R. D. Laing and Anti-Psychopathology:

The Myth of Mental Illness Redux[1]

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The theme of this paper concerns R. D. Laing's conception of psychopathology, or as we typically encounter this term in the media, "mental illness." This is not such a simple matter to explore because Laing was undeniably dubious about the concept and avoided employing it altogether . In *The Politics of Experience* Laing even questioned whether schizophrenia, the form of psychopathology he is most identified with, exists. Yet many of the people who Laing saw in therapy suffered miserably, and sought his help hoping that he could relieve them of the most unbearable anguish imaginable. So what, exactly, was it that Laing was hoping to relieve them *of*, if not a psychopathological condition? Surely, if there is such a *bona fide* activity as psycho-therapy (i.e., the "treatment of the mind"), then there must be some condition or state, however we have come to name it, that the so-called therapeutic process presumes to relieve. What else is the one person, the patient, paying the other person, the therapist, for?

I will never forget when Thomas Szasz, the author of *The Myth of Mental Illness* (1961), in the 1970s accused Laing of betraying the cause of anti-psychiatry (though Szasz hated this term) by advocating the treatment of the mentally ill, despite Laing's

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condemnation of the psychiatric community for the way they conducted this practice. Szasz accused Laing of wanting it both ways, on the one hand to condemn psychiatry for treating a disease whose existence Laing believed was dubious at best, while on the other hand advocating his own treatment for it at Kingsley Hall. Szasz built his career around the notion that mental illness is a myth, that there is no such thing as an "illness" of the mind, and that psychiatry had orchestrated a hoax by insisting that mental illness does exist and that psychiatrists are treating it with relative success. Szasz argued that Laing was merely advocating a more benign form of treatment than, say, drugs, lobotomy, or electric shock, but that he was advocating *treatment* nonetheless and, by it, perpetuating the same hoax as the psychiatrists Laing condemned. The gauntlet that Szasz threw down was nothing if not direct: "Do you believe in psychopathology or not? And if you don't, then what is it exactly you claim to be relieving, if not mental illness?"

Laing, in fact, did not believe in psychopathology or mental illness, but he took a more nuanced and less polemical approach to the problem than did Szasz. Whereas Szasz insisted that the entire structure of psychiatry, including its psychological derivative, psychotherapy, should be abolished, Laing believed that however flawed psychiatry is, we still need it, or something like it, to help those people who need someone to relieve them of their unremitting emotional and mental distress. Laing took issue with the way these people were being helped, not with the fact that they needed help, even if what they needed help with is not a mental illness. Though this distinction is not an easy one to articulate, I hope that the following will help to bring some clarity to the problem.

Let us begin with the term itself. The word psycho-pathology derives from the medical term *pathology*, which in turn derives from the Greek *pathos*, meaning suffering. The term was also employed by the Greeks to connote passions or feelings more generally.

The first psychotherapists were physicians and the term psychiatry, which was only coined in the nineteenth-century, became the medical specialty of doctors whose mandate was to treat the psyche or the soul, or as we say today, the mind. Laing's first book, *The Divided Self* (1960), was his most concerted effort to show why psychiatrists, and for the most part psychoanalysts, have misunderstood the kind of suffering that people labeled schizophrenic, say, are experiencing, and why psychiatric nomenclature does little to help us understand the phenomena so labeled. If what psychiatrists believe they are treating is, as Laing suggested, not schizophrenia, or *any* form of psychopathology, then what is it they are treating? And why do we, whether psychiatrists, psychologists, psychoanalysts or lay psychotherapists, still refer to the conversations we conduct with our patients *treatment*, or its derivative, psychotherapy?

In order to ponder these questions I shall explore some of the arguments Laing put forward in *The Divided Self*, and then try to explain why Laing believed what we psychotherapists do, though not a medical activity, is nonetheless a kind of "therapy," so-called. Whereas some of my comments will be based on Laing's published writings, for the most part I will rely on my personal relationship with Laing, which included being supervised by him while I was training as a psychoanalyst in London, and over the course of numerous informal conversations I enjoyed with him until shortly before his death in 1989.[2]

It is instructive to note that the subtitle Laing assigned to *The Divided Self* was "an existential study in sanity and madness." It was not an existential study in *psychopathology*. Why is this distinction important? Are the two terms, madness and

[2] For more on my critique of Laing's contemporary relevance, see Thompson 1996, 1997, 1998, 2000, 2006, 2012.

psychopathology, not the same thing? In order to answer this question, let us first take a look at what Laing set out to accomplish in that study, why he qualifies it as a study that is specifically *existential* in nature, and how this classic work laid the foundation for everything that Laing would write subsequently.

