested an unusual temporal differentiation of self, which can be seen as an ability to exist temporarily on several different levels of the self at or about the same time. In other words, she was capable of simultaneous multiple regression. (Regression is a return to an earlier version of oneself.) However, there was always a primary level of self to which Mary had returned, and from which she could move 'up' or 'down'. Once I had formed a relationship with Mary, her primary self, say 'baby' Mary, was easy to discern. And general movements up or down, that is, towards adulthood or towards babyhood, were also pretty clear. But it was hard to follow sudden shifts of position based on an internal incident, like a memory or dream, or an external event of which I might not be aware. Mary often responded to my confusion by bashing me one.

The relationship between Barnes and Berke functioned on each of the various levels that Mary acted:
Our first encounter consisted of my growling at her and she growling back at me. Mary loved this and would shake with fright and laughter. She thought I was a bear who was going to eat her up... As she got stronger she would race around the room on all fours and I after her. Other times we would pretend we were fish and reptiles hunting for prey. Sharks and alligators were great favorites and we would snap and bite at each other just like the real thing.21

"Another game was for her to grab ahold of me and squeeze me around the middle as hard as possible. I would say, 'Is that all?' and she would squeeze harder and harder and I would say 'Is that all?' and she would drop back to bed exhausted."22

Berke believed that this sort of play formed an important part of the early stages of their relationship. Because she found that I was not engulfed, incorporated, digested, poisoned, mangled or otherwise injured, no matter how hard she bit or squeezed me, she allowed herself to relax with me and worry less about the effects of her greediness. Similarly, when Mary realized that my greediness, and/or her own greediness which she attributed to me (projected) would not destroy her, she began to trust me.23

A good part of her relationship to the Kingsley Hall community focused on her demand that the physical spaces throughout the hall ought, properly, to be made available for her self expressions. This constituted her therapy, and therefore was the reason for the existence of Kingsley Hall. Often these expressions were unacceptable to a large part of the community. Berke relates that the breasts she scrawled, dabbed, smeared and splattered throughout Kingsley Hall were not ordinary breasts. They were black and were
made of shit, so smelly that people gasped upon entering a room. Later when such productions were forbidden, the breasts were made with black paint. . . . They rode the walls like storm tossed waves across a demonic sea. They proclaimed the orgy of hate and destruction which lay lightly concealed beneath the pale skin of baby Mary.24

Berke reports that he gave Mary painting equipment and books on artists to encourage her to chronicle her journey down and up over a number of years at Kingsley Hall. The stories she wrote and illustrated, in Berke's viewpoint, "give the story of Mary. They are parables about elemental characters like seeds and birds and fish and children who search for, insist upon, and are rewarded with the proper environment in which to flourish. For Mary the seed, Kingsley Hall was the soil, I was the sun, and her paintings were the flowers."25

She insisted that the community recognize her needs and that its members stand ready to help her meet her goals. This was an impossible hope given the multiple competing, acutely felt needs expressed by everyone else around the place. Berke evaluates the results of Mary's unity demands and performances.

Mary had tried to unite the community with her. She succeeded in uniting it against her. Whereas the residents did not settle their disagreements, they did agree to hold Mary responsible for them. 'The problem isn't with ourselves, the problem lies in Mary. Get rid of her and everything will be OK.' The price of peace was their allowing Mary to turn herself into a scapegoat for the ills of the community. How strange that a group of people devoted to demystifying the social transactions of disturbed families should revert to behaving like one.26
Berke believes that the psychological rage that Mary demonstrated for years was the hostility she received and harbored as the focus of the anger of other members of the Kingsley Hall community. People persisted in negatively responding to her demands. "She didn't want the rage. She tried to expel it in any way possible. What she didn't realize was that she was acting for the whole of Kingsley Hall."²⁷ Her painting demonstrated her feelings about the community.

The painting continued, but with darkened colors and chaotic brushwork. Her images grew sinister and ominous. Hideous monsters appeared and tore at and devoured other hideous monsters. People paled when they saw them. Many couldn't tolerate the disturbance they saw (a strong reflection of their own!) and stopped using the games room and other public places where the pictures hung.²⁸

Berke believes that her down periods became a "response to being scapegoated by the residents. It also represents another purposeful attempt to bring people together by creating a crisis about herself."²⁹ He labels this a "psychotic intentionality," or the unconscious but purposeful moves and countermoves of a psychotic.³⁰

Tasks such as housework and maintenance were done by certain persons who lived at Kingsley Hall, but not by others. As Berke explains the situation,

Not everyone who stayed at Kingsley Hall was asked to pitch in with the housework. There was always a minority who had chosen to 'go into themselves' and who had to have things done for them. Mary is an extreme example of such a person. At any one
time there might be two or three regressed individuals in the community. There was a great deal of prestige associated with this 'down state'. I remember one girl complaining that she hadn't been able to 'go down' and asking people to help her do so.3

Before he takes on his professional task of "untangling Mary's knot," Berke relates the significance of Mary assuming responsibility for her own nutritional needs.

That Mary could cook for herself, and supply herself with needed food items, either from the larder or from the local grocer when she went out, indicated that she had taken into herself the capacity to nourish herself. Previously she thought that this nourishment could only be provided by some outside figure, originally her mother. Once Mary had separated herself from her mother, she did not have to repeat to herself the relationship that her mother had had with her. Mary did not have to feel guilty when she wanted to eat aside from the times when her mother wanted her to eat. She didn't have to feel guilty about eating in her room, or taking food from the larder, or even being greedy. She could stuff herself with all the food she wanted and no internalized mother would punish her for doing so. Furthermore, she no longer felt that 'mother' would only love her if she did not eat. She could eat and still feel love. This love was the love I or others at Kingsley Hall felt towards her when we took care of her.32

Berke as the therapist of Mary Barnes is often less the healer, and more the professional analyst. At times his psychotherapeutic analysis is less than lucid. For example, he writes that she was jealous and envious of women who had, or were about to have babies:

Mary wanted to have a baby because she wanted to be the baby, but she couldn't allow herself to make this baby in the usual way because of the enormous guilt associated with violating self-imposed
family and sexual taboos. Consequently Mary set out to make babies by turning herself into a baby. If genital sexuality had been Mary's preoccupation, she could have worked through her guilt. This was not the problem, however.

Deep down, Mary wished to remain a baby in the womb. Whether this ontogenetic primitivism actually stemmed from the period before she was born, or afterwards is debatable. The important point is that Mary constantly thought about returning to a period in her life before she was born and when she was actually carried inside another person. Consequently she refused to allow a baby to grow inside her, she even refused to allow a man to put his penis inside her. She desperately wanted to be the penis or the baby inside the woman, not the woman into which these objects were put, or grew.

Berke goes on to suggest that the label "mad" does not do justice to Mary, since all people cope with the same sorts of problems. "That Mary confronted her physical, psychic or spiritual demons may mean that she was just more in touch with them than most people." He considered Barnes psychotic, but not mad. He makes no distinctions or elaborations to explain the differences between psychosis and madness. Perhaps the task of theorizing about her schizophrenic etiology inexorably leads Berke into employing the categorizing language of psychiatry.

The response of the community to Mary's barrage of demands seems to constitute, at one level of analysis, the major focus of her going down and coming up experiences.
She did well when the community was peaceful or willing to give her what she wanted—attention, spaces to work and paint, and so forth. On a second level, her ups and downs were a consequence of internal psychological battles with her internalized mother's pronouncements of good and bad learned very early in Mary's life. The whole point of her Kingsley Hall activities, as she explains it, is to re-do this system of injunctions and attributions projected onto her.

Berke distinguishes between neurosis and psychosis by specifying the level of development that does not work—i.e., the level to which the therapist traces back the breakdown. As with Esterson's case of Sarah Danzig, Berke finds that Mary Barnes was not truly mad. She was merely angry, confused, and afraid to express her anger and confusion about some basic developmental experiences in her life. She was determined to get what she believed to be proper attention—therapy—to allow herself to regress back as far as possible, and to come up again having new and positive experiences to build upon. Sarah Danzig was basically mystified about the roles she was playing in her family's phantasy realm of private and public propriety. Danzig represents the destructive phase of the psychiatric attribution activity. Barnes represents the positive, healing, coming up phase of schizophrenia as well.
as the destructive phases. Danzig did not figure out what others were doing to her. Barnes knew and was determined to correct, to re-do herself. Both were mystified by others. Barnes knew not only that she was mystified, but how to correct the situation. Danzig was in a state of mystification—she didn't know what was going on. The label terms schizophrenia, psychosis, or mad are not relevant to this distinction. Yet Esterson and Berke persist in utilizing them. Perhaps they believe that only by using these professional names can they get the attention of their fellow professional psychiatrists.

No schizoids (about-to-be-schizophrenics) are discussed by Laing after The Divided Self. Would the later Laing reject the labeling activity and concern for psychosis demonstrated in The Divided Self, or with the work of Berke and Esterson?

With Danzig, Barnes, and persons discussed by Laing, the organic and medical criteria become political criteria. Categories of experience and attribution are shown to be utilized to achieve particular ends within the family and the community. To unmask the attribution system, and to allow the psychotic experience to be understood and lived through—rather than stopped—becomes the goal. Attributing, labeling others back in retaliation, and going down and then up become goals in Laingian
therapy. Interpersonal and societal change is possible, and thereby politics becomes a consideration of therapy. It doesn't seem to matter much what the distinction between real psychosis and attributed or labeled psychosis is, since the schizophrenic state is to be sought and worked through at places like Kingsley Hall.

This approach reverses normal psychiatry and becomes a political statement about the goals and purposes of psychiatry itself. Laing has written in each of his books about the chief concerns of political science, community, and alienation. All of this theoretical positioning on political questions, however, is predicated upon his model of the opportunities inherent in his version of schizophrenia.

As Clancy Sigal explains the Laingian model of schizophrenic going down:

Last said that for months it has been apparent to him that my neurosis was caused by my having 'forgotten' that I was a hero in the ancient mold. Heroes were twice born. First through their natural mothers, then through a symbolical sequence usually involving a trip—a sea voyage, descent into Hades, even return to the original country of exile. Many embarked, few came back. After being swallowed by the metaphoric mother (the sea, a whale, the mother country) the hero usually had to fight his way out of her belly to a state of rebirth. Oedipal conflict with my human mother had been a groping, imperfect expression of this yearning for the dangerous journey to a new, second life. Psychoanalysis and LSD ... were vivid evidence that I was now ready to begin my real, truly Heroic Voyage.36
Anna, by a pseudonymous author who calls himself David Reed, demonstrates the dangerous consequences that can result from serious attempts to treat persons suffering from schizophrenic symptoms at home, without the use of drugs or other forms of medical technology. Anna was a "diagnosed schizophrenic" who had had a number of therapists and who had spent time in a number of public and private mental hospitals. Her last therapist—named Dr. Landis in the book—was a follower of Laing's method of therapy. Anna was taken care of at home by her husband and a number of helpers assigned to the task by Landis. After a lengthy effort to provide care and supervision which proved unsuccessful, Anna made an attempt to kill her own child, and then she successfully killed herself. This case illustrates the dangers involved in the schizophrenic condition, as well as the continuing lack of institutional alternatives for the care of persons who need help but who refuse chemical or electrical "therapy."

Reed reports that Anna was found one day bewildered and mesmerized by the speeding commuter traffic around their London home. Anna wanted to know why the drivers were acting so maniacally. Reed recognized that in one respect this was a reasonable concern:

There was this—as Laing was at pains to point out in other cases—a sanity-within-insanity, perhaps a higher sanity in what Anna said.
But to me this interpretation seemed naive --irritatingly so. While wishing to feel with Anna as best I could, I felt it vitally important not to go too far: we had to preserve our common sense and sanity lest we actually encourage Anna on a course that, if it went on too long, could only end in disaster, for her or for us. However she behaved, we had to preserve a practical, everyday world to which she could one day return and to which she would be able to cope with the oppressions of noise, etc.: a world she could respect however much she might temporarily reject it. Somehow it seemed ridiculous to treat Anna as some kind of guru or prophet when she was in such obvious distress. Reed believed that her struggle "was fundamentally with her self; it was not a social phenomenon. She should be encouraged to feel there was a real world she could return to, and which loved her." Laing would probably agree with part of this statement in that he doesn't glorify or recommend schizophrenia as a permanent condition to be celebrated. He sees it as a tough, hard series of experiences to be gone through. Laing would not, however, agree to neatly separating self from other, or to Reed's thesis that a person's self system was fundamentally not connected to her interpersonal situation. Reed does not fully explore his complicity in Anna's life--though he does recognize that their marriage was not a happy one for her.

