

Homage to R.D. Laing: a New Politics of Experience

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Mad individuals in a mad society

In 1967, R.D. Laing published his groundbreaking book, *The Politics of Experience*. In it, Laing expressed the radical view that insanity, however one chooses to define it, is only “mad” when viewed from the perspective of a mad society which forms its social context.

Psychiatric diagnosis, he points out, is based on a consensus view of reality which circumvents the notion that we are each constrained to filter reality through our own understanding, through our own experience. This applies to psychiatrists as well as to patients. Laing likens psychiatric diagnosis to judging prospective patients according to what is very likely yet another form of insanity. The failure of a person to concur with this possibly mad consensus state is called insanity.

Laing quite agrees that the states which we call mad may not be pleasant ones. He compares them with death, since they represent the death of the person’s ego identification. But ego death is not, in and of itself, an illness, no matter how unpleasant, challenging or even permanent it may be. It is only an illness to a society which sees it as such. Healing, to such a society, means restoring the person to a “normal” state of personal isolation, greed, loneliness or any of the other concomitants of “properly functioning” ego boundaries.

To risk a vast oversimplification of Laing’s intent, he sees madness as a necessary and potentially effective vehicle for social and spiritual transformation, in which the alienated individual becomes re-connected with the whole of humanity and the world. He acknowledges that this path is fraught with peril; the general disavowal of such processes in society at large virtually guarantees

the individual’s failure to make something useful of the experience of ego death. Madness is therefore a problem, but it is not necessarily the individual’s problem. It is, rather, the problem of society as a whole. Were society to pay more attention to the experiences and values which seem important to people in their states of madness, we could provide a safe vessel for individuals called to embark upon the journey to redeem the self through the death of the ego.

Arnold Mindell’s book, *City Shadows: Psychological Interventions in Psychiatry* (1988), represents a similar position. Working with clients in extreme states of consciousness, Mindell finds that their experiences express the shadow (in Jung’s sense) of the society of which they are a part. The experiences of which these clients partake typify just those experiences which are disavowed and often despised by society as a whole—by extension, the people themselves form a disavowed and despised minority. In *The Politics of Experience*, Laing never explicitly defines schizophrenia. He does, however, give some of its characteristics, the most prominent of which is “ego death.” The person has evidently lost the capacity of identification.

This corresponds to Mindell’s notion of the missing metacommunicator. The metacommunicative function permits a person to speak about the states of consciousness which she or he experiences. A person who, for instance, is given to wild fits of passion, in which he produces a deluge of verbal material without much regard to the other person’s feedback, is not necessarily in an extreme state of consciousness. If he can tell you, in the midst of