As Laing says in the preface to that work, this book is "a study of schizoid and schizophrenic persons," and its basic goal "is to make madness, and the process of going mad, comprehensible" (*1960, p. 9*). At the outset, the diagnostic language Laing employs is readily familiar to every psychiatrist and psychoanalyst who works with this population. Terms such as psychotic, schizoid, schizophrenic, paranoid – all standard nosological entities with which therapists the world over are familiar – proliferate throughout this book. He is speaking *their* language, but the meaning he is assigning to these terms is anything but ordinary. Laing explains that he has never been particularly skillful in recognizing the diagnostic categories that are standard in every psychiatric diagnostic manual in the world, including the *Diagnostic and Statistical Manual* (*DSM*) that is the bible of the mental health community in America. Laing had trouble recognizing the subtle nuances that are supposed to distinguish, for example, the various types of schizophrenia, of which there are many, or even what distinguishes schizophrenia from other forms of psychotic process, including paranoia, bipolar disorder (previously manic-depressive syndrome), or dementia.

None of these terms is written in stone. In fact, they are constantly changing and undergo revision in every new edition of the DSM. So what is Laing saying here? Is he suggesting he is too stupid to understand the complexity of these entities? I don't think so. Rather, he is suggesting that because there is no agreement in the psychiatric community as to how to recognize these symptoms and the mental illness they are purported to classify, it is impossible to take them literally, or seriously. No two practitioners agree on

how to diagnose a person, and given the never ending revisions to these categories, practitioners often change their own minds as to how to recognize what it is they are proposing to diagnose and treat. This is hardly the science it is purported to be.

What did Laing conclude from this disarray in categorization? That there is no such thing as mental illness, or psychopathology, so no wonder there is no agreement as to what *it* is. When a doctor sets out to diagnose a typical medical illness, he customarily looks for physical symptoms in his patient. The color or tone of one's skin, dilation of the pupils, body temperature, and so on may indicate an abnormality. Additional tests may be administered that examine the blood or urine, and if that fails to provide conclusive results, perhaps x-rays, CAT scans, EKG's, heart stress tests, mammograms – all ways of examining the chemistry or interior of the body – may be utilized in order to hone in on what is malfunctioning. For so-called psychiatric symptoms, however, such tests will be useless, because no one has ever been able to locate the symptoms of psychopathology inside or on the surface of the body. Even an examination of the brain, which is now the darling of neuropsychiatry and neuropsychoanalysts, has yet to locate the presence of any form of mental or emotional disturbance that we can label a mental illness. (Organic conditions such as Alzheimer's or drug-induced psychosis are not labeled "mental illness," because they are specifically organic in nature, meaning they can be detected inside the brain or because there is a direct correlation between ingesting a drug and the resulting psychotic symptom.)

When seeking signs of mental illness, what we are able to examine, according to the *DSM*, is the *behavior* of the person being diagnosed, whether, for example that person is suffering from delusions or hallucinations, confusion, disorganization, incoherent speech, withdrawal, flights of fancy, or depression, anxiety, dissociation or maladaptation,

or perhaps a persistently elevated, expansive, or irritable mood, and so on. This list is hardly inclusive, but what all these symptoms share in common is that they refer to experiences that *everyone* has, at one time or another, some more than others, some less. Even delusions and hallucinations, the gold standard for schizophrenia, are common in dreams, and not that uncommon when we are awake. Yet most people who exhibit or experience these so-called symptoms are never subjected to a formal diagnosis or treated for them. So why is it that some people are and some people are not? Why are some people deemed crazy and others sane, when they exhibit the same symptoms?

The principal mode of treating psychotic conditions today is in fact not psychotherapy, but "medication." Medication is typically prescribed for a medical illness or condition, so why is it prescribed for mental illnesses that do not really exist? How is it that drugs are used to treat people who do not suffer from a *bona fide* medical condition? There is nothing about drugs, inherently, that possess medicinal properties, though some do. Drugs were around a long time before they were adopted by medicine, and most of the drugs we use today are not the kind you need a prescription for, and do not claim to "medicate" illnesses. Alcohol, marijuana, opium and its derivatives, coffee, sugar, tea, tobacco are only some of the traditional mind-altering drugs that nearly all cultures throughout history have employed. For what purpose? For the most part, to reduce anxieties, and perhaps the tedium of an unsatisfying life or a stressful occurrence. There is nothing wrong with this. Drugs have always been used to enhance our lives, though some in desperation have erred in believing they can be used to obliterate their problems. We call such people "addicts." What distinguishes the drugs they become addicted to from the kind promoted by psychiatry is that street drugs are used episodically, when the need arises, usually prompted by anxiety. Prescription drugs, such as Prozac, Paxil, Zoloft,,

Wellbutrin, Thorazine, Haldol, Abilify, Lithium, Adderall, or Xanax are employed variously for depression, psychosis, manic episodes, attention deficit disorder, or anxiety and are ingested daily in order to remain in the nervous system *continuously*. Whereas street drugs are ingested in *response* to anxiety or boredom, prescribed drugs are ingested to *prevent* such feelings from arising, or to keep them in check. Virtually all drugs, if ingested habitually, are addictive, including those prescribed by a doctor.