Anna was not placed in a public mental health hospital because none were available that would agree to omit electrical or chemical treatments. Reed recounts one experience in the admissions ward of a state psychiatric hospital:
I try to explain my point of view; but . . . he reiterates that Dr. S. wishes to use 'electrical treatment' and intravenous injections; so that I was left with an ultimatum: either Anna received ECT or she left the hospital. And that based on an 'interview' they (he and Dr. S.) had had with Anna that morning during which she refused to speak to them. 39

Reed, Landis and Anna also tried to get her placed at a Laing-oriented Kingsley Hall-type community. Each of several attempts, however, was rebuffed by various interests from within the institution. Reed relates one episode following Anna's attempt to strangle one of her children when

A group from the Community dropped by to introduce themselves in the morning. I felt their foreignness to my situation, that they could have no notion how frightening it was, the true terror of a child's life being threatened. . . . They seemed all so very much concerned with their own equilibria, their own psyches, like a group of hippies trying to "tune into" the countryside. It wasn't that I took exception to them as individuals: only their fatuousness as "helpers" in a dilemma as terrifying as this. I told some of them what had happened in the night. They showed not the least concern. 40

Anna was apparently unable to persuade either the leaders of the community, or those who organized and ran it, to accept her as a member. Unlike Mary Barnes, she was unable to convince them of the urgency or importance of her needs. She could either take the treatments offered at the public facility or stay home. The consequences tragically demonstrate the failings of both the publicly funded mental hospital, and the anti-psychiatric alternative. Her case also demonstrates the significance of institutions in dealing with
schizophrenic regressions, hallucinations, and so forth. The solution of Thomas Szasz to do away with all psychiatric institutions can be seen as inadequate from this example.

David Cooper writes in *The Grammar of Living* about a proposal he made in Cuba to eliminate the professional psychiatric system. He proposed that it be replaced with local-community-based volunteer helpers—people who meet Laing's criteria for physician-priests by having had psychotic experiences of their own. Apparently these helpers would not be physicians or medical doctors. Cooper states, however, that such a system could not be applied in first-world countries because of the entrenched nature of medical and psychiatric professional organization and power.

Cooper also proposes the use of LSD as a means of promoting systematic, voluntary regressions at will for those seeking to explore their early past experiences. He asserts that "A total personal 'regressive' experience, risking social breakdown, is an essential part of the 'training' of any psychiatrist. . . ."  

Laing has pursued the idea of rebirthing as a means of achieving a natural healing process in his essay, *The Facts of Life*. He writes about his visit with the late Elizabeth Fehr in New York. Fehr had "birthed" over one hundred persons of "both sexes, all ages; some many times."  

Laing relates her first rebirthing:
One day a man of twenty-four was in her office. He had run away from a mental hospital where he had been told (after his third suicide attempt) that he was an incurable psychotic, and if he did not have a lobotomy, he would have to be committed for the rest of his life, probably.

He had felt (he told me) all his life, stuck, as it were, in a manhole; he could not get in or out.

In her office two years ago he began to go into writhing, twisting movements (catatonic stereotyped movements supposedly).

It occurred to her that he was trying to be born.

He slithered from his chair to the floor, and she enacted with him his birth, playing the part of the midwife.

It was over in about twenty minutes. He was delivered.

He was out of the manhole, he felt, for the first time in his life. He felt completely different. No longer desperate, or frantic.

Subsequently he went through other "birthnings." Now he has a girl friend. Is working. Looks, moves, talks ordinarily.

Laing writes extensively in The Facts of Life about human prenatal and postnatal experiences, and of the importance of myths in understanding "our embryological experience." He postulates that:

There are I suspect even greater varieties of prenatal experiences (and of more interest and moment, remarked S. T. Coleridge), than there are postnatal experiences.

He suggests that what most psychiatrists in psychiatric facilities read as a catatonic regression may be seen as a birthing experience which cannot be put off any longer. For example:
a young person
takes to his/her room
discards his/her clothes
huddles up in what is commonly called a "fetal posi-
tion," or adopts another position
which he/she may stay in for hours,
even days on end,
urinates and defecates without moving.

the person loses interest in talking or being spoken to
he gives indications of great disturbance if "inter-
rupted" by external stimuli

This type of behavior almost irresistibly reminds
those who see it
of the unclothed fetus in a womb.

The person concerned will often openly say that that
is how he or she feels.46

He postulates a new stage of human development.

May there be
a placental-umbilical-uterine
stage of development
preceding the breast-oral stage?47

Laing mentions the work of Arthur Janov and Stanislav
Grof as establishing important advances in the development
of the model of the new psychiatric definition of schizo-
phrenia as natural healing process. According to Janov,
normal psychotherapeutic insight therapy fails because it
"does not produce those painful connections from the cortex
to the lower brain centers. In order to produce the connec-
tion which is usually an infantile or early childhood set of
experiences, the patient must be allowed to be that little
child so that his early feelings are connected."48 Janov
asserts that adult-to-adult explanations are no substitute
since they do not "produce the connections to reverberating
Primal circuits."49 That is, explanations do not provide
the requisite organic experiences.
This primal pain comes as a consequence of unfulfilled needs which produce tensions in the body. And,

If the need, or need-feeling cannot be fulfilled or resolved—i.e., if the child is not allowed to cry, for example—then tension remains. One does not get over unfulfilled needs just as one does not get over their denial. These pains remain encapsulated in the human system, producing layers of tension (which is how the pain is experienced) which build progressively, requiring one outlet or another. But discharge of tension is not eradication—no matter how many drinks one has or how many times he masturbates, Primal Pain will not disappear.\(^5^0\)

Primal therapy, however, does effectively deal with this Primal Pain which Janov finds so prevalent in our culture: "A Primal is a kind of psychotic episode in that the person is not 'here' but rather is living a scene completely out of the past. Both the person in a Primal and the psychotic have lost their third-line orientation, the former temporarily and the latter almost permanently."\(^5^1\) Janov's goal is here expressed as the creation of a psychotic state in his patients. A psychotic state that can be created, controlled and dissolved at will.

Primal man not only sheds his Primal Pain, but is also expert at eliminating his anxieties whenever they might occur. Objective measurements of brain alpha and beta wave tracings indicate that primaling is the first objective therapy in the history of psychiatry. Janov and E. Michael Holden, in their *Primal Man: The New Consciousness*, make this claim because the effects of primal therapy can be determined by measuring the levels of brain activity in
patients before and after their therapy.

Janov's attitudes toward other realms of social theory are at once radical and extremely naive. His primal and rebirthing techniques, however, do provide an insight into Laing's thesis that schizophrenia can be a natural healing activity. Primal therapy applies this thesis to the neurotic or anxious person. The research of Stanislav Grof amplifies and develops Laing's and Cooper's ideas about the potential role of LSD in therapy in psychiatry and psychology. Grof's research hypothesis is that the LSD reaction is highly specific for the personality of the subject. Rather than causing an unspecified 'toxic psychosis', LSD appeared to be a powerful catalyst of the mental processes activating unconscious material from various deep levels of the personality. Many of the phenomena in these sessions could be understood in psychological and psychodynamic terms; they had a structure not dissimilar to that of dreams. During this detailed analytical scrutiny, it soon became obvious that LSD could become an unrivaled tool for deep personality diagnostics. . . .

Pursuing this insight, Grof organized a research program involving extensive psychotnerapeutic sessions with LSD. Instead of rejecting the founders of psychoanalysis for their hopelessly value-laden subjectivity as Janov does, Grof reaffirms their basic findings. He reports that "The psychosexual dynamics and the fundamental conflicts of the human psyche as described by Freud are manifested with unusual clarity and vividness even in naive subjects who have never been analyzed. . . ." or exposed to psychoanalytic information. Grof reports that
Under the influence of LSD, such subjects experience regression to childhood and even early infancy, re-live various psychosexual traumas and complex sanctions related to infantile sexuality, and are confronted with conflicts involving activities in various libidinal zones. They have to face and work through some of the basic psychological problems described by psychoanalysis. . . .

Grof organizes his patients' LSD therapeutic experience into COEX systems—layers of experience related to a central core experience. A COEX system is defined as "a specific constellation of memories consisting of condensed experiences . . . from different life periods of the individual." Each COEX system, in its turn, becomes the dominant experience in sequential LSD sessions. "Elements . . . keep appearing in the sessions until the oldest memory . . . is relived and integrated. Following this . . . [the] system permanently loses its governing functions." Thereupon the next COEX system takes over.

The major impetus for this layered regression sequence is a death and rebirth experience. "To prevent misunderstanding, it is necessary to emphasize that the encounter with death on the perinatal level takes the form of firsthand experience of the terminal agony that is rather complex and has emotional, philosophical, and spiritual as well as distinctly physiological facets." These sequences of death and rebirth "seem to be related to the circumstances of the biological birth. . . . subjects frequently refer to them quite explicitly as reliving of their own
Grof observes that this perinatal experience is not a part of the theoretical repertory of the psychoanalytical system. He does recognize, however, that many traditional cultures have ceremonies and techniques to facilitate these rebirth experiences.

Grof organizes this death-rebirth experience into component parts based upon the biological sequence of birth. Each stage of biological birth appears to have a specific spiritual counterpart: for the undisturbed intrauterine existence it is the experience of cosmic unity; the onset of the delivery is paralleled by feelings of universal engulfment; the first clinical stage of delivery, the contractions in a closed uterine system, corresponds with the experience of 'no exit' or hell; the propulsion through the birth canal in the second clinical stage of delivery has its spiritual analogue in the death-rebirth struggle; and the metaphysical equivalent of the termination of the birth process and of the events of the third clinical stage of delivery is the experience of ego death and rebirth.

In a fascinating systematization, he next relates the four perinatal stages (experienced in LSD sessions) to "related psychopathological syndromes", "corresponding activities in Freudian Erogenic Zones", and "associated memories from postnatal life." Grof finds that persons undergoing this perinatal experience come to realize the important philosophical truth that no matter what he does in his life, he cannot escape the inevitable: he will have to leave this world bereft of everything that he has accumulated and achieved and to which he has been emotionally attached. The similarity between birth and death--the startling realization that the beginning of life is the same as
its end—is the major philosophical issue that accompanies the perinatal experiences.\textsuperscript{63}

Concomitantly, every individual who encounters the phenomenon of his own inevitable death becomes aware of religious and spiritual considerations in his existence, according to Grof. Consciousness of the meaningfulness of transpersonal phenomena is often a consequence of perinatal therapy. "For a large group of professionals, transpersonal phenomena are clearly too bizarre to be considered within the framework of variations of normal mental functioning. Any manifestation of this sort is readily labeled psychotic," in whomever it occurs.\textsuperscript{64} Grof finds that transpersonal experiences regularly become categorized as pathological symptoms in psychiatry today. He deplores this situation and rejects the use of tranquilizers (the standard psychiatric response) to control the breaking-out of such experiences.

Rebirthing, primal therapy, and perinatal therapy are approaches to psychiatry which reverse the stigma of regression and schizophrenia by making over these mental illness experiences into expressions of basic human needs. With Laing, Cooper, Janov and Grof, the pariah of schizophrenia becomes the model for achieving growth and understanding. Rather than curing psychosis; controlling its symptoms; dismissing it out of hand as organically-based and out of the realm of the social scientist's concern; or
rejecting it as an unacceptable narcissistic acting out; these theorists and researchers make it the focus of their model of human possibility, of change and growth. They do not endorse schizophrenia as the model that all ought to follow. Rather, exploration of one's original human experiences is believed to be the base upon which additional self understanding must be anchored. In the psychosis of schizophrenia however, this return to origins is uncontrolled, felt to be inexorable and often not successful due to lack of guidance, positive interference and intolerance of others.

Transpersonal experience is a significant factor in Laing's model of psychiatry. To demonstrate its importance in Laing's interpretation of psychiatry, his work can usefully be contrasted to that of Aarne and Martti Siirala, a Finnish theologian and psychiatrist, respectively. The Siirala brothers focus their attention on the impact and meaning of schizophrenia on the local community. In so doing, they demonstrate a fine sensitivity towards the role of community in mental illness. By not going beyond a particular community or political situation, however, the Siiralas are unable to say much about options demonstrating wider ranges of human possibility than those available in one particular community at any time.

