Anti-Psychiatry:

A Critique of the Normal

AT FIRST GLANCE it might seem that Anti-psychiatry, described in the two articles following, has nothing to do with the concerns of the "ordinary" person and very little to do with revolutionaries. Such a superficial glance would, however, be completely wrong. For in fact, the theories and conclusions of the anti-psychiatry school (Laing, Cooper and Esterson are its main proponents) are crucial to an understanding of society and its sicknesses. For the layman, anti-psychiatry exposes some hitherto hidden features of his everyday life and his interaction with others, particularly in his family.

For revolutionaries, there is the revelation of features of our society which they had not previously suspected: detailed mechanisms of how people do psychological violence to one another, and how "normal" people, who are often themselves "sick" — expressing a sick society — bind up innocent (and, the anti-psychiatrists say, highly sensitive) people in impossible social situations, then sacrifice them as "sick" people to a brutal god — the conventional psychiatric system — in order to maintain the illusion that their own lives are normal and healthy: to reaffirm their own belief in themselves.

In much the same way, society reaffirms its own values when it sentences a criminal. One can learn a lot about a society by looking at those whom it defines as criminals and puts in prison. In our society, a big chemical company which pollutes the atmosphere, thus affecting millions, is fined $130, while a 20-year old who refuses to kill innocent peasants gets two years' goal.

Anti-psychiatry can be seen on a number of levels. On one, it is an examination of the interaction between a person defined as mentally ill and his social context showing how the actions of such a person, although "mad" when viewed in isolation, become quite intelligible when seen in their social setting. The anti-psychiatrists do not necessarily say that the mentally ill are not really ill at all. They concede that they may very well be "sick", but that this sickness may simply be triggered off by their social environment, rather than being an individual disease.

On another level, it can be seen as a social psychology — a theory about certain aspects of people's behaviour towards one another, and how this behaviour, regarded as "normal", influences and deforms others. This has far-reaching consequences, beyond the analysis of the "mentally ill". In fact, the anti-psychiatrists see an urgent need for an analysis of the state of "normal" society, where they see many of the real problems existing. Laing calls for a "pathology of the normal" (a call which Freud also made some thirty-five years ago).

On a third level, anti-psychiatry is a critique of existing society and also of conventional social science, especially institutional psychiatry. To make this critique, the anti-psychiatrists have had to get right outside the conventional
framework for looking at the mentally ill — a framework in which the abnormal, different, peculiar person, who acts "mad", must be insane, while the normal people around him must be sane. They constructed their own framework, in which they assume only that the person is different and try to examine in a reasonably objective way the actions of both the person and others in his social environment. They maintain, and have amassed certain evidence to show, that when we approach the situation in such an open-minded way, it immediately becomes apparent that the "sickness" of the person may be actually a reasonable reaction to the behaviour of those around him. Indeed, one might even go so far as to say that his environment is "sick" and needs a "cure", not him.

Thus, we can deduce the necessity for a "pathology of the normal" — an examination of social illness inherent in the very structure and relations of social groups — not just a study of individual mental disorder.

Now if the implications of anti-psychiatry were confined to the field of mental illness and the treatment of the insane, then society would owe much to it. However, anti-psychiatry has much wider implications, for it calls into question many conventional analyses of society. Such analyses tend to look at social situations and events from the point of view of the observer, who very often regards himself as "objective", but who, just as often, tends to adopt the point of view of the majority or the powerful. Anti-psychiatry shows us that it can be very helpful to look at these situations and events from the point of view of all participants in them. This is a position which other schools, notably the existentialists, have previously adopted, but the anti-psychiatrists, while using the existentialists' philosophical basis, have taken the theory further by their practical use of it. Two examples of current interest might illustrate:

1. Revolutionaries have always said that part of their struggle for the liberation of the working class was to struggle for the emancipation of women and of oppressed races, which were seen also as class issues. Now, although they partly are class questions, there is more to it than that. Today, we have flourishing anti-racist, black liberation and women's liberation movements which exist somewhat independently of the class struggle.

Now the interesting point is that it was only when women and blacks started speaking for themselves and analysing the situation as they saw it, that these movements really came into their own. Only the consciousness of their own oppression, and the verbalisation of this by a number of writers, who themselves experienced this oppression from the point of view of the oppressed, enabled these movements to have a concept of their own identity and the need to struggle for their own emancipation. A beautiful analysis of the importance of the point of view of the oppressed is given by Angela Davis in her Lectures on Liberation.

Those who like to say "it's all a class question" have failed to see the situation from the point of view of women and blacks. Even a well-meaning male/white revolutionary cannot fully understand the problems faced; the analysis of their own situation was the pre-condition for the growth of the movements.