What all these drugs share in common, whether prescribed or recreational, is not that they are good for treating a medical condition, but that they are capable of altering our *states of consciousness*, depending on the state of consciousness we wish to alter, and to what degree it is distressing. We like to say that alcoholics are self-medicating their depression or anxiety, but in fact they are not *medicating* anything. They are simply using a drug to mitigate their suffering whenever they feel unable to cope with it. Again, there is nothing wrong with this, nothing immoral or sick about it. We all draw the line somewhere. Some of us are able to handle a lot more anxiety than the next person, and some of us are fairly astute at solving our problems before they get out of control. We don't know why some people manage the stress and strain of everyday life more ably than others, but whatever the root cause or causes might be, we are nonetheless left with a choice when confronted with such feelings: we can either examine why life is making us so anxious and adjust our behaviour accordingly, or we can render ourselves senseless with this or that drug. What do we gain by calling these problems incidents of mental illness? I don't think one has to ponder that question for very long in order to arrive at the obvious answer. There is a massive and highly lucrative drug industry that makes enormous amounts of revenue selling so-called remedies to an unwary public who don't know any better. This is nothing new. The desperate have been victimized by

unscrupulous vendors throughout history. We have simply become more sly about it, and sophisticated.

These are only some of the questions that Laing alluded to in *The Divided Self*, and even more forcefully in *The Politics of Experience* (1967), but he never arrived at a conclusive solution for them. In matters of the mind, the act of diagnosis can just as often be a political as medical ceremonial. Laing believed that we will never succeed in understanding such phenomena as long as we persist in looking at people from an alienating, and alienated, point of view. It is the *way* that we look at each other, the way that psychiatrists and psychoanalysts typically see a patient when they look at him or her, that Laing believed is the crux of the problem. The reason Laing called *The Divided Self* an existential study instead of, say, a psychiatric, or psychoanalytic, or even psychological study is because the existential lens is a supremely *personal* way of looking at people, a person to person manner of regarding others and recognizing them, as Harry Stack Sullivan once said, as more human than otherwise. This is another way of saying that the person, or patient I am treating is not a sick person, but a person *like me*. And it is the fact that he is just like me that makes it possible for me to understand and empathize with him in the first place.

Laing began writing *The Divided Self* while still working at a mental hospital in Glasgow, when he was just in his twenties. It doesn't sound like he had an opportunity to do much psychotherapy there, but he did have lots of time to hang out with the patients under his charge, all of them diagnosed schizophrenic. Instead of looking for symptoms of recognizable forms of psychopathology, Laing sought instead to simply talk to his patients, as he was fond of saying, "man to man," and to listen to what they had to tell him. What he heard, which he recounts in *The Divided Self*, is nothing short of amazing. They told

him stories about their life, their belief systems and experiences, the things that worried them and the things they thought about, day in and day out. The thing that I remember standing out for me when I first read this book – and I have probably read it a dozen times in the past forty years – was that I felt he was talking to *me*. This, from what I have subsequently gathered from others, is not an unusual experience. It is this reaction that has made this book the classic that it is.

Instead of trying to determine what makes "us," the sane ones, so different from "them," the ones that are crazy, Laing sought to explore what we share in common. Laing used the term schizoid – quite common in Britain but only marginally employed in the U. S. – to depict a state of affairs that lies at the heart of every person labeled schizophrenic, as well as many who are not so schizophrenic, in fact all of us to varying degrees. The common thread is this: that the person so labeled, in his or her personal experience, suffers from a peculiar problem in his relationships with others: *he cannot tolerate getting too close to other people, but at the same time cannot tolerate being alone*.