Martti Siirala grants that schizophrenics are manifestly different from non-schizophrenics, but disagrees
with normal psychiatrists as to the reasons for their
difference. He does not feel that, "the basic difference
is that they suffer from the formal mechanisms. Rather,
the major difference seems to be that they suffer from them
individually, whereas we do it collectively." Schizo-
phrenics suffer individually, usually on behalf of the
community. Aarne Siirala postulates the reasons why com-
munities hold schizophrenics at arms length instead of
seeking to learn from them:

Being out of place means at the same time being
a prisoner in the network common to all men.
Not only the original cause of the anguish but
also the continuation of it, and his increasing
aloneness, are connected without withholding
our association from him. We protect ourselves
from becoming entangled in this skein because
what is revealed in him exposes our common guilt.
... what we encounter here perhaps calls into
question our whole reality, our faith, our con-
duct, our self-understanding. 66

To legitimize schizophrenia is to admit that normal com-
unity life is not in complete harmony. Persons in the com-
munity who outwardly act with rectitude, upholding the
standards expected of them are hesitant to admit that they
are guilty--in a religious sense that all men are guilty by
nature of their human status.

The Siiralas postulate a new role for the schizo-
phrenic in the community. Martti Siirala finds that "in
every schizophrenia there was an Anliegen--a treasure of
potentialities for a new type of relatedness missing in our
ways of being together, and challenging us in the form of
the distortions of the psychosis." The role of the schizophrenic is to take on the burdens of his fellows: "the schizophrenic embodies our basic splits; in him they become a manifest predicament." The therapeutic encounter with illness, according to Aarne Siirala, "seems to point clearly to the communal nature of illness and to the question of the very structure of our existence as a totality, as a community organism." This view of schizophrenia is not regularly considered in psychiatric practice. The nature of the regular, normal community is rarely, if ever, called into question by the psychiatrist. Laing following Sullivan and the social sciences generally, does question the nature of community normality.

Aarne Siirala calls for the creation of a therapeutic process for the community. The goal here is to utilize the schizophrenic perspective to teach the community lessons embodied by the patient. As important messages for the community are hidden in mental illness . . . psychoanalytic work with most difficult schizophrenic patients can give insights that create a therapeutic process for the community. Mental illness is not only a burden on the society. It has a meaningful function, a broader healing function, if its voice is heard.

Martti Siirala tells us that the most "basic function at the root of schizophrenia is man's desperate attempt to be in a position to distinguish good and evil." Determining good versus evil in the community, according to the examples provided requires one to focus on such achievements as
establishing to some local factory workers and their religious leaders that Hitler was a bad man, and not a hope for the future; or that anti-semitism is not a good basis for perceiving political and social situations. Another example related to a person named Bengt who was diagnosed as a schizophrenic because of unreasonable expectations placed on him by his parents. They believed that "'a happy human being is a person living in well-to-do, high social circles--I am now in those circles--therefore I am happy.' This mode of implicit reasoning, a subtype of the 'capitalistic' view of life, is inherent in the endeavor of people like Bengt's parents to meet the challenge of life in their social setting." The Siiralas fail to demonstrate the importance of their approach because they provide only mundane examples which seem to illustrate the banality of local community mores and of their therapy for schizophrenia as well. Laing avoids this pitfall—and the related one of taking particular foibles of local school teachers or particular family mores too seriously—by moving to encourage the human possibilities existing in transpersonal psychological situations. Local conditions thereby do not limit general human opportunities. Hannah Arendt writes about the ability of a philosophical perspective to move beyond the birth and death cycle of particular men. She believes this is a critical ingredient for a successful philosophic interpretation of man. "A philosophy of life that does not arrive, as did
Nietzsche, at the affirmation of 'eternal recurrence' (ewige Wiederkehr) as the highest principle of all being, simply does not know what it is talking about." The transpersonal probings of Laing are intended to demonstrate that any particular family or community conditions can be overcome. The specific concerns of morality then become the philosophical concerns of ethics, of human experiential possibility.

Laing discusses community, alienation, modern science and medicine within the framework of his model of schizophrenia—its risks and opportunities. Schizophrenia as potential natural healing process comprises Laing's central thesis and metaphor, around which he organizes his social and political perspectives.
CHAPTER X

R. D. LAING: POLITICS AND MEDICINE

It is not schizophrenia but normality that is split minded; in schizophrenia the false boundaries are disintegrating. . . . Schizophrenics are suffering from the truth. Norman O. Brown, *Love's Body*

From the end of the eighteenth century, the medical certificate becomes almost obligatory for the confinement of madmen. But within the asylum itself, the doctor takes a preponderant place, insofar as he converts it into a medical space. However, and this is the essential point, the doctor's intervention is not made by virtue of a medical skill or power that he possesses in himself and that would be justified by a body of objective knowledge. It is not as a scientist that *homo medicus* has authority in the asylum, but as a wise man. Michel Foucault, *Madness and Civilization*

5. Alienation and Community

In Chapter I of his first book, Laing posits that the most serious failure of psychiatry is that no concept of the unitary whole exists:
The thought is the language, as Wittgenstein has put it... The most serious objection to the technical vocabulary currently used to describe psychiatric patients is that it consists of words which split man up verbally in a way that is analogous to the existential splits we have to describe here. But we cannot give an adequate account of the existential splits unless we can begin from the concept of a unitary whole, and no such concept exists, nor can any such concept be expressed within the current language system of psychiatry or psychoanalysis.¹

The technical vocabularies available to Laing "refer to man in isolation from the other and the world... or to falsely substantialized aspects of this isolated entity."² All the terms are abstract; they fail to allow the professional psychiatrist to adequately describe a unitary whole. He cannot even describe a personal relationship between self and another.

This abstract and incomplete professional model of man is unacceptable to Laing. He asserts that it is worse than useless to try and study schizoid and schizophrenic people "with a verbal and conceptual splitting that matches the split up of the totality of the schizoid being-in-the-world."³ Laing concludes that existential theory is the only acceptable--or available--starting point to construct a human science.

Laing's goal for the future of a scientific psychology is to break away from the physiological and biological to a personal theory of unity and wholeness of man in the world. Until that goal is achieved, however, "the task...
is, therefore, the formidable one of trying to give an account of a quite specifically personal form of depersonalization and disintegration at a time when the discovery of the logical form through which the unity of the personal can be coherently conceived is still a task for the future."4

Relatedness is possible with all humans, even the most rigid catatonic, Laing asserts, in a reaffirmation of Fromm-Reichmann's thesis. Quoting Kraepelin's impudent patient case, Laing finds that the patient's behavior can be seen either as signs of a disease, or as "expressive of his existence."5 Communication, and thereby community, is possible if the student of schizophrenia understands that what is being related is not a symptomatology of brain disease, but rather this person's alienation from his fellow man and the splits within his own self concept.

The Politics of Experience seeks at once to document contemporary forms of alienation--"of our contemporary violation of ourselves"6--and to transgress the boundaries of a variety of academic disciplines to create a unitary point of view "that the author has refused to cut up into small pieces."7 On the first page, Laing violates John Schaar's basic principle of political criticism by fusing ethics and aesthetics: "Our social realities are so ugly if seen in the light of exiled truth, and beauty is no longer possible if it is not a lie."8
Laing finds contemporary persons alienated and not liking their condition of alienation. Persons crave experience. Therefore, studying persons with the methods of a natural science which does not admit the possibility of human experiences into its considerations, is the great mistake of psychiatry, psychology and all sciences which purport to deal with human reality. A science organized to recognize the basic postulates of the possibility of human experience is the only appropriate human science for Laing.

Behavior is what can be seen on the outside by other persons. Experience is what people make of their behavior: it is what they think about it to explain it, justify it, and so forth. Theory is experience that is articulated or expressed to others. Laing states as axiomatic that "behavior is a function of experience; and both experience and behavior are always in relation to someone or something other than self." Therefore

When two (or more) persons are in relation, the behavior of each towards the other is mediated by the experience of each of the other, and the experience of each is mediated by the behavior of each. There is no contiguity between the behavior of one person and that of the other. Much human behavior can be seen as a unilateral or bilateral attempt to eliminate experience. A person may treat another as though he were not a person, and he may act himself as though he were not a person.

Treating persons as though they were not persons results in those persons experiencing themselves as less than human, and then treating others in turn as less than human--
incapable of experiencing. In this interactional pattern of human relationships "If our experience is destroyed, our behavior will be destructive. If our experience is destroyed, we have lost our own selves."11

In a world where alienation from experiential possibilities is the norm, most action on one's experience and towards the other is normally destructive. The psychological "defense mechanisms" which constitute the body of psychiatric theory is the vocabulary of destructive action on self and other. Alienation is negative experience, or the lack of experience. Alienation enhances and introduces into a person's world nonbeing. Nonbeing or nothing manifests itself as the absence of person or thing, as emptiness. Laing finds that "Being and nonbeing is the central theme of all philosophy, East and West. These words are not harmless and innocent verbal arabesques, except in the professional philosophism of decadance."12

Action for the political theorist connotes the essential human activity, politics. Laing posits that experience is the essential human component of action: "If we are stripped of our experience, we are stripped of our deeds; and if our deeds are, so to speak, taken out of our hands like toys from the hands of children, we are bereft of our humanity."13 Laing finds that this is currently the normal human condition. For Laing, as for
the contemporary political theorist, political action constitutes an extraordinary human achievement in view of the normal alienation from experience.

Creation is the achieving of being from nonbeing. The meeting of two human beings establishes the creation of being from nonbeing. This action creates something new in the world; something is created out of nothing, ex nihilo, for Laing.14

Classic theories of psychoanalysis do not provide for collectivities, i.e., for self in the context of other and community. These theories, therefore, are inadequate for a psychiatry recognizing the significance of community. Continuing this critique from The Divided Self, Laing asks in The Politics of Experience why it is that

almost all theories about depersonalization, reification, splitting, denial, tend themselves to exhibit the symptoms they attempt to describe? We are left with transactions, but where is the individual? the individual but where is the other? patterns of behavior, but where is the experience? information and communication, but where are the pathos and sympathy, the passion and compassion?15

Classical psychoanalysts persist in positing biological analogies. Laing and Cooper find that "unfortunately even the best psychoanalytic papers are written in these terms or fall back into them. Indeed, it is often unclear when a psychoanalytic writer supposes that he is being metaphorical or analogizing or attempting an explanation."16

Quoting an extensive passage from a case study by Karl Jaspers, from his General Psychopathology, Laing
disagrees with Jaspers's conclusion that the transcendental experience related by the schizophrenic patient is morbid. Laing points out that Jaspers's phenomenological analysis limits itself to the study of egoic experiences. "And yet, with the consensual and interpersonal confirmation it offers, it gives us a sense of ontological security whose validity we experience as self-validating, although metaphysically-historically-ontologically-socio-economically-culturally, we know its apparent absolute validity as an illusion." All religions and all existential philosophies teach that such egoic experience is not reality.

Phenomenological analysis, however, is constrained in attempting to understand a person going through ego-loss to a transcendental experience. If a person becomes confused and lost in attempting such a transition, he may be regarded as mad. "But to be mad is not necessarily to be ill, notwithstanding that in our culture the two categories have become confused. It is assumed that if a person is mad (whatever that means) then ipso facto he is ill (whatever that means). Phenomenological analysts, such as Jaspers, cannot understand such attempts to move beyond egoic existence, so they must consider schizophrenia as morbid after all is said and done, and exhaustive attempts at understanding the patient have been made.

Ludwig Binswanger, for example, asserts that schizophrenia is caused by a "still unknown schizophrenic noxa."
Doris Lessing has explored this Laingian point about the relationship between various levels of awareness in her *Briefing for a Descent into Hell*. As she explains in an afterword, she sought in the novel to make the question of "What is wrong with this man?" irrelevant by seeking to convince the reader that each of the realities portrayed is equally acceptable. Transpersonal modes of experience, moving beyond the phenomenological, demonstrate opportunities beyond the local, current, and community-accepted situations.

In psychiatry, the major professional activity is the categorizing and appropriate treatment of patients. The diagnosis of schizophrenia has become today the major psychiatric ceremony. Laing believes, contrary to standard professional practice, that "schizophrenics have more to teach psychiatrists about the inner world than psychiatrists their patients." Psychiatric labeling itself is an important power move since it is a declaration by one or more persons that a particular person is not credible, and therefore must be so labeled, controlled, and constrained. Laing finds, however, that "There is no such 'condition' as 'schizophrenia', but the label is a social fact and the social fact is a political event." Psychiatrists must find causes or attach blame as a part of their societally assigned political responsibilities. Family therapy often becomes a regimen of
attaching blame on the "schizogenic mother" or the sick family group--as in the work of Theodore Lidz. Social analysis by therapists often results in the assigning of blame on the society or the local community in part or as a whole. Laing wants to remove or reverse the scape-goating, castigating, name-calling, and diagnosis activities of psychiatry by seeking to understand schizophrenia as a natural healing process, and as a possible introduction to additional--transcendental and interpersonal--realms of human experience.