2. One of the important components of anti-psychiatry theory is the notion of the scapegoat. This says that in many social situations, a social group selects out (not consciously, but rather as part of its own process of development) one of its member to be a scapegoat — to be punished by the group in order to
take the blame for the group's own inadequacies: the majority avoids analysing its own faults and focusses them instead in a single member or a minority. Anti-psychiatrists see schizophrenics as "scapegoats" for their families, but the idea can be extended outside the psychiatric sphere.

Although the analysis and understanding of such situations still has a long way to go, the anti-psychiatrists have provided us with valuable insight into their dynamics. The consequences for a revolutionary critique of society are obvious.  

BRIAN AARONS

Beth Freeman

R. D. LAING, BRITISH PSYCHIATRIST, has developed a theory about being and going mad — about being and going schizophrenic. His theory grows out of Searle's and Bateson's mammoth efforts at explaining schizophrenia in terms of "being driven" crazy by crazy interpersonal situations (usually within the family). The philosophical heritage of the theory is existential-phenomenological, hence terms like "existence" and "experience" are used to refer to the totality of a person's "being in the world", man as a unitary whole.

"Experience" is a central concept. Laing sees it as the outcome not only of the given (the "real" physical world) but also of phantasy and personal thinking systems (assumptions about the world). An important consequence of this is that observation is never "neutral", "objective", "uninterpreted". It is always "X as Y perceives it". Assumptions about the world (cultural influences, family habits, theoretical foundations) affect the experiences of it. This strikes a blow at the prevailing myth that scientists, professional helpers and the like are objective observers.

The framework of clinical medicine (in which psychiatry is still commonly placed) entails a commitment to this idea of objectivity. Also, the psychiatric "illness" idea (parallel to physical disease) involves the notion that "the heart of the illness resides outside the agency of the person. That is, the illness is taken to be a process that the person is subject to, or undergoes".  

1 The Divided Self.

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Laing rejects both the medical model of conceiving of so-called “mental illness” and the medical model way of “assessing” and treating the diseased individual. Laing’s alternative is to view the psychiatric patient’s behavior as expressive of his “being-in-the-world”, his existence; as symbolically integrative and meaningful.

For Laing the genesis of schizophrenia lies in the disconfirmation (or invalidation) of a person’s perceptions, feelings and memory (his experience). This results in confusion about what is important or significant to the person, real or imagined, memory or fantasy.² Chronic invalidation leads to a feeling of “ontological insecurity”, the opposite of which Laing describes:

A man may have a sense of his presence in the world as real, alive, whole, and in a temporal sense, a continuous person³. The individual may then experience his own being as . . . whole; as differentiated from the rest of the world in ordinary circumstances so clearly that his identity and autonomy are never in question⁴.

However, this may not be the case:

The individual in the ordinary circumstances of living may feel more unreal than real . . . precariously differentiated from the rest of the world so that his identity and autonomy are always in question⁵.

Intense anxiety is generated by these feelings, and takes three forms. The first is the fear of engulfment:

In this the individual dreads relatedness as such with anyone or anything . . . because the uncertainty about the stability of his autonomy lays him open to the dread lest in any relationship he will lose his autonomy and identity⁶.

The main manoeuvre to preserve identity under pressure from dread of engulfment is isolation.

Implosion is the second form of anxiety:

The impingement of reality . . . the full terror of the experience of the world as liable at any moment to crash in and obliterate all identity, as a gas will rush in and obliterate a vacuum⁷.

Bizarre behavior which successfully keeps the world at bay is probably the manoeuvre here, though Laing is not explicit.

Fear of petrification, being turned into stone, and the dread of this happening is Laing’s third type of anxiety. The manoeuvre to deal with this is depersonalisation, i.e., the magical act whereby one attempts to turn someone else to stone (and by extension regards him as a thing, negates his autonomy).

Psychosis develops as ontological insecurity and the associated anxiety becomes more intense. A “false self”, embodying all

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³ The Divided Self, p. 39.  
⁴ The Divided Self, p. 42.  
⁵ The Divided Self, p. 42.  
⁶ The Divided Self, p. 44.  
⁷ The Divided Self, p. 45.
those tricks and manoeuvres above, becomes more extensive. The real self
in order to be safe from persistent threat and danger from the world, has cut
itself off from direct relatedness with others, and has endeavored to become
its own object: to become in fact directly related only to itself. The
individual in this position may appear relatively normal, but he is main-
taining his outward semblance of normality by progressively more and more
abnormal and desperate means . . . the defences against the world fail even in
their primary functions: to prevent impingements and to keep the self alive
by avoiding being grasped and manipulated as a thing by another. Anxiety
creeps back more intensively than ever.
Gradually psychosis develops.