This is a terrible dilemma to be faced with. Most of us either hate to be alone and throw ourselves into the social milieu with others (Jung would have called them extroverts) or we cannot bear social situations and opt instead to spend most of our time by ourselves. These more introverted, private individuals may be gifted writers or artists or scientists or psychotherapists, well suited to their relative isolation, whereas the extroverts among us make excellent politicians or salesmen or actors or any number of other callings that entail contact with others. We tend to incline in one direction or the other, and either may be a perfectly viable way of existing and living a happy, contented life. The person who is schizoid, however, doesn't excel at either. He cannot tolerate isolation, nor can he get genuinely close to others. He is caught in a vise, a kind of hell, that is rife with unrelenting

anxiety, what Laing calls *ontological insecurity*, because simply existing is a serious and persistent problem for him. Intimacy is such a problem that in his relations with others this person must, in effect, hide himself behind a mask by pretending to be somebody else, a phenomenon Laing termed a "false self," living incognito among others, like a spy. In speaking of a person this way we are not really diagnosing him, we are simply describing what it is like to be him.

Laing makes a careful distinction between the kind of person who struggles with schizoid character traits, and the kind of person who gets labeled schizophrenic. The so-called schizophrenic is at the extreme end of the pendulum, though it is notoriously difficult to generalize about this for reasons we have already explained. It is often impossible for a person who struggles with schizophrenia to work at a job or enjoy satisfying sexual relationships. The reason is due to the extreme anxiety that close proximity to people, which is a given with jobs or sexual relationships, exacts. We all find the work environment stressful, but the person who struggles with paranoia often finds these stresses and strains intolerable, even with medication. Better to avoid such relationships altogether than to risk being at the mercy of somebody else. There are exceptions to this, usually the consequence of many years of psychotherapy, but even with that caveat intimacy can be an ongoing problem. The schizoid person shares a similar repulsion to intimacy, but is much better at *acting the part* of an employee, lover, or spouse, and can often function perfectly well in work situations where the expectation of intimacy is mitigated. The problem is that there is always a part of him that is held back, the part that struggles with paranoid worries about the power that others may have over him. This is the kind of person who, like the neurotic, is much more likely to seek therapy and, in time, even benefit from it. Indeed, Laing wondered if the schizoid condition is the

normal condition in the present age, due to the extraordinary alienation that has become the norm.

When I first read this I couldn't help but wonder how many of us are really all that comfortable being alone, and how many of us are truly at ease in our relationships with others, which is to say, free from anxiety. Isn't this a problem, for example, that psychotherapists typically share with their patients? Psychotherapy is a fabricated relationship whose purpose is to achieve uncommon intimacy with another person, while placing extraordinary constraints on it, conducted by two people who, to a considerable degree, have problems getting close to others. Isn't this rather like the lame leading the blind? Laing didn't think so, but he was acutely aware of the paradox, of how wounded a person must be to even want to spend all of his professional time in the company of people who are so obsessed with their problems.

Laing, however, was not the first to recognize this paradox. Nor was he the first to accuse psychiatrists of employing means of helping others that are for the most part ineffectual. For that Sigmund Freud would have to be credited, arguably the first anti-psychiatrist. Freud was a neurologist, not a psychiatrist, and he was scathing in his commentary about the psychiatrists of his day who, Freud believed, knew nothing about why their patients suffered and how to help them. Freud believed that people develop symptoms of hysteria and neuroses, or worse, because they have been traumatized by unrequited love in their childhoods. He was the first to recognize the powerful effect that our parents, in fact all our social relationships, have on us and how our capacity to love is also the source of our most profound suffering. Freud was also the first to recognize that our demand for love is unremitting and insatiable, no matter how much we get, and that we are most vulnerable when at the mercy of the person we love. Laing loved this about

Freud and was writing a book on love when he died. He was also planning to write a book about Freud.

Yet Freud was not interested in the kind of person Laing described in *The Divided Self*, because he did not believe that a person who suffers from psychotic anxiety is capable of attaching himself to the person of the psychotherapist who is treating him. Freud was correct in recognizing how incredibly vulnerable such people are, but mistaken in his prognosis about their treatment. It has been argued that Laing accomplished for the so-called schizophrenic what Freud accomplished for the neurotic: a way of establishing an intimate relationship with them that may, *in itself*, serve as a vehicle for healing. Freud was unhappy with the brutal way that the hysterics of his day, mostly women, were typically treated, and even less happy with the prevailing conception of psychopathology. Unlike psychiatrists, Freud did not believe in an us versus them mentality. He did not believe, for example, that some people are neurotic and that some people are not. He believed that *everyone* is neurotic and that this is an essential aspect of our human condition. He also believed that neurotics may, on occasion, become psychotic if pushed far enough. So if everyone is neurotic and curing us of neurosis is not feasible, then what is psychotherapy good for?