Laing's incisive comments on the objective neutrality of much social scientific research reiterates his views of politics. In the theoretical and descriptive language of much social science research, Laing finds that

The choice of syntax and vocabulary is a political act that defines and circumscribes the manner in which "facts" are to be experienced. Indeed, in a sense it goes further and even creates the facts that are studied.

The "data" (given) of research are not so much given as taken out of a constantly elusive matrix of happenings. We should speak of *capta* rather than data. The quantitatively interchangeable grist that goes into the mills of reliability studies and rating scales is the expression of a processing that we do on reality, not the expression of the processes of reality.25

The difference between persons and things is that persons experience the world of other persons. "Natural scientism is the error of turning persons into things by a process of reification that is not itself a part of true natural scientific method."26 The failure of social science, beyond a
disagreement about what political choices are made—and the reasons for making these choices as opposed to the alternatives—is, for Laing, that these methods fail to appreciate the rich variety of human experiential possibilities. It removes us from the array of non-everyday modes of experience: fantasies, dreams, transcendental experiences, and so forth. Even simple human reality, egoic experience, is not to be understood by such isolating tactics as searching out parts of reality, "capta." This criticism does not, however, leave Laing without examples of good and bad human activities.

As for statist politics, Laing finds himself frightened by it:

It is terrifying that having moved up through irrationality/rationality of sets of sub-systems until we reach the total social context, we there seem to glimpse a total system that appears to be dangerously out of control of the sub-systems or sub-contexts that comprise it. Here we face a theoretical, logical and practical dilemma. Namely, we seem to arrive at an empirical limit which itself appears to be of no obvious intelligibility, and beyond this limiting context we don't know what further context there may be that may help us to set the total social world system in a larger pattern or design in which it finds its rationality.  

In a lecture series, "The Politics of the Family", presented originally as the eight annual series of Massey Lectures on the Canadian Broadcasting Corporation, and subsequently published as Part II of a volume of the same name, Laing castigates what he terms Western consciousness:
When one does no more than scratch the surface of the structure of one of the varieties of Western 'conscience', one must marvel at its ingenuity. It must constitute one the biggest knots in which man has ever tied himself. One of its many peculiar features is that the more tied in the knot, the less aware we are that we are tied in it.

Anyone fully caught in the full anticalculus of this kind cannot possibly avoid being bad in order to be good. In order to comply with the rules, rules have to be broken. Even if one could wash out one's brain three times a day, part of one's self must be aware of what one is not supposed to know in order to assure the continuance of those paradoxical states of multiplex ignorance, spun in the paradoxical spiral that the more we comply with the law, the more we break the law: the more righteous we become the deeper in sin: our righteousness is as filthy rags.28

This is a curious assertion to make in a public address ostensibly delivered to a general radio audience to explain how families work. It is difficult to encourage self-examination and self-understanding in persons while assaulting them in this manner. The religious overtones (albeit a liberated religion) predominate over the scientific. A professional social scientist, well-versed in the literature of alienation could perhaps appreciate this passage as a meditation on the double binding nature of familial morality training and its societal consequences. Most of the lecture material, however, is a careful exposition of Laing's psychiatric framework.

An earlier metaphorical venture of Laing's, "The Bird of Paradise," appended to The Politics of Experience, had a much different tone and message. This autobiographical essay has been very controversial, with many of Laing's
fellow psychiatrists charging that it was written under the influence of LSD. A collage of dreams, phantasies, hallucinations, medical and human experiences (a variety of experiential modes) this essay is a personal testimonial of Laing's confidence.

Bookshop, Glasgow. Usual copy of Horizon. The last number!

"It is closing time now in the Gardens of the West. From now on a writer will be judged by the resonance of his silence and the quality of his despair."

All right—you did not have a circulation of more than eighty thousand. You ran out of money. But you bastard, speak for yourself. Write Horizon off. I'll be judged by my music not by my silence and by the quality of whatever pathetic shreds of faith, hope and charity still cling to me.29

Most of the stories related tell of medical inevitability and the frailty of human bodies, juxtaposed with portrayals of the inhuman bureaucracies of hospitals. And the phantasies that spring from these realities are skillfully blended into a vivid picture of the distinctive world of the medical doctor:

Two men sit facing each other both of them are me. Quietly, meticulously, systematically, they are blowing out each other's brains, with pistols. They look perfectly intact. Inside devastation.

I look around a New Town. What a pity about those viscera and abortions littering the new spick and span gutters. This one looks like a heart. It is pulsating. It starts to move on four little legs. It is disgusting and grotesque. Doglike abortion of raw and red flesh, and yet alive. Stupid, flayed, abortive dog still persisting in living. Yet all it asks after all is that I let it love me, and not even that. . . .
Body mangled, torn into shreds, ground down in powder, limbs aching, heart lost, bones pulverized, empty nausea in dust. Wanting to vomit up my lungs. Everywhere blood tissues, muscles, bones, are wild, frantic. Outwardly, all is quiet, calm, as ever. Sleep. Death. I look all right.

In Jean-Paul Sartre's *Nausea*, Roquentin climbs a hill to look over Bouville. He speculates about the relationship between nature and the bourgeois city he is overlooking. Nature is everywhere in the city, according to Roquentin. It is quiet and unobtrusive. He wonders,

What if something were to happen? What if something suddenly started throbbing? Then they would notice it was there and they'd think their hearts were going to burst. Then what good would their dikes, bulwarks, power houses, furnaces and pile drivers be to them? It can happen any time, perhaps right now: the omens are present. For example, the father of a family might go out for a walk, and across the street, he'll see something like a red rag, blown towards him by the wind. And when the rag has gotten close to him he'll see that it is a side of rotten meat, grimy with dust, dragging itself along by crawling, skipping, a piece of writhing flesh rolling in the gutter, spasmodically shooting out spurts of blood. Or a mother might look at a child's cheek and ask him: "What's that--a pimple?" and see the flesh puff out a little, split open, and at the bottom of the split an eye, a laughing eye might appear. . . . And someone else might feel something scratching in his mouth. He goes to the mirror, opens his mouth: and his tongue is an enormous, live centipede, rubbing its legs together and scraping his palate.

John Vernon in *The Garden and the Map*, asserts about this passage: "This is schizophrenia, and it is the terrible significance of *La Nausee*; Roquentin was an ordinary man in an ordinary world, but holes have opened up in the most substantial, firm aspect of that world, in its objectivity."

Laing's meditations in his "The Bird of Paradise,"
are in this light, schizophrenic in that they merge aspects of reality and phantasy: the inorganic regularity of normal urban life, with the flesh and blood phantastical organic dreams and experiences of the medical doctor. And Laing's schizophrenic writing is not unifying or organically whole. Like Sartre's perspective in the above passage, it is disjunctive and "horrifying"; no less than Mary Barnes's journey. The going-down experiences are inseparable from the coming-up experiences and together are a prerequisite for Laing's holistic conception of man.

Laing's writing can be compared to that of the schizophrenics reported by Sechehaye, Rosen, Arieti, etc., and found to be different in that it seeks to understand the world in human experiential terms. He does this by dismembering and taking apart the regular, normal situation, and demonstrating the applicability of a schizophrenic perception to this normality. Laing's goal is different from those psychiatrists who seek to cover-up and cure such perceptions of the world. He seeks purposely to display and demonstrate how these distortions can be utilized to re-make the normal into a more comprehensive situation by incorporating the schizophrenic perception in its integrative and its disintegrative phases. The experiences he relates constitute a part of his human experience as a medical student and a young doctor. They are potential experiences of all human beings.
Laing wants to be counted, heard, and listened to. He writes, while at the same time he professes his consciousness of the egoic nature of his undertaking:

This writing is not exempt. It remains like all writing an absurd and revolting effort to make an impression on a world that will remain as unmoved as it is avid. If I could turn you on, if I could drive you out of your wretched mind, if I could tell you, I would let you know.  

And:

What would life be like if there were no one to remember us, to think of us when we are absent, to keep us alive when we are dead? And when we are dead, suddenly or gradually, our presence, scattered in ten or ten-thousand hearts, will fade and disappear. How many candles in how many hearts? Of such stuff is our hope and our despair. 

Laing persists in striving to deal with a full range of human experiential modes, even though, as a psychiatrist, he is continuously criticized and rejected for overstepping the grounds of his profession. Although he does this mixing and blending of human modalities in all of his writing, nowhere is this more prevalent than in "The Bird of Paradise." There is nothing new in this essay, except the declaration of his refusal to be bound by the norms of professional limits. All that he says is stated in conventional, impersonal terms in the first part of the volume. In "The Bird of Paradise," between his cat and a wonderous bird seeking to avoid the cat, Laing elaborates a personal vision of human consciousness.
Cat is a cat is a bird is a nonbird of effably frail space suddenly spreading in parabolic grace of authority. How foolish to worry, to try to save her. Let be. Cat and bird. Begriff. The truth I am trying to grasp is the grasp that is trying to grasp it.

I have seen the Bird of Paradise, she has spread herself before me, and I shall never be the same again.

There is nothing to be afraid of. Nothing
Exactly.
The life that I am trying to grasp is the me that is trying to grasp it.

Despite the overwhelming evidence of alienation in the professions surveyed, Laing insists that all can be overcome. His assurance that alternatives are available is a demonstration of his praxis or political action. This orientation, almost an instinct, of Laing's continuously infuses his psychiatry with politics. The proof Laing offers is the schizophrenic experiences of Mary Barnes and others who overcame their deep alienation and desperation to return to the world of others with enhanced capacities and creative accomplishments. Schizophrenia shows how persons can reclaim the origins of their human experience. If schizophrenics can overcome alienation, all men and human institutions can do so.

The visceral, organic, most basic level of human life for which Laing finds so much medical compassion is the same level that he appreciates and extolls as a student of interpersonal perception. His critiques of alienation in the various human sciences, bureaucracy,
the family, and so forth all rest on a belief in the integrity and the incorruptibility he finds innate in human nature.

Everyone to begin with is constitutionally alive. I have never come across anyone who is alive as most babies still are, at least for a few weeks after birth, [they do not] envy life in any other creature. The baby who is alive delights in life. Constitutionally, life dances with life.\(^{36}\)

In *The Facts of Life*, an essay in the tradition of Montaigne, Laing admits to being obsessed by philosophical and political concerns. He concludes that

This book is haunted by the question: What is the correct way to live? When I put this question, through an interpreter, to a reputed saint in Kashmir, said to be over a hundred years old (he looked like an ancient bird) the instant answer, through the interpreter, was:

Let your heart be like the sun
Shine alike on everyone.

Whence did he derive this knowledge? Or was it mere opinion?

"The scientific and technical world of modern man," writes C. F. von Wieszacker, "is the result of his daring enterprise, knowledge without love." Chilling. I cannot see how knowledge without love can yield knowledge of love; how a heartless method, yielding heartless results, can do anything else than explain away the heart.

Werner Heisenberg . . . after a searching probe into our capacity to "understand" the world mathematically, suggests that "patterns in our minds," called archetypes by Plato, may "reflect the internal structure of the world," in ways mathematics cannot.

This book makes no pretensions to be a guide to the perplexed. But I have tried as best I can, to convey the nature of my perplexity.

Can what is morally wrong be scientifically right? Two worlds shatter each other.
Laing is troubled about politics and mental hospitals. He is increasingly at odds with the scientific method and purpose basic to his life work as a medical doctor. The skepticism he writes about is increasingly a set of doubts about the human virtues of science and medicine.