Laing has little to say about treatment: there is a suggestion
that once the patient finds someone who “loves” him, the process
can continue on to resolution. In later works he speaks of the
necessity of converting confusions (about memory, perception,
imagination) into conflicts which can then be dealt with. There is
even a suggestion that the schizophrenic episode is a “journey”
(something like a “trip”) from which the traveller returns sane,
not normal. The appeal in this account of the genesis and treat-
ment of schizophrenia is to approach the patient from the point
of view of his phenomenological-existential “reality”, to let his
behavior be seen as expressive of his being-in-the-world, his
existence. This allows of the possibility that the schizophrenic’s
behavior is meaningful and understandable, as opposed to the
traditional “medical model” approach, which sees the “disease”
as something the person is subject to, or undergoes.
So far the treatment of the topic has been concerned with
the individual. In The Politics of Experience, a series of papers
published in 1967, he sets his notions about schizophrenia in a
socially relevant context. Three of Laing’s more contentious
claims about schizophrenia are:
1 that the procedures of traditional psychiatry are “violent”;
2 that schizophrenics are more aware of the “truths” about society
than normal people; and
3 that schizophrenia is a kind of healing process (not a disease
to be interrupted and stopped).
To accept the first claim it is necessary to believe that almost
all of us are incredibly alienated — that the whole of our society
is alienated. In one of many senses, Laing uses this to refer to
the kind of state which allows us to accept as truths those claims
of our culture which are patently false, for example, that we are a
peaceful egalitarian society. This involves confirmation of false

8 The Divided Self, p. 137.  
9 The Divided Self, p. 138.
notions and the refutation of “true” ones in much the same way as the schizophrenic experiences it (but for him it is his perceptions, memory and so on which are refuted and these are more vital).

When a psychiatrist treats a schizophrenic he proceeds to invalidate the experience of his patient in exactly the same kind of way as that person’s family and close friends have—not seeing his behavior as symbolically expressive of his existence, but as “mad”—and in the same kind of way that our society acts on us to make us alienated. Hence, this alienated psychiatrist—alienated as we all are—is simply perpetuating and perpetrating the violent destruction of the self of the schizophrenic. He is of course unaware of the existential “murder” he is committing since he, like everyone else lacks the sociological imagination, the ability to perceive the relevance of intra and interpersonal events for the wide social context and, importantly, vice versa. He is, therefore, no more or less violent than everyone else and no more or less culpable.

However, Laing heaps invectives and accusations on psychiatrists because they are important agents of social control; the growing trend is to define deviance as “illness” and thus to bring more and more into the domain of the psychiatrist (e.g. crime, child rearing problems). He wants to shock them into knowing better, believing that if they would accept his view of schizophrenia they could carry their “treatment” through and resolve things. As it is they are simply putting up barriers—tranquillisers and electro compulsive therapy — which stop the flow onward, and Laing asserts that this is a violent process. Laing’s second, seemingly outrageous claim that the schizophrenic is the super-perceiver, not out of touch, but more in touch with reality, who is more aware of alienation than the rest of us, follows from this. If alienation in the sociological sense is simply another example of the invalidation of “true” and validation of “false” notions, then we could expect that persons who are subject to invalidation on another more personal level and who acknowledge it by eventually going “crazy”, will be better able to generalise this personal experience and insight into the larger sociological field.

In this light Laing’s third contentious proposition that schizophrenia is not a biologically dysfunctional process but some kind of natural healing process can be understood more clearly. If you accept any interactional concept of schizophrenia then this becomes a real possibility. Laing says, however, that we are so busy “treating” the patient that we never give the hypothesis a chance to be confirmed or refuted. The implication is that if a schizophrenic undertakes the “journey” and comes through, he will
be closer to sanity than our alienated existence which we call normality.

Laing is not explicit about therapy; he speaks almost mystically about providing “guides” who have “been there and back” and surroundings suitable for the “journey”. The impression is that it has something to do with the dismantling of the false self systems in a thoroughly trustworthy atmosphere and with thoroughly trustworthy people. It seems that the schizophrenics stopped “trusting” others and themselves a long time ago and have to go back a long way to really grow again.

The most vigorous criticism of Laing is that he is impressionistic, not rigorous, but I think that appeals to him to refine and clarify his ideas will fall on deaf ears. Like McLuhan he is just not that sort of person, and I think, too, that he would regard all that “hair splitting” and “academic nonsense” as just so much bourgeois clap-trap, and as the sort of approach which has so far doomed psychology to irrelevance as far as the human condition is concerned.