Freud was never able to definitively answer this question, at least not as definitively as we would like, but he thought it could help.[3] If you read between the lines, you can't help concluding that Freud viewed anxiety, and the other forms of alienation that Laing was so good at describing, as an essential aspect of our human condition. So what we call "ill" versus "healthy," or crazy versus sane is not black or white, but a matter of degrees. If

[3] For Freud's most succinct thought about treatment outcome, see Freud, 1937, and Thompson, 1994.

all of us are neurotic, and on some occasions even psychotic, some more, some less than others, then all of us are also healthy *and* sane, to varying degrees. Though he was reluctant to admit it, Freud rejected the concept of psychopathology as it is commonly understood, *and replaced it with an existential perspective that emphasized the management of anxiety as an inescapable aspect of living*.

Freud's invention of psychoanalysis was a huge step forward in treating people we think of as nuts or crazy as human beings like ourselves. But once it was embraced by psychiatrists, psychoanalysis became yet one more weapon – and in America a very popular one – in the war on mental illness. Whereas psychiatrists had depersonalized the relationship between doctor and patient by pretending that it wasn't the person, but rather his illness, that was being treated, psychoanalysts depersonalized the treatment relationship by insisting that it wasn't the person who was responsible for his condition, but his *unconscious*. Though psychoanalysis made extraordinary gains in humanizing the treatment relationship over prevailing psychiatric practices, Laing believed that both disciplines seem strangely incapable of formulating a genuinely symmetrical therapy relationship between equals. There have been notable exceptions to this, and Laing himself stood proudly on the shoulders of practitioners like Sullivan, Fromm-Reichmann, Winnicott, and other psychiatrists and psychoanalysts who advocated a more personal way of treating their patients, not treating them for illnesses, but treating them like they would want to be treated themselves were they in a similar predicament, which of course they all had been, at one time or another.

This isn't to say that Laing was advocating simply being nicer, or kinder to his patients, as though that alone was sufficient. Instead, his concern was with being more real, or authentic with them, in a word, more honest. That is considerably more difficult

than just being nice. This, he believed, could only happen if we stop objectifying our patients into diagnostic categories that only serve to alienate them from us. Perhaps the model that best exemplifies what Laing advocated is not a relationship between therapist and patient, per se, or parent and child, but one between friends. After all, friends confide in each other, and confiding is an essential aspect of what therapy entails. In one of his more mischievous moments Laing suggested that therapists might even call themselves prostitutes, because what patients are buying is not treatment, *per se*, but a *relationship*. Whether we think of ourselves as friends or prostitutes to our patients, or neither, Laing didn't have a problem with calling the people who paid to see him his "patients," any more than he resisted calling what they were doing "therapy," both undeniably medical terms. But isn't this inconsistent with what Laing has been saying about the myth of psychopathology?

Whatever problem Laing had with the institution of psychiatry, he never had a problem with being a *doctor*. He was proud of his medical training, and while such training is not necessary to practice psychotherapy, he thought is was as good a preparation as any to enter the field with. After all, what doctors share in common is that they want to help people. This is also basically what therapists want to do. Laing was fond of pointing out that the word therapy is etymologically cognate with the term *attention* or attendant. In ancient Egypt a religious cult called the *Therapeutae* were literally attendants to the divine, the first psychotherapists.[4] So the term predates the subsequent medical appropriation of it by the Greeks. *If we take the term literally, a therapist is simply a person who is attentive, or pays attention to the matter at hand, the suffering of his patient*. Similarly, a patient is literally a person who "patiently" bears his suffering without

[4] For a lucid discussion of these ancient therapists see Meier, 1967.

complaint. The term doesn't necessarily refer to someone in *medical* treatment because the kind of suffering is not specific. Laing concluded that if you put these two terms together you get one person, the therapist, who is attentive and attends to the other person's, or patient's, suffering. To what end? Hopefully, such attention, with enough patience, good will, and most importantly, time, will lead to something, to a point where the patient no longer requires such attention and can get along perfectly well without it. This is something that Thomas Szasz never understood. He seemed more interested in the legalities of the issue than he was with helping people.

According to Michel Foucault, a close friend of Laing's, it was purely by chance that medical doctors became responsible for treating crazy people in the first place, in eighteen-century Europe. If fact, it is very recent in history that mad people were deemed mentally ill. Historically, people who acted crazy were thought to be possessed, either by evil spirits or by the gods. In the seventeenth century Europeans began to feel unsafe with the crazy people in their midst, who wandered the streets (not unlike the homeless people who wander about our cities) and began to confine them as a means of protection. Not surprisingly, such confinement made them even crazier and their jailors began chaining them to the walls of the Lunatic Asylums they were in. They soon developed diseases, which only escalated their problems further until the French physician, Philippe Pinel, was brought in to attend to their specifically *medical* maladies. Pinel couldn't help but observe that the way they were being treated was inhuman. Pinel argued they should instead be treated more compassionately, as sick people, who deserved the kind of attention and consideration that any sick person would expect. It was then, according to Foucault, that mad people were first deemed mentally ill.