6. Science and Medicine

Laing's understanding of science and of scientific experimentation is expressed in detail in his *Reason and Violence*. He recognizes the distinctions to be drawn between biology and human biography:

The original project, always a reflection of self to being, cannot be expressed in physicalistic metaphor and biological analogy without fatal confusion and ambiguity. Unfortunately even the best psycho-analytic papers are written in these terms or fall back into them. 38

In contrast, Sartre traces the life of the person to its own ultimate issues, which are to be found only within personal life itself. The ultimate 'original project', or original choice of self, provides the intelligible basis for all the acts and experiences of the person. The reductive biologism prevalent in psycho-analytic thinking explains all as it explains nothing. 39

Comprehension for the researcher, for Laing and Cooper, "is nothing other than my real life, that is to say, the tantalizing movement which gathers together myself, the other person, and the environment in the synthetic unity of an objectification in process. . . .
Our comprehension of the other is never contemplative, it is a moment of our praxis, a mode of living." The human project can never be explained or understood in a physicalistic metaphor or biological analogy. Human activities of a self-defining variety cannot be explained by any type of analysis which does not fully account for human experience. It remains to be explored how the medical or biological realm of human explanation is related to the ethical and political for Laing and his medical colleagues acting as experts on the human condition. For Sartre, this sorting out of the medical from philosophical expertise presents no problem. But for Laing (and all psychiatrists) the sources of his authority and the grounds for his writing and acting in the world of psychiatry can become blurred or confused. His goal of having physician-priests minister to the needs of schizophrenics leads one to ask: Why are physicians necessary?

Clancy Sigal, a member of the Philadelphia Association Board of Directors and a co-founder of Kingsley Hall, has written an account of Laing and his colleagues where Laing is fictionalized as Dr. Willie Last. Last exemplifies a diabolical Laing. Sigal reports that according to Dr. Last, psychiatrists are

' a careerist cabal of public-school sadists, time-servin' quacks and knife-crazy leucotomists.' Mental Hospitals were 'Auschwitzes of the soul; most psychiatrists were 'mind butchers' who induced the 'disease' of schizophrenia which existed in their own disordered brains. At best, therapists
were 'mai-dical mechanics retreadin' overexposed minds till they pairminently blew oot'; at their too frequent worst 'feld-polizei huntin' doon sassiety's natural deserters--th' shock truips of the comin' psychic revelushun'. . . . th' lead scouts of a children's crusade fightin' tae retake th' Holeh Land for oor Primal Unspoilt Selves.41

Yet Sigal found a real reluctance among Last and his medical colleagues to relinquish their medical identities.

Last's refusal to give up his despised medical identity he justified in terms of realpolitik. A doctor carried more weight than a layman in the battle to penetrate official medical lethargy. . . . the three doctors or 'officers,' were 'point men,' while us noncoms were 'coverin' fire,' guerrillas striking at the very heart of the system.42

Living at Kingsley Hall (called Clare Council House), Sigal found that a clear-cut hierarchy existed. The pecking order was organized on the same principle as at any psychiatric hospital: "strange, isn't it? They're all supposed to be in ecstasy, withdrawn, possessed and all the rest of it. Yet they fly like homing pigeons straight into the arms only of men who have medical school diplomas."43

In Sigal's account, Last and his medical colleagues don't hesitate to use their medical authority or access to drugs in order to maintain or enhance their positions in the community. Joseph Berke reports that Mary Barnes refused to allow non-medical doctors to be involved in her treatment. She believed only medical doctors could properly give therapy. Berke purports not to know where she got this idea.
Judging by his own writing, Laing's confidence in his profession, however, seems to greatly decline over time. Science and medicine are not looked upon with favor and hopefulness by Laing in his 1976 essay, *The Facts of Life*. Laing writes about experimental medical science as if he no longer believed in its possibilities. His discussion on the implications of rat research is especially skeptical.

The first piece of RAT research I came across was in the fifties. A biologist I knew was doing research with distant hopes of a Nobel Prize. Since he belonged to the left, he didn't think there was much chance of hitting a Nobel, though you could never tell. His work was to get rats under laboratory conditions, and turn the heat down, colder and colder. The game was to see how cold you could get them before they would stop copulating. Now, he was a pure scientist, not an applied scientist. He had a permanent camera set up to film them "at it." Little bits of fluff would be given to them so that they could just warm themselves up a wee bit if they huddled together as tightly as possible. Even after they were deep-frozen stiff, when they got a little warmth back, they would still make love.

His was no trivial occupation. I often find it difficult to realize that probably every major government in the world has stashed away, through vast underground labyrinths, food for those people the computer determines as having priority for survival at the last roundup. But the rats are a major menace because even in extreme cold, if there's still only a little bit of something they can huddle in, they can still keep it going. So it's a problem. Some of the so-called best, so-called scientific, so-called minds are engaged in the rat race for the Nobel Peace Prize on rat research.

I once spent a lifetime (when I woke up and found myself back in my bed, I couldn't decide for a while what was dream and what was "reality") as a rat in the sewers of contemporary Tokyo. I ended my rat lifetime in a way that my rat consciousness couldn't make out, but it was something like bubonic plague. I began to swell up. Pus was oozing out of my blind eyes and all over the place. I staggered around, then collapsed, faded out, and faded back into my bed.
I must say, I preferred that death to the deaths meted out to some people in our hospitals. Laing tells us that tranquilizers were developed for rat control and conditioning experiments. They were applied to humans to achieve the same purpose. He reports that his first mental hospital experience was a comparatively good one: "Gart Naval wasn't too bad as a genuine refuge." Laing finds that with the development of tranquilizers, ECT (electric and chemical shock techniques), psychiatry has become more scientific and less humane. Medical training is "bedeviled . . . by its own insane theory and insane practice." In most mental hospitals, Laing asserts, "there is complete local power to chop and cut people up, physically as well as theoretically, in the name of the exact opposite of what is said is being done. The error in psychiatry is not just a casual one. It's an error of one hundred and eighty degrees in the opposite direction without insight." Looking for help at a psychiatric hospital would be like "the Aztecs rushing into the mouths of the Spanish cannon in hopes of finding deliverance." Doing so would really drive a person crazy by perhaps permanently depriving him of his complete brain.

His faith in science, medicine, and psychiatry has lessened considerably since his idealistic refusal to be counted out in the "Bird of Paradise." Yet, Laing seems deeply tied in his professional and personal life to science and medicine. While quite willing to utilize his
Laing concludes The Facts of Life with a declaration of his skepticism. In the midst of reciting the sins of natural scientific investigators, Laing switches to a description of an analytic session where a woman reports to him that her six-year-old daughter and husband "were having an affair," and as a result the daughter was doing much better in school. The woman evaluates the situation as follows: "... I can't tell the police because I love him and she would never forgive me, and now he's having an affair with her best friend and I think her whole class is starting to queue up what do you think?" And, "When I challenged him he just asked me to join them then I thought this is probably what I wanted to do with my father if I had done that with my father I wouldn't be all screwed up like I am now very likely. I wish he had been my daddy."
Do you think there is a problem?" Laing professes not to know the answer to her quandry, or what to advise her to do. As for himself, he reconsiders his commitment to science. In his life he had abandoned everything else and took to science. Not what science might at any time present us with as, provisionally, fact, but the scientific method. Here at least the human mind had arrived at a way of proceeding which, if it perhaps could never solve the riddle of the universe . . . might reconcile us to the necessary disenchantment at resigning ourselves, more or less gracefully, to our limitations.

Laing concludes with the declaration that "This book is haunted by the question: What is the correct way to live?" Laing's medical role allows him immediate access to the organic level of human experience. This access has enabled him to help formulate a new concept of schizophrenia as an opportunity for wholeness. Vernon shows how this organic view of humanity can lead to a new or renewed consciousness of human experience. It can also reveal the impact of schizophrenic alienation on normal culture and literature.

Vernon effectively contrasts the schizophrenia of William S. Burroughs and that of Theodore Roethke. He begins with the assertion that the novel and modern Western culture seek to isolate human experience and "repress" human unity, "by separating reality and fantasy, object and subject, world and self. . . . This is the defining characteristic of Western culture: it is schizophrenic, in
that it chooses to fragment its experience and seal certain areas off from each other. It drains the fantastic, the mad, and the subjective out of their unity with the self and the world. . . ." Vernon characterizes this as the world of the map. He postulates that it constitutes the distinguishing characteristic of the realistic and naturalistic novel. The map "refers to that schizophrenic structure whereby areas of experience are extricated from each other and arranged in discrete spaces, often as opposites." The term garden refers to a "structure the opposite of the map, one that unites opposites and enables all areas of experience to be accessible to each other."

The writings of William S. Burroughs represent for Vernon the highest achievement of this dualistic Western consciousness. Vernon points out that Burroughs "asserts, not entirely ironically, that a movie and sound track of sexual activity are as good as the real thing." Any human contact is organization, and for Burroughs, all organization is control.

Burroughs is well-known for his cut-up method of writing. Vernon finds this perfectly appropriate, given the nature of his world view.

Burroughs' world is one in which objects have become so objective, so one-dimensional, so thin, they have dropped out of the words they are dressed in, leaving only those words—as objects—behind. . . . words are consequently objectified and fragmented. This is how and why they can be exploded, cut-up. . . .
The anality of Burroughs' world is repulsive for Vernon because it "can be enjoyed only in regressive fantasy and violence." 58

Theodore Roethke, like Burroughs, has been diagnosed as a schizophrenic. Vernon finds that Roethke's world represents a return to the garden, the way of the future of the Western world. Roethke's images are found to be, in many respects, "similar to those of Burroughs, but whose world is the opposite of Burroughs'." 59 Roethke's "schizophrenia represents liberation and renewal rather than confinement and death, and thus in every respect represents a return to the garden and its structures." 60

Roethke's poetry starts from the "primordial wholeness of the child's world," and carries that wholeness through all further stages of the life cycle. Roethke's poem, "Unfold! Unfold!" illustrates this schizophrenia wholeness that Vernon and Laing find to be an alternative Western consciousness:

Easy life of the mouth. What a lust for ripeness!

All openings praise us, even only holes. The bulb unravels. Who's floating? Not me. The eye perishes in the small vision. 61

Vernon finds that human potential for wholeness is here

Carried into the growing world of every day experience and united with each separate entity in that world. "The eye perishes in the small vision" because it is drawn into the bottomless hole of each separate thing, thus is drawn into the world itself. This is possible because the space of Roethke's world--of the garden, and of
schizophrenia as the most ideally sane state of consciousness--is one in which all things open upon each other and upon the body, in which subject, fantasy and reality, are perfectly united.62

And:

This metaphoric space, this space of mouths, is the reason Roethke's world . . . is a world of correspondence--correspondence between things and between the body and things. It is also the reason objects of that world so often speak and ring, not only to the protagonist but also to each other.63

Communicating verbs abound in the work of Roethke. The oral stage of development is the basis for the organic unity of all things. In Burroughs's world, wholeness can only be achieved through violent regression since all unity is denied in his realm of schizophrenic dualisms.

Vernon demonstrates the existence of two very different kinds of schizophrenia. One, standing for the dualistic actuality of Western consciousness and culture; the other seeking a holistic curative perspective for contemporary Western man. This holistic schizophrenia is based on human cultural traditions going back to ancient sources. Shamanism and traditional, or "primitive" cultures, documented by Mircea Eliade, represent that old tradition. Contemporary psychiatry is also of two kinds. One kind, shown in the work of Arieti, Lidz and the chemico-genetic researchers, seeks to enforce normal dualisms at whatever costs by demanding the return of schizophrenics to their world of dualisms. The alternative psychiatry, demonstrated fully in Laing, is based on the alternative model of schizophrenia as a natural curative experience which persons may
crave in order to unify themselves in light of a disharmonious, split and destructive societal normality. Two antithetical schizophrenias, and two opposing psychiatries to match. One based on control of deviance and the other based upon seeking alternatives to a dualistic normality. Laing, however, is not as sanguine as Vernon that Roethke's schizophrenia is the way of the future. His pessimism deepens in later writings.

Laing, Cooper and Esterson have written extensively not on skepticism, but rather on the existentialism of Jena-Paul Sartre. Their reliance on Sartre's philosophy presents a serious problem in trying to locate their political and philosophical principles.

Aaron Esterson has devoted the second part of The Leaves of Spring to an exposition of existentialism as it applies to the treatment and analysis of schizophrenia. Esterson's first principle is that only with the methods of dialectical science, as developed by Sartre, can persons deal with each other as persons. Only with the dialectical method can a true human therapy be developed and practiced. The natural scientific and the clinical psychiatric [the perspective Laing takes in his critique of Kallman] stance "relates to the field primarily from a position outside it." 64

The primary principle of dialectical science, according to Esterson, is that "It is reasoning in, through
and for action in the field it is reasoning about; an action research." He proceeds to explain to the reader the reason for Che Guevara's failure in Bolivia was that he didn't understand the nature of the group praxis of the Bolivian peasant. Because "A social revolutionary group praxis cannot be so annihilated except by genocide. For the social revolution is the praxis of a revolutionary people reflectively constituting and participating in a functional hierarchy of interdepending revolutionary groups..." Next, we are told that the success of Lenin in 1917 was due to his correct understanding of the revolutionary group praxis. In the U.S.S.R., old contradictions were replaced by new ones, however. And, Mao tells us, failure calls for retotalizing the situation.