Harry Freeman

ANTI-PSYCHIATRY AROSE as a reaction to two important problems in psychiatry. The first is the undeniable failure of psychiatry to do much with schizophrenics, still one of the biggest groups of the “mentally ill”. The second, a problem common to all contemporary sciences, is that of social significance—whether it is an insidious agent of social control. In exploring both these problems I wish to show how they have been crystallised into a theory of schizophrenia by R. D. Laing and others. His theory involves the complete negation of the medical model in psychiatry and rejects the notion that a psychiatric patient is a diseased individual among normal sane others. It espouses the idea that “schizophrenic” behavior is meaningful and integrative if seen from the perspective of processes in a field of relationships which are in disharmony.

Laing’s description of some schizophrenics as the most eloquent and perceptive critics of society and his assertion that they are one of the most grotesque results of society’s inherent alienating nature have brought him a huge multi-disciplinary following. He has become a guru though many of the anti-psychiatry cult have no real idea of what they are against.

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The medical model, where deviant behavior is regarded as the symptom of diseased thinking, harbors the possibility that the wide social context of a piece of behavior can be missed. Inherent in it too is the idea that a doctor can be an objective observer of a patient's world. This idea can lead to methodological inhibitions.

The inappropriateness of the model is well shown in the situation of the terrified patient who feels that all roads lead to the Gap.* Psychiatry says all roads do not lead to the Gap so the patient must be "deluded". Delusions are present in many situations, one of which is schizophrenia. We must exclude all the other causes and then show the schizophrenic that the feeling is invalid—not related to "reality". The possibility that in some entirely valid experiential way all roads do lead to the Gap for that person, while occasionally being acknowledged (as a symbolic presentation of suicidal tendencies), is really missed by the medical model since such a phenomenon can only be the symptom of a diseased mind. To feel that the experience was valid some sort of existential phenomenology would be helpful (since this really means being simple and descriptive), but not, I think, necessary, and it would require a flexible world view to see it as at all appropriate.

Anti-psychiatry, with its sociological perspective and an existential phenomenology seems well equipped then to re-examine the problem of schizophrenia. When this "disease" was first described it was classified into various types which have changed over the years, but the central theme has always been that schizophrenics have crazy ideas which they do not recognise as crazy. It begins in their early adult years and generally results in a gradual decline of social performance; hence the original conception of dementia praecox of Kraeplin. This decline has usually resulted in commitment to an institution for the sake of the individual and society, and the relentless nature of the process, regardless of psychiatric intervention "proved" that it was a "disease" for which there was no available cure. Various "treatments" have changed the course of the "disease" and it is being diagnosed more frequently, especially in the USA. Today about half the schizophrenics spend only episodes in institutions; a quarter gradually deteriorate and about a quarter have "it" only once. Half of all people hospitalised in the USA are psychiatric patients and of these two-thirds are schizophrenics so it is easy to see why this "disease"

* The cliff at the South Head of Sydney harbor, which has been the scene of many actual and attempted suicides—Ed.
has baffled and challenged psychiatrists and also why it is central to anti-psychiatry.

In the current era of electicism most people acknowledge both constitutional predisposition and environmental influences as aetiological (causative) phenomena in schizophrenia. The existential and Gestalt schools refer to a schizophrenic field of societal and interpersonal processes with a focal individual whose behavior is labelled “schizophrenic”. This view does not preclude biochemical concomitants and even predisposition of the process.

In contrast, Cooper stresses the essentially integrative nature of “schizophrenic” behavior in the field of operation. Schizophrenia to him is the phenomenon observed when an individual perceives continued normal behavior on his part as being potentially annihilating for the field (“if I don’t act mad there’s going to be a breakdown in this group somewhere”). This perception need not be conscious (and may of course be a misperception) but is available to consciousness if the social and interpersonal processes in the field are elucidated.

Laing feels that seeing oneself as a potential annihilator is just the other side of the coin to seeing oneself as potentially annihilated or annihilatable, and that this feeling is existential anxiety which is ontological insecurity, (i.e., fear about being). Sartre’s enormous contribution to this view is recognisable here. Laing postulates that the experience of the schizophrenic is related to his doubts about his existence and its meaning and that these doubts exist because of his socialization which involved repeated disconfirmation of certain fundamental feelings of his being in the world. The schizophrenic is therefore highly tuned to perceive contradictions in his field at an interpersonal and also at a much wider level.