This was a remarkable step forward in treating such people as human beings who warranted society's help, but it also initiated the slippery slope that occasioned the birth of psychiatry and, with it, the diagnostic universe we now live in. Laing was proud of being a physician but recognized that we now find ourselves in an historical quandary. Like the Europe that invented the Lunatic Asylum, our society feels the need to protect itself from crazy people, some of whom are undeniably dangerous and capable of savage violence, even murder, but most of them are perfectly harmless, and even more vulnerable than you or me. When the violence does erupt, if indeed it does, someone needs to make the call: Is the person in question crazy enough to lose, if only temporarily, his constitutional rights and be confined to treatment, which is to say, "medication," intended to render him senseless or worse, against his will? Whether we like it or not, that task has been assigned to psychiatrists, and it has given them enormous power over those it deems dangerous, whether to themselves or others. Laing had no ready or easy remedy to this problem, but believed that all of us is implicated in it.

Laing never formulated an overarching theory of psychopathology to replace the edifice that psychiatry and psychoanalysis have built. For the most part, his focus was on schizoid phenomena and schizophrenia, not as specific diagnostic categories but, like Freud's conception of neurosis, as a metaphor for varieties of mental anguish that compromise our ability to develop satisfying relationships with others, prompted by unremitting anxiety. As the subtitle of *The Divided Self* suggests, Laing was more comfortable thinking in terms of sanity and madness than psychopathology. But what does it mean to be crazy? And what does it mean to be sane?

These terms lack precise definition when compared, say, with the plethora of diagnostic categories in the *DSM*. Because they are used colloquially, as a manner of

speaking, it is up to each of us, individually, to determine how to employ them. Laing thought that the essence of what it means to be crazy, in the way this term is ordinarily used, can be broken down into three components, the combination of which will tell us just how crazy a person is. The first concerns how a given person exercises his or her judgment; the second concerns how agitated that person may be; and the third concerns the lengths a given person will go to mitigate his anxiety.

Our use of judgment is probably the most critical of the three, because it determines how we make sense of things, including the situation we are facing at a given moment. The judgment of a person suffering a manic episode, for example, is said to be seriously compromised, but so is that of a person who suffers from acute paranoia or hallucinations. Our judgment is where we live, and there's no escaping it, though we can improve it if, and only if, we have the presence of mind to realize that we cannot trust it. Yet, who gets to decide whether a given person's judgment is impaired or sound? If I judge that I need help in improving my judgment and take my plight to a therapist, can I trust the judgment of that therapist over my own? I'm not going to get much out of therapy if I am unable to trust his judgment, but who is to say that my therapist's judgment is more sound than mine is? How can I render such a judgment if, say, I don't trust *my own* judgment? This is a problem, and one that Laing thought makes therapy almost, but not quite, impossible.

A person's judgment is for the most part a private affair. The person who is crazed is often in a state of agitation, which others can't help but notice. It is this state than usually makes my judgments public, when, for example, I am about to leap off a tall building, or assault someone for no discernable reason. This is the prototypical image we all have of the crazy person, who is acting crazy, and often in a manner that not only gets our

attention, but frightens us, because we don't know what he is going to do next. Each of us has been crazed at some time or other, but the moment usually passes before any real harm has been committed. If it persists, that is a different matter, and things can quickly spiral out of our control. This is when I am most likely to be taken to a mental hospital, whether I wish to be taken there or not.

The third way I may feel or appear crazed concerns what psychoanalysts call defenses, the mind-games I employ to mitigate my anxiety.[5] This was the issue that Laing was most concerned with in *The Divided Self*, evidenced in the so-called schizoid person. We see his defenses in the way he engages social space. As we noted earlier, this is a person who cannot tolerate being isolated from or being intimate with others because either position makes him intolerably anxious, so he walks a tightrope in the middle where he feels the least amount of anxiety, but still too much to navigate his relationships effectively, which is to say satisfactorily, in a way that is pleasing to himself. Much of what we do to cope with our anxieties does not appear crazy to others and does not feel crazy to ourselves, and works for us, more or less. It is the most severe states of anxiety, such as ontological insecurity, that are the most problematic and result in extreme measures to mitigate, such as catatonic withdrawal.