Following this perhaps misplaced concreteness in his theory of the dialectical elaboration, Esterson tells us that in his field, psychotherapy, "A psychoanalyst... must not seek to impose on the analysand his idea of what the other should or should not be. There is no question of seeing it as his task to teach the other to conform to society or to any particular morality. He is there to learn from and to help the other discover and actualize his own existential possibilities like the capacity to make heterosexual love." Beyond the questions of permissiveness or the valuation of heterosexual love, Esterson seems unable to
establish any human values to be achieved over other competing values. Perhaps the ideal here is that the patient ought to live like the therapist.

Nonetheless Esterson proceeds to try to specify his values. He tells the reader that no research "simply for the sake of technique" is to be allowed in dialectical science.\textsuperscript{68} All science is to serve human ends. How this declaration can be applied to complex ethical issues is not addressed by Esterson. Esterson's assertion about science is perhaps akin to--though not nearly so startling as--Laing's rejection of all rat research because, looking at things from the perspective of the rat, all such research is anti-human (anti-rat).

As for schizophrenia, in Esterson's view, the only "splitting" of the classic disease theories of Kraepelin, Bleuler, and others, occurs inside the psychiatrist who refuses to take his patient as a fully human being and respond appropriately.\textsuperscript{69} This is quite different from the perspective taken in the early Laing of \textit{The Divided Self}. This difference marks the change in the later Laing to a social intelligibility approach to explain all schizophrenia.

The Danzigs, studied in depth by Esterson, are a family which declared itself to have a "harmonious praxis, apart from a daughter," who deviated from their norm.\textsuperscript{70} Praxis is the study of the intentions of persons,
in contrast to the study of mechanically determined processes examined by clinical psychiatry. In *Sanity, Madness and the Family*, Laing and Esterson define praxis as the attempt to find out "Who is doing what," and process is defined as the attempt to discover "What is going on?" No additional distinctions about the nature of praxis are to be found in their work. The concept of praxis serves as an undefined base point for Laing and Cooper in their study of Sartre, *Reason and Violence*.

Sartre's philosophy introduces problems into Laing's theory of politics. No distinctions between good and bad—ethical or moral, as opposed to unethical or immoral—are made in theoretical terms. Plenty of examples are given by Laing and Cooper (and by Sartre) of good and bad in human affairs. But the theoretical and philosophical distinctions between good and bad in human affairs are not made.

This failure of Laing reflects the failure of Sartre to distinguish the aspects of being; and therefore, the conditions and chances for political, and ethical, achievement. For Sartre, philosophy is anchored on the rejection of the Hegelian possibility that being-in-itself can ever unite with being-for-itself, in the view of Richard Bernstein's *Praxis and Action*. Therefore: "'Man is a useless passion,' [Being and Nothingness, p. 615, p. 708] because he can never achieve what he lacks
and most desperately desires—to become identical with himself, to achieve an integration and harmony with himself as a for-itself and the ideal self that he projects." 

Bernstein continues that for Sartre,

> We are choosing what we are to become at every moment of our existence. These choices are ultimately grounded in our own nothingness. When we strip away all illusions, all attempts to deceive ourselves, all attempts to escape from our own freedom and nothingness, we realize that nothing can serve as a ground or justification of our choices. But even this reflective "lucidity" about our human reality, this realization of the impossibility of ever becoming an in-itself-for-itself does not help us to escape from the perpetual attempt to seek some form of self-identity. We are condemned to seek for what is impossible.

Bernstein points out that for Sartre "none of our choices or acts are justifiable and consequently there is no ultimate sense in saying that one project, choice or act is better than another, then what possible ethical significance . . ." can be attached to any action. If all human activities are equivalent, than bad faith is the only possible conclusion of praxis. Achieving human freedom, Sartre's being-of-itself-for-itself, is an impossibility for Sartre. Bernstein concludes that

> If we take Sartre literally, we simply have no ultimate reason for valuing or preferring one rather than the other. We should have the courage to admit that the consequence of Sartre's analysis of human reality is not only despair, but nihilism in the coldly technical sense. There never is nor can be any reason or justification for one value, end, choice, or action rather than another.
Clancy Sigal has his fictional Laing making a declaration demonstrating the bitter realistic end of Sartre's philosophical existentialism:

He genuinely perceived life as pure terror, a concentration camp to which we had been condemned by a heartless, random fate. Everything he measured by standards of Auschwitz. Mother and father were kapoes of the bourgeois state, family love a crematorium. Not only Last but all three doctors were so spooked by, almost in love with their patients' self-disgust and self-hatred that paltry human emotions like laughter and affection were considered "unseemly" (a favorite Last word), even a betrayal of the Task. . . . 'How else d'ye think we presume tae call oorselves healers? We are th' disease we're tryin' tae cure.'

Yet Laing himself declares his refusal to give-up and participate, for example, in the decline of the west, or to accept alienation as a substantial given in human affairs. This refusal to be counted out, and his search for alternatives to professional and personal alienation, is a strong assertion of his seeking to move beyond nihilism. Laing does subscribe to Sartre's existentialism as his philosophical starting point. He is unable to make ethical distinctions based on his existentialist philosophical principles. He continuously makes them in practice, however. Often, as in The Facts of Life, Laing poses as a philosophical skeptic. Perhaps he does so to maintain the requisite status to make moral and ethical distinctions. Moving beyond contemporary Western data also allows Laing to postulate alternatives and examples of non-alienated man. His interest in traditional shaman,
primitive religions, and Eastern religious practice allows him to seek options. All of this does not overcome the inadequacies of the Sartreian framework, however.

Today schizophrenia is the central concern of two opposing schools of psychiatry. Both the psychiatry seeking to control and eliminate schizophrenia by chemical and genetics research, and the psychiatry seeking to enlarge the realm of the personal and community range of normality focus on schizophrenia as its greatest challenge and opportunity. One school seeks to eliminate this medical/social disease, along with all of its bizarre symptoms. The other school strives to allow persons to experience and learn from this interpersonal situation, under experienced guidance. Neither side recognizes the other as legitimate. One position, clearly the liberal historical one, knows schizophrenia to be an organic ailment which can be controlled and eventually eliminated with the inexorable progress of science. The antithetical view sees schizophrenia as caused by interpersonal attributions, scapegoating, and inadequate early human care. With Laing and his colleagues, schizophrenia comes to be a concern of the social and political scientist, as well as the philosopher, because ethical issues are inherently involved in its development and treatment. Beyond the patient, the goal becomes to understand the
society that distinguishes schizophrenia from normal alienation, and from human experience.

In evolutionary progressive terms, the (re)claiming of schizophrenia as a human cultural and social disorder is clearly a triumph over the dementia praecox, irreversible organic deterioration view of Kraepelin, Bleuler, and Jung. More human possibilities are introjected into social and political life by Laing's vision of schizophrenia than in the versions proclaimed by the chemical and genetics schools. Yet the hostility of Rosen to his patients, the rejection of schizophrenics by Szasz, the failure to accept regression by Sechhaye, and the urge to cure, conquer, and eliminate all vestiges of the disease found in Kallman--and contemporary psychiatry in general--shows that what many mean by medical treatment is total control and elimination of a phenomenon which Laing finds indispensable to achieving a complete conception of man. What Kallman seeks to genetically purge from the human race is what Laing wishes to encourage as a way to expand human experiential realms, and thereby, to allow the chance for human creativity and action to become the respected aim and purpose of a new kind of psychiatry.

One psychiatry operates strictly within the confines of medicine. The other psychiatry claims its authority from the medical training of its practitioners,
as well as from the humane tradition of medical psychiatry represented by Freud and Pinel, among others. The aesculapian authority of the medical doctor is apparently not to be seriously questioned by either psychiatry.

The state leaves little doubt about its orientation in its distribution of monies and resources. The fact that psychiatrists are medical doctors is a historical accident. As Michel Foucault demonstrates in his *Madness and Civilization*, doctors were introduced into the new liberal model of treatment because they could effectively act the role of wise men. Their medical expertise was irrelevant to their asylum function.

Yet psychiatrists today control the data of schizophrenia, in an essential monopoly granted by the state. They are placed in charge of mentally ill persons by the community, the government, and by their own families. Claiming schizophrenia as a phenomenon exclusively under the control of psychiatry, the medical psychiatrist is provided with his source of authority. Teaching and controlling those who are out of control becomes the purpose of medical psychiatry. Without schizophrenia, psychiatry would have a severely curtailed role in contemporary life. Whether or not psychotherapy is the preferred treatment in psychiatry, as suggested by Anselm Strauss, et al., in *Psychiatric Institutions and Ideologies*; control via chemical means or ECT is the potent defense of the
therapist against patients who "act out" or who seek to pursue non-egoic, transcendental realms of experience. No social scientist or philosopher can exercise this legitimate control (violence) over the organisms of his constituents.

This medical authority of the psychiatrist is based upon the institutionalization of the physical control of the bodies of their patients. The development of anti-schizophrenic drugs has expanded and regularized the control of the therapist in and out of the hospital. As Siegler, Osmond, Humphries, and Mann know, the directive to "Take your medicine!" has become the new battle cry against schizophrenic "acting out." The medication is the power of the psychiatrist to interfere with the regressions and anti-normal behavior so possible with schizophrenics. If the cure of schizophrenia is yet to be discovered, the believers of medical progress tell us that this achievement is imminent. If counseling has not succeeded in stopping the birth of schizoids, than control via chemical tranquilizers is a practical possibility.

Laing and his followers do not see this achievement of medical control as a forward step. Control stops the healing process. A person experiencing schizophrenic symptoms, or eliciting them to others, comes under the
purview and control of the psychiatrist. If such a person is not forcibly brought under control, he may seek help in dealing with these strange and upsetting experiences. The kind of help such a person receives demonstrates the consciousness, awareness, and understanding of his local psychiatrist. Few are told about schizophrenia as a potential experiential break through, as a healing process. Fewer, if any, are left alone to make discoveries for themselves. Progress for the chemical psychiatrist is destructive regression for Laing. And progress is the elimination of mental hospitals that might serve an asylum function. The Laingians control few, if any, hospitals or mental health centers. Drugs and ECT are utilized in most psychiatric settings as the therapies of choice—or as the way to control the patient and maintain order.

Perhaps these two schools of schizophrenia and psychiatry have a dialectical relationship. If so, the triumph of Laing's school is far off. His view of schizophrenia as documenting the failings of Western consciousness and culture makes a major contribution to the social scientist seeking to comprehend the impact of alienation. For Laing's perspective to develop further, it is necessary for its adherents to sort out their medical from their philosophical, ethical, and political sources of authority. And they must try to move beyond the limits
of existentialist ethics established by Sartre. The study and treatment of schizophrenia will become increasingly important to persons trying to understand the human community in our time. The psychiatric function of controlling schizophrenia will undoubtedly continue until legitimate authoritative relationships between the schizophrenic and the governing authorities can be established. Reliance on surgical and chemical control mechanisms can readily be seen as less than fully human responses, as the substitution of power for authority, and as the rejection of abnormal behavior, "acting out," or regression. The proper study of the phenomena of schizophrenia can demonstrate the failings of a particular cultural normality, and help to suggest alternatives to human alienation.

Only when Laing fully embraces a political viewpoint does the medical dimension of schizophrenia find its limits. In his development, when the political comes into its own, the limits of the medical approach are demonstrated. Taking a political-philosophical approach to the problem can tell us the meaning and significance of a behavior and experience heretofore thought to be irrational and pathological. The infusion of politics into Laing's work, starting with "The Obvious" and The Politics of Experience, serves to illustrate the interface between politics and medical psychiatry; and
between the occurrence of human alienation and the organic-
pathological. Laing teaches that in schizophrenia human
purpose predominates over the metabolic and the neurological
approaches. With Laing's schizophrenia, Sullivan's Human
Species Identity Theorem—"everyone and anyone is much more
simply human than otherwise, more like everyone else than
different"—is completely realized. All psychotic
behavior is human. For the first time in Laing's work,
not only the personal, but also the public consequences
of schizophrenic splitting, mystification, hallucinations,
catatonia, and so forth, are clarified and fully compre-
hended.