While I realise that the word violent may outrage people who see their actions as being motivated by concern and compassion, its use can be justified in relation to conventional psychiatry when we examine the suffering of all the people in the field during the genesis of a schizophrenic and in the psychiatric solution—that is the cleavage of the field into a sick member whose experience is invalidated, and a family still containing a number of individuals in considerable psychic pain. If there is anything magnificent and unique in the human condition there is little evidence of it anywhere in that field! Laing suggests that this is a second-rate solution to the problem of a schizophrenic field but that it is inevitable when psychiatry is part of some nebulous piece of institutionalized thinking like clinical medicine, and when psychiatrists are just other alienated humans.
Nobody denies that the institution of war is violent but somehow most people feel it is being waged by “the others”—that there is an inevitability about it which ritually absolves them of individual responsibility. This is alienated human experience — the same phenomenon exhibited by the psychiatrist who regards certain consequences of treatment as inevitable, even desirable, and to whom the totality of violent processes is actually invisible. That contemporary society must contain such families is not his concern since he is adjustment orientated. He must adjust the deviant to society, a society where he believes there is mutuality between society and its institutions and the fullest possible expression of human potentialities. Marcuse would call this one dimensional thinking. Erikson’s personality theories are excellent examples of it.

It can be seen now that Laing, seeing that the treatment of schizophrenics involved the systematic invalidation of their experience, noted the similarity between medical treatment and the process whereby contemporary society socializes and existentially murders its individuals—develops a false consciousness by repeated disconfirmation of experience. Psychiatrists perpetuate the essential alienating process of our society and, of course, at this point of the exposition, having been cast into the role of villains, they understandably become defensive and angry. This is unfortunate since anti-psychiatry is appealing to society and psychiatrists.

Anti-psychiatry is a plea for unalienated human consciousness. It does not lay blame but elucidates processes. It is a cry for some sort of personal liberation and it says some sort of here-and-now phenomenological way of regarding the world is the way to achieve it. It simply says open your eyes and look at the obvious. If we do this we can see that to be concerned about what might replace psychiatry is really beside the point. The problem itself suggests that we need the institutions but we may not if we look at the world in a different way. This does not imply that some institutional thinking is not essential to societal existence, but the suggestion is that personal liberation will bring with it the recognition that such thinking about psychiatry or science, for example, carries a propensity to create alienated humans.

Schizophrenics will probably not disappear just because psychiatrists look at them differently, and people who seem “schizophrenic” will no doubt be thrown up in varying numbers by most cultures, so the problem of what to do about their pain remains with us. Laing has little to say about treatment except to show
that major tranquillizers and shock treatment do something that should hardly be graced by the word "cure". The numerous cases that Laing and others document indicate that they feel the validation of these people's experience decreases the anxiety they feel but there are so many other people concerned in the existence of a schizophrenic who disconfirm their experiences that this process would be very difficult to achieve. It seems then that tranquilizers will remain an integral part of the management of schizophrenic fields for some time and the question as to whether or not Laing's theoretical exposition is essential for a successful therapeutic encounter still remains.

In the light of most recent research into psychotherapy I believe that regardless of the psychiatrist's theoretical position, the ingredients for a successful outcome in psychotherapy are related to the relationship between him and his "patient". If the relationship is characterised by warmth, empathy and genuineness and they both expect it to help, there is likely to be a good result; if it is not then the patient's condition will stand as even chance of remaining unchanged or of becoming worse.

I am convinced that Laing's approach would lead inevitably to a relationship characterised by those important ingredients and equally convinced that most conventional approaches which operate within the medical model would not. Such approaches could, therefore, both harm the patient and, as I have shown earlier, obscure certain phenomena, the recognition of which is imperative in view of the critically alienated state of human conditions.

Why Laing and Cooper call themselves anti-psychiatrists is obvious (to use Laing's favorite word). If they were existential psychiatrists they could be dismissed as "just existentialists". But they have recognised the legitimising role that psychiatry plays in the horribly violent game we call societal existence. Although they are not the only ones to have noticed this, they have a sense of urgency about the situation which they feel can only be adequately expressed in the convulsive act of calling themselves anti-psychiatrists. I hear Eldridge Cleaver's words: "If you're not part of the solution, then you're part of the problem" ringing in my ears. For psychiatrists are a group of people who think they are part of the solution, but who are at the same time so obviously part of the problem.

Suggested reading: The Divided Self, The Self and Others, and The Politics of Experience, by R. D. Laing (all in Pelican). Reason and Violence, by R. D. Laing and D. G. Cooper; Sanity, Madness and the Family, by R. D. Laing and A. Esterson; and The Leaves of Spring, by A. Esterson (all published by Tavistock).