Not all states of craziness, however, occasion distress. Schizophrenia and schizoid states generally occasion various degrees of anxiety and the unpleasant, even haunting, sense of distress that drives us into treatment. We feel distressed when we have reached the end of our tether and can no longer cope. When we arrive at this point we *need help*, and we turn to others to assist us. Manic states are usually contrary to this, because the

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[5] For a phenomenological discussion of the true meaning of "defense mechanisms" see Laing, 1961, pp. 17-32.

person experiencing a manic episode does not typically feel *distressed*. Indeed, he usually feels the opposite, he feels excited, happy, and alive. The world is a wonderful place, and he is the master of it. This would appear to be the ideal state to be in. After all, don't we all aspire to happiness, even giddiness, as a measure of how happy we are with our lives? Feeling good *is* good, isn't it?

Unfortunately, it isn't as simple as that. We cannot always rely on our feelings to tell us if we are behaving in a sane way or a way that is crazy. It is easy to determine when we feel bad that we are in a bad way. But feeling good does not always indicate that things are well in the world. The manic state depicts a person who *feels* good, but has lost all sense of proportion and self-control. In a word, his judgment has become completely impaired, despite the complication that he feels so good. The reason bipolar disorder was once called manic-depression is because when a person experiences a manic episode, it doesn't last. Before long, it reaches a terminus, and then gives way to profound, sometimes suicidal depression. One way of understanding this phenomenon is to regard the manic "high" as a *defense against depression* and its accompanying anxiety. It is a sort of denial, an escape from an unacceptable or intolerable development in one's life (such as divorce or other catastrophic loss). Manic episodes often occasion intense sexual activity, profligate spending, in short, unreasonable and highly risky, often self-destructive behavior.

If you happen to know someone who is exhibiting such behavior, you may also note that this person is not being "himself," and you soon realize that something is the matter. But if you do not know this person, and meet him for the first time when in the throes of this episode, you might even think of him or her as a perfectly interesting, charismatic, even exciting person to be with. Given the intensity of this person's libido, you might even fall in love with him. Don't be fooled. This behavior is nothing more than

a mask, intended to camouflage the underlying anguish which, for whatever reason, this person cannot, in his current state, handle.

People suffering from manic episodes are not the most promising candidates for psychotherapy. The reason is simple. They do not feel that they need help, so why should they seek it? If a family member tries to persuade them to seek help, they will often resist, because they feel perfectly fine. How do you reach a person who is incapable of self-doubt, who is under the illusion that everything is okay in the world, when you can see that they are behaving crazy? Not very easily, if at all. Yet not everyone who suffers a manic episode enjoys the experience. They may feel agitated, anxious, or angry, but the thing they have in common with the person who relishes it is that they, too, are impervious to therapeutic intervention. Just because a person acts crazy doesn't mean he recognizes it and accepts your judgment over his. A person who does not want help and does not seek it cannot, by definition, benefit from psychotherapy. He may, however, and often does, respond to "medication." And how motivated is this person to voluntarily take this medication when he doesn't believe there is anything the matter with him? I think you can guess the answer to that.

Even under the best of circumstances, determining what it means to be crazy, and who can be deemed to be crazy, is not so simple. Sometimes a person who is behaving in a way that you think is crazy happens to feel crazy himself and doesn't like the experience one bit. Sometimes that person, behaving the same way, feels that there is nothing the matter with him. How do you convince a person, who does *not* believe he is crazy, that he is? This dilemma sometimes comes down to just how much craziness a given society is willing to tolerate amongst its citizens, and how much is perfectly acceptable, as long as it isn't harming anyone. Some cultures are more tolerant than others, some less. This is

where the psychological leaks into the political, the place where we are confronted with how tolerant we are of our fellow human beings, despite their obvious eccentricities.

If these criteria offer a rough and ready means of discerning what it means for me, or you, to be crazy, what does it mean to be sane? It would more or less approximate the exact opposite of feeling crazy. Our judgment would be sound, relatively speaking; our use of defensive maneuvers would be minimal because we would bear our anxieties with relative ease; and we would not find ourselves in a state of panic or agitation, but one of serenity, and being at peace with ourselves and the world. When we weigh the two, there are no crazy people, or sane people. Every single one of us goes from one state to the other over the spectrum of our lives and oftentimes in the course of a single day. By this definition, all of us have been crazy, no matter how sane we are most of the time. If this were not so there would be no way for a psychotherapist to connect with or empathize with a person who has been diagnosed, say, schizophrenic. *We can only help people with problems we ourselves can relate to, and have experienced ourselves.* This doesn't mean that one has to be schizophrenic in order to empathize with someone who is, but the underlying experience that all persons diagnosed schizophrenic suffer is something we all share in common, a sense of *alienation*. Not everyone is in touch with their alienation, and for the most part we mask it, but every psychotherapist worth his salt is acutely aware of it. This is all it takes to recognize a fellow traveler who, by the grace of God, may, under different circumstances, be me.