During the twentieth century, schizophrenia has
been the major preoccupation of psychiatry—indeed, it is
the invention of twentieth century psychiatry. Beginning
with the work of Kraepelin, the disease was defined as the
most difficult conundrum of psychiatry. The organic
deterioration and premature death which supposedly inevit-
ably resulted were sure signs of the dangerous nature of
the disease. Kraepelin's and Bleuler's schizophrenias
continue to inform today's organic, chemico-genetic, and
categorizing investigators. It is the chief basis for the
medical predominance over psychiatry and mental illness.
As Fromm-Reichmann found, however, even withdrawal and
(psychological) deterioration are consequences of the
personal fears of the therapist, not of the organic deterioration of the patient. In the tradition of Sullivan, Fromm-Reichmann, Searles, and Laing, all cases of schizophrenia are examples of human failure and the striving for rebirth experiences. Regression, as Searles and Laing show, is always a strategy designed to re-do the person's relatedness to others when their situation becomes hopeless. Attempts at suicide are often responses to schizophrenic hallucination or despair. This demonstrates the powerful impact such factors can have on the person undergoing this experience.

For the therapist, the prerequisite is an attitude of hope and possibility. In Fromm-Reichmann and Laing, this an intellectual position as well as a perceptive human feeling of generosity and hope. This philosophical appreciation of schizophrenic possibility introduces politics into the situation. Good therapy must be politically informed. With the introduction of human alternatives, the medical domination of psychiatry is shown to be inadequate; it has failed to provide for human experience. The limits of medicine and psychiatry can be appreciated if we fully understand the impact of Sullivan's thesis that schizophrenia is a human ailment. Only when Laing explores the political implications of schizophrenia
can we completely see the role of politics, and the limits of aesculapian authority. Laing's politics seeks to enhance human life and limit dehumanization in his professional and personal existence. With Laing schizophrenia comes fully into the purview of the student of politics, culture, and society.
Chapter I


3 Ibid., p. 171.


6 Ibid., pp. 486-87.

7 Ibid., p. 465.

8 See Ibid., p. 477 and p. 512.

9 Redlich relates what sorts of therapy he would seek and accept if he developed a schizophrenic psychosis:

When asked by students, I usually answer that my own preference, in case I developed such a psychosis, would be to obtain prolonged, intensive dynamic psychotherapy by an experienced psychoanalyst who likes schizophrenics. . . . I hope I would be able to find and afford such a therapist and hospital, for they are extremely rare. If such a procedure failed, I would consent to shock treatment and later a to a lobotomy. ("The Concept of Schizophrenia," in *Psychotherapy with Schizophrenics*, ed. by Eugene B. Brody and Fredrick C. Redlich (Stanford, 1952), p. 35.

10 Ibid., p. 513.

11 Ibid., p. 521.

12 Solomon and Patch, *Handbook*, p. 120.

14 **Ibid.**, p. 488.
15 **Ibid.**, p. 700.
16 **Ibid.**, p. 488.
17 **Ibid.**, p. 666.
18 **Ibid.**, p. 450.
19 **Loc. cit.**
20 **Ibid.**, p. 455.
21 **Loc. cit.**
22 **Ibid.**, p. 458.
23 **Ibid.**, p. 540.
24 **Ibid.**, p. 128.
25 **Ibid.**, p. 127.
26 **Ibid.**, p. 263.
27 **Loc. cit.**
28 **Ibid.**, p. 369.
29 **Ibid.**, p. 381.
30 **Ibid.**, p. 584.
31 **Loc. cit.**
32 **Ibid.**, p. 269.
33 **Ibid.**, p. 195.
35 **Ibid.**, p. 455
37 See Chapter III.
Here is Arieti's case of Geraldine, a 32 year old woman during the time of this report:
Geraldine believes in the reality of her hallucinations. From her account of them I realized that they occurred when she expected to be criticized. For instance, in the choir she expected the director to criticize her, and the alleged voices from the choir members came to criticize her. She went home, lonely and melancholy, with the feeling of being an inferior and blameworthy person, a person lacking confidence in herself and despairing about her own life. She expected the neighbors to blame her and there they were: she could hear them in the act of criticizing her. Every day, as soon as she expected to hear them, she heard them. She was putting herself in what since then I have called the listening attitude. Under my guidance, Geraldine became capable of distinguishing two stages: that of the listening attitude and that of the hallucinatory experience. At first she strongly protested and denied the existence of the first two stages, but later she made a little concession. She said, "I was thinking that they would talk about me, and there they were, talking about me."

And:
Eventually she recognized that she was putting herself into that attitude when she was in a negative mood. . . . In these circumstances, she was automatically finding ways to exchange this feeling with the feeling that she was not inferior but rather a victim, the object of the hostility and malevolence of others. In other words, a feeling that made her accuse and condemn herself was transformed into another one in which the others—the neighbors—were accusing and condemning her.

And:
As she used to say, Silvano had taught her to recognize hallucinations, and she could no longer indulge in the luxury of having them. As a matter of fact, once the hallucinations would start, one could never know when they could be checked. They could multiply and give vent to a full psychotic episode. (Arieti, Interpretation, p. 633)
Chapter II


2 Loc. cit.

3 Emil Kraepelin, Lectures on Clinical Psychiatry 2nd ed. (New York, 1906), Table of Contents.

4 Zilboorg, History, p. 456.

5 Ibid., p. 455.

6 See the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."

7 Kraepelin, Lectures, pp. 21-3.

8 Ibid., p. 24.


10 Loc. cit.

11 Ibid., p. 28.

12 Ibid., p. 29, emphasis in original.

13 Ibid., p. 36.

14 Loc. cit.

15 Ibid., p. 33.
16 Ibid., p. 29.
17 Ibid., p. 82.
18 Ibid., p. 28.
19 Ibid., pp. 28-9.
20 Ibid., p. 29.
21 Ibid., p. 3.
22 Ibid., pp. 3-4.
23 See Chapter VI.
24 Ibid., p. 34.
26 Loc. cit.
27 Loc. cit.
29 Ibid., p. 33.
31 Ibid., p. 441.
32 Ibid., p. 439.
33 Bleuler, Dementia, pp. 33-4.
34 Ibid., p. 237.
35 Ibid., p. 299.
36 Loc. cit.
37 Ibid., p. 298.
39 Bleuler, Dementia, p. 391.
41 Ibid., p. 377.
42 Ibid., p. 384.
43 Ibid., p. 385.
44 See loc. cit.
46 Bleuler, *Dementia*, p. 22.
47 Ibid., p. 22.
48 Ibid., p. 44.
49 Ibid., p. 143.
50 Loc. cit.
51 Ibid., p. 300.
54 Ibid., pp. 354-55.
55 Ibid., p. 355.
56 Ibid., p. 358.
59 Ibid., p. 460.
60 Ibid., p. 464.
61 Ibid., p. 466.
62 Ibid., p. 432.
64 Loc. cit.
65 Ibid., p. 525.
66 Bleuler, Dementia, p. 462.
67 Ibid., p. 284.
68 Ibid., p. 477.
69 Ibid., p. 488.
71 Ibid., p. 36.
72 Ibid., pp. 36-7.
73 Ibid., p. 69.
74 Loc. cit.
75 Ibid., p. 96.
76 Ibid., p. 194.
77 See ibid., p. 193.

Chapter III

3 Ibid., p. 222.
5 Ibid., pp. 187-88.
6 See ibid., p. 189.
7 Ibid., p. 326.
8 Loc. cit.
9 Ibid., p. 327.
10 Loc. cit.
11 Ibid., pp. 352-53.
12 Ibid., p. 352.
13 Ibid., p. 304.
14 Ibid., p. 306.
16 Ibid., p. 32.
17 Loc. cit.
18 Ibid., p. 23.
20 Ibid., p. 73.
21 Sullivan, Schizophrenia, p. 251.
23 Ibid., p. 371.
24 Ibid., p. 162.
25 Ibid., p. 182.
26 Ibid., pp. 198-99.
27 Ibid., p. 199.
28 Ibid., p. 155.
29 Ibid., p. 136.
31 Ibid., p. 367.
32 Sullivan, Clinical, p. 364.
33 Sullivan, Schizophrenia, p. 327.
36 Ibid., p. 47.
37 See ibid., p. 273.
38 Ibid., p. 237, emphasis in original.
39 Loc. cit.
40 Ibid., p. 143.
42 Ibid., p. 261.
43 Loc. cit.
44 Sullivan, Clinical, p. 377.
46 Ibid., p. 325.
47 Sullivan, Schizophrenia, p. 316.
48 Ibid., p. 285.
49 Ibid., p. 308.
50 Ibid., p. 223.
51 Ibid., p. xvi.
52 Ibid., p. xxi.
54 Ibid., p. 227.
56 Ibid., p. 270.
57 Ibid., p. 224.
59 Ibid., p. 448.
60 Loc. cit.
61 Frieda Fromm-Reichmann, Psychoanalysis and Psychotherapy (Chicago, 1959), pp. 4-5.
62 Ibid., p. 10.
63 Loc. cit.
64 Loc. cit.
65 Ibid., p. 23.
66 Loc. cit.
67 See ibid., p. 31.
68 Ibid., p. 38.
69 Ibid., p. 134.
70 Loc. cit.
71 Ibid., p. 40.
72 Ibid., p. 117.
73 Ibid., pp. 122-23.
74 Ibid., pp. 124-25.
75 Ibid., p. 119.
76 Ibid., p. 120.
77 Ibid., p. vii.
78 Ibid., p. 123.
79 Ibid., p. 131.
80 Loc. cit.
81 Ibid., p. 132.
83 Fromm-Reichmann, Psychoanalysis, pp. 147-48.
84 Ibid., p. 175.

Ibid., pp. 2-3.

Ibid., p. 66, footnote 2, emphasis in original.

Loc. cit.

Chapter IV


2 Ibid., p. 21.

3 Ibid., p. 22.

4 Loc. cit.

5 Loc. cit.

6 Ibid., p. 23.

7 Loc. cit.

8 Ibid., p. 24.

9 Ibid., p. 32.


11 See ibid., pp. 17-8.

12 Ibid., p. 19.

13 Ibid., p. 24.

14 Ibid., p. 30.

15 Ibid., pp. 35-6.

16 Loc. cit.

17 Ibid., p. 37.
18 Sechehaye, Symbolic, p. 37.
19 Ibid., pp. 47-8.
20 Loc. cit.
21 Ibid., p. 49.
22 Ibid., p. 50.
23 Ibid., pp. 50-1.
24 Ibid., pp. 55-6, direct quote on p. 56.
25 Sechehaye, Autobiography, pp. 94-5.
26 Sechehaye, Symbolic, p. 110.
27 Loc. cit.
28 Ibid., p. 112.
29 Loc. cit.
31 Ibid., p. 106.
32 Loc. cit.
33 Sechehaye, Symbolic, p. 122.
34 Sechehaye, Autobiography, p. xi.
35 Loc. cit.
36 Ibid., p. 19.
37 Sechehaye, Symbolic, p. 20.
38 Ibid., p. 72.
39 Ibid., p. 75.
40 Ibid., p. 76.
41 Ibid., p. 83.
42 Ibid., p. 84.
43 Ibid., p. 86.
44 Ibid., p. 88.
46 Ibid., p. 94.
47 Ibid., p. 96.
48 Ibid., p. 57.
50 Ibid., p. 146.
51 Ibid., p. 153.
53 Ibid., p. 256.
54 Ibid., p. 276.
55 Ibid., pp. 278-9, emphasis in original.
56 Ibid., p. 279.
57 Ibid., p. 23.
58 Ibid., p. 34.
59 See loc. cit.
60 Ibid., pp. 346-7.
61 Ibid., pp. 420-1.
63 Ibid., p. 422.
64 Loc. cit.
65 Ibid., p. 716.
66 Loc. cit.
"Analysts' preference for and advocacy of either the neutral screen" technique of classical analysis, or the "warm responsiveness" or "ceaseless 'activity'" provide, Searles suggests, "characterologically opposing solutions of the early developmental phase which involved conflict between a self-identity as inanimate, or self-identity as animate." (Searles, *Nonhuman*, p. 377.)
Chapter V

2 Ibid., p. 3.
3 Loc. cit.
4 See ibid., p. 5.
5 See ibid., p. 6.
6 Ibid., p. xvii.
8 Ibid., p. 8.
9 Ibid., p. 21.
10 Ibid., p. 71.
12 Ibid., p. 139.
13 Loc. cit.
14 Rosen, Direct Psychoanalytic, p. 223.
15 Loc. cit.
16 Ibid., p. 69.
17 Ibid., p. 70
18 Ibid., p. 175.
19 Ibid., p. 184.
20 See Rosen, Direct Analysis, pp. 24-6.
21 Rosen, Direct Psychoanalytic, p. 29.
22 Ibid., p. 29.
23 Ibid., p. 62.
24 Ibid., p. 63.
25 Loc. cit.
26 Ibid., p. xiv.
29 Ibid., p. 114.
32 Ibid., p. 175.
33 Ibid., p. 177.
34 Ibid., p. 178.
36 Ibid., p. 192.
37 Ibid., pp. 196-97.
38 Ibid., p. 198.
40 Ibid., p. 34.
41 Ibid., p. 24.
42 Ibid., p. 50, emphasis added.
43 Ibid., p. 54.
44 Ibid., p. 55.
46 Loc. cit.
47 Ibid., p. 65.
Chapter VI


3 Loc. cit.
4 Ibid., pp. 27-8.
5 Ibid., p. 8.
6 Ibid., pp. 42-3.
7 Ibid., p. 43.
8 Loc. cit.
9 Ibid., p. 134.
10 Ibid., p. 164.
11 Ibid., p. 165.
12 Ibid., pp. 167-68.
13 Ibid., p. 272.
15 Ibid., p. 263.
16 Ibid., p. 252.
17 Loc. cit.
18 Ibid., p. 151.


21 Loc. cit.
22 Ibid., p. 113.
23 Ibid., p. 118.
24 Ibid., p. 140.
25 Ibid., p. 146.
26 Ibid., p. 154.
27 Ibid., p. 131.


29 Ibid., pp. 21-2.
30 Ibid., p. 22.
31 Ibid., p. 64.
32 Loc. cit.
33 Ibid., p. 65.
34 Loc. cit.
35 Ibid., p. 68.
36 Loc. cit.
37 Ibid., p. 66.

38 Solomon Snyder, Madness and the Brain (New York, 1974), see p. 93.

39 Ibid., p. 16.
40 Ibid., p. 18.
41 Ibid., p. 7.
42 Ibid., p. 118.
43 Ibid., pp. 170-71.
44 Ibid., p. 246.
45 Loc. cit.
48 Loc. cit.
49 Ibid., p. 146.
50 Ibid., p. 196.
51 Ibid., p. 201.
52 Ibid., p. 217.
54 Ibid., p. 206.
55 Ibid., p. 244.
56 Ibid., p. 256.
57 Ibid., p. 258.
58 Loc. cit.
59 Ibid., p. 2.
60 Miriam Siegler and Humphry Osmond, Models of Madness (New York, 1974), p. 43.
62 Siegler, Models, p. 181.
63 Ibid., p. 156.
64 Loc. cit.
65 Ibid., p. 59.
Siegler, Osmond, and Harriet write about Laing that:

Bright young schizophrenics, like bright young people generally, are interested in reading about their condition. From the vast and varied selection of literature available to them, they show a marked preference for R. D. Laing's *The Politics of Experience*. It is not surprising. . . . Most of the possible roles open to them are of lower status than those enjoyed by normal people. And some roles, like the sick role, are of special status. But Laing has made a very bold move: he has offered them a status above that of normal people. They can hardly be expected to ignore this fine offer, especially when their daily lives are so miserable.


68 *Loc. cit.*
69 *Ibid.*, pp. 63-4
74 *Loc. cit.*
77 *Loc. cit.*
79 *Ibid.*, p. 120.
81 Ibid., p. 167
82 Ibid., p. 162.
83 Ibid., p. 184.
84 Loc. cit.
85 Ibid., p. 144.
86 Ibid., p. 197.
87 Ibid., p. 181.
88 Ibid., p. 200.
89 Ibid., p. 213.
90 Loc. cit.
92 Hoffer and Osmond, How to, p. 1.
93 Loc. cit.
94 Ibid., p. 125.
95 Ibid., p. 129.
96 Ibid., p. 132.
97 Ibid., p. 133.
98 See loc. cit.
99 Snyder, Madness, p. 56.
100 Hoffer and Osmond, How to, p. 159.
102 Ibid., pp. 99-100.
103 Ibid., p. 102.
105 Osmond, *Understanding*, p. 147.

106 Ibid., p. 143.

107 Loc. cit.

108 Ibid., p. 144.

109 Ibid., p. 141.


112 Ibid., p. 209.


114 See *ibid.*, p. 205.

Chapter VII


2 Loc. cit.


4 Loc. cit.

5 Ibid., p. 288

6 Ibid., p. 302, from *A Treatise on Insanity*.

7 Ibid., p. 96, from *The Burden of Our Time*.

8 Ibid., p. 94.

9 Loc. cit.

10 Ibid., p. 134.

11 Ibid., p. 23.

12 Ibid., p. 65.
13 Ibid., p. 179.
15 Ibid., p. 42.
16 Ibid., p. 132.
17 Ibid., p. 133.
18 Ibid., pp. 168-70.
19 Ibid., p. 172.
20 Ibid., p. 188.
21 See *ibid.*, p. 253.
22 Ibid., p. 247.
23 See *ibid.*, p. 248.
24 Ibid., p. 249.
25 See *ibid.*, p. 255.
26 See *ibid.*, p. 257.
27 Ibid., p. 258.
28 Ibid., p. 81.
30 Ibid., p. 5.
31 Ibid., p. 6.
32 Loc. cit.
33 Ibid., pp. 6-7.
36 See *ibid.*, Chapter III.
37 Ibid., p. 93
38 Ibid., p. 48.
39 Ibid., pp. 49-50.
40 Ibid., p. 52.
41 In ibid., p. 79.
42 Loc. cit.
43 Ibid., pp. 64-5.
44 Ibid., p. 65.
46 Ibid., p. 76, my emphasis.
47 Ibid., p. 77.
48 Ibid., p. 81.
49 Ibid., p. 82.
50 Ibid., p. 83.
51 Ibid., p. 134.
52 Ibid., p. 136.
53 Ibid., p. 160.
54 Ibid., p. 136.
56 Ibid., p. xix.
58 Ibid., p. 181.
60 See Thomas Szasz, Karl Kraus and the Soul Doctors (Baton Rouge, 1976), Chapter I.
61 Szasz, Heresies, p. 152.
62 Ibid., p. 165.
65 Ibid., p. 100.
66 Ibid., p. 92.
67 Ibid., p. 93.
68 Ibid., p. 17.
69 Ibid., p. 165.
70 Szasz, Heresies, p. 171.
71 Szasz, Ideology, p. 16.
72 Loc. cit.
74 Ibid., p. 168.
75 See ibid., p. 75.
77 Ibid., p. 160.
78 Ibid., p. 225.
79 Szasz, Heresies, p. 86.
80 Ibid., p. 100.
81 Szasz offers a series of suggestions in Psychiatric Justice on how to make this determination.
82 Szasz, Heresies, pp. 128-29.
83 Ibid., p. 133.
84 Szasz, Myth, p. 266.
Chapter VIII

2 Ibid., p. 12.
3 Loc. cit.
4 See ibid., p. 14.
5 Ibid., p. 22.
6 Ibid., p. 23.
7 Ibid., p. 25.
8 Ibid., p. 31.

See Voegelin's Plato (Baton Rouge, 1966).
9 Loc. cit.

10 Ibid., p. 35.

11 Loc. cit.

12 Ibid., p. 139.


14 Ibid., p. 38.

15 Ibid., pp. 41-2.


18 Loc. cit.

19 Laing and Cooper, Reason, p. 90.

20 Ibid., p. 127.


22 Ibid., p. 96.

23 Ibid., p. 97.


25 Ibid., p. 25, emphasis in original.


28 Loc. cit.

29 Ibid., p. 66.

30 Laing, Politics of Family, p. 5.

31 Loc. cit., emphasis in original.
32 Ibid., p. 6.
33 Ibid., p. 9.
34 Loc. cit.
36 Ibid., p. 15.
37 Ibid., p. 17.
38 Ibid., pp. 16-7.
39 Ibid., p. 33, emphasis in original.
40 Loc. cit.
41 Ibid., p. 42.
42 Laing and Cooper, Reason, p. 176.
43 Laing, Politics of Family, p. 65.
44 Ibid., p. 77.
45 See Ross Speck and Carolyn Attneave, Family Networks (New York, 1974), for a fine therapeutic interpretation and action program based on this point about closed family systems.
46 Laing, Divided Self, Chapter II.
47 See ibid., Chapter III.
48 Ibid., p. 76.
49 Ibid., p. 77.
50 See ibid., pp. 82-3.
51 Ibid., p. 87.
52 Ibid., p. 94.
53 Ibid., pp. 94-5.
54 Ibid., p. 95.
55 See ibid., p. 106, and p. 112.
56 Ibid., pp. 140-41.
57 Ibid., pp. 142-43.
58 Ibid., p. 165.
59 Ibid., p. 171.
61 Loc. cit.
62 Ibid., p. 13.
63 Ibid., pp. 13-4.
64 Ibid., pp. 22-3.
65 Ibid., p. 23.
66 Ibid., p. 27.
68 Ibid., p. 91.
69 Ibid., p. 92.
70 Ibid., p. 99.
71 Ibid., p. 181.
72 Ibid., p. 191.
73 Ibid., p. 185.
74 Ibid., p. 186.
76 Ibid., p. 203.
77 Ibid., p. 266.
78 Loc. cit.
Chapter IX


2 Ibid., p. 75.

3 Ibid., p. 81.

4 Loc. cit.

5 Loc. cit.

6 Ibid., p. 83.

7 Ibid., p. 87.

8 Ibid., p. 89.

9 Ibid., p. 110.

10 Loc. cit.

11 Ibid., p. 113.

12 Mary Barnes and Joseph Berke, Mary Barnes (New York, 1972), p. 117.

13 Ibid., p. 118.

14 Ibid., pp. 122-23.

15 Ibid., pp. 144-45.

16 Ibid., p. 157.

17 Ibid., p. 175.

18 Ibid., p. 212.

19 Ibid., p. 218, my emphasis.

20 Ibid., p. 220.

21 Ibid., p. 221.

22 Loc. cit.

23 Ibid., p. 222.

24 Ibid., pp. 223-24.
25 Ibid., p. 328.
26 Ibid., pp. 243-44.
27 Ibid., p. 244.
28 Ibid., p. 248.
29 Ibid., p. 251.
30 Ibid., p. 252.
31 Ibid., p. 258.
32 Ibid., p. 268-69.
33 Ibid., pp. 346-47.
34 Ibid., p. 348.
35 Ibid., p. 349.
37 David Reed, Anna (New York, 1976), p. 61.
38 Ibid., p. 62.
39 Ibid., p. 95.
40 Ibid., p. 106.
43 Ibid., pp. 70-1.
44 Ibid., p. 36.
45 Loc. cit.
46 Ibid., p. 57.
49 *Loc. cit.*


58 *Loc. cit.*

59 See *ibid.*, p. 98.

60 See *ibid.*, pp. 99-100.


63 *Loc. cit.*


Chapter X.


2 Loc. cit.

3 Ibid., p. 18.

4 Ibid., p. 22.

5 Ibid., p. 31.


7 Ibid., book jacket.

8 Ibid., xiii.

9 Ibid., pp. 9-10.

10 Ibid., p. 10, emphasis in original.

11 Ibid., p. 12.

12 Ibid., p. 20.

13 Ibid., p. 13.

14 See ibid., p. 21.

15 Ibid., p. 31.


17 See Laing, Politics Experience, p. 95.

18 Ibid., p. 96.
19 Loc. cit.


22 Doris Lessing, *Briefing for a Descent into Hell* (New York, 1972), Afterword.

23 Laing, *Politics Experience*, p. 75.

24 Ibid., p. 83, emphasis in original.

25 Ibid., p. 39.

26 Loc. cit.


33 Ibid., p. 134.

34 Loc. cit.

35 Ibid., p. 137.

36 R. D. Laing, *Self and Others* (New York, 1969), p. 120.


38 Laing and Cooper, *Reason*, p. 25.
39 Loc. cit.
40 Ibid., p. 63.
42 Ibid., p. 99.
43 Ibid., p. 216
45 Ibid., p. 120.
46 Ibid., p. 114
48 Loc. cit.
49 Ibid., p. 147.
50 Loc. cit.
51 Ibid., p. 150.
52 Ibid., p. 151.
53 Vernon, Garden, p. xi.
54 Ibid., p. xii.
55 Loc. cit.
56 Ibid., p. 92.
57 Ibid., p. 102.
58 Ibid., p. 103.
59 Ibid., p. 114.
60 Loc. cit.
61 Ibid., p. 188.
62 Ibid., pp. 188-89.
63 Loc. cit.

Ibid., p. 230.

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