What about the genetic theory? It is commonplace to believe that "mental illness" runs in families, so it must be genetically inherited, from one generation to the next, right? There is no denying that many of these diagnostic entities, including schizophrenia, bipolar disorder, and depression do show up with remarkable regularity in family members. So

how does that happen? It is quite possible that temperaments, predispositions, and certain character traits are somehow "passed on" from *some* fathers, to *some* sons, but not others, in ways that we simply cannot detect. We have no way of knowing if some of these traits or characteristics are discreetly modeled and adopted by regular contact with a parental figure, in other words, environmentally. Perhaps some of us are born with considerably greater sensitivity to our environment than the next person, and this sensitivity, while it may predispose some, under certain environmental triggers, to become artists or thinkers, may predispose others, with different triggers, to become psychotic. But even if some are genetically transmitted, why call them *mental illnesses*? So we regard political dynasties, that tend to run in families, genetically transmitted? Is the Irish proclivity to drink and literature, which I share, a mental illness? I don't think so.

Laing never developed an etiological theory of what causes us to become neurotic, or psychotic, or just plain crazy, though he clearly favored the environmental thesis over the biological. Neither model, he concluded, is satisfactory and, like the good sceptic he was, Laing believed that our mental states and what accounts for them are for the most part a mystery, and may always be. We may never know why this person is crazier than the next person, or why, in fact, all of us is crazy in some contexts and not in others. It seems that some people are capable of driving others crazy, but there are those who appear to be perfectly capable of becoming crazy on their own. Laing thought that common deception is a problem, but difficult to recognize.[6] The bottom line, given the inherent ambiguity of

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[6] See Laing and Esterson's brilliant *Sanity, Madness and the Family* (1964) for a detailed study of deceptive practices in families of schizophrenics. See also Thompson, 1996.

the situation we are in, is to proceed cautiously, with a degree of humility, in how we treat such people when we meet them.

This is because Laing's principal concern, when all is said and done, was not explanatory, but *ethical*. What is the right way to treat people who are the most vulnerable members of our society? Whenever Laing addressed this topic, whether in writing or in public, he often invoked the Golden Rule. How would you, if you lost your wits, fell apart with grief or consternation, want to be treated by those who have you at their mercy? When the shoe is on the other foot, shouldn't you treat them the way you would like to be treated yourself? It is impossible to separate Laing's thinking about psychopathology from the work of psychotherapy. If he met a mad person on the street who was threatening him, Laing would defend himself without hesitation and, if need be, ask the police to confine that person. But if you made an appointment to see him, no matter how crazy you were, and wanted his help, and you were not trying to assault him, that was another matter. And that was the matter that concerned him, for the most part, over the course of his life. How to meet another person in dire straights, whether you are that person's therapist, family, or friend, and how to treat that person in such a way that, in the name of the Hippocratic oath, you do no harm.

And what of today? Twenty-five years after Laing's death, are we more humane and compassionate in our treatment of those at our mercy? It is difficult to say. But one thing we cannot deny, our culture has become even more "medicalized" than at any time in history. The medical metaphor that Laing found more or less acceptable when explaining what he thought therapy is, has become effectively literal. In California, we even have medical marijuana. Pot is not just a pleasing way of altering one's consciousness, it has become *medicine*. When you imbibe you are not getting high, you are medicating yourself

for whatever ailment you believe you are "treating." You are no longer a recreational pot smoker, you are a "patient." More and more, anything that pains us is treated as a "condition" that can, indeed must, be treated as such. If you are caught having extra-marital affairs with a dozen women, you are not necessarily a philanderer. You may simply have a sex addiction, which – you guessed it – is a medical condition for which you can seek treatment, perhaps mandated by the court. This means you are not responsible for this behavior, because you are suffering from a condition that has "caused" you to behave in this way. This seems to be the one thing our culture, in the era in which we live, is most concerned about: to escape responsibility for who we are and the mischief or confusion we sometimes get up to.

I find this trend in our culture creepy, because it implies that just about anything we do that might get us into trouble or prove embarrassing is nothing more than a condition for which we bear little if any responsibility. Is this a sane way of proceeding? Is this what our capacity for judgment has come to? I think you can guess what Laing would have had to say about that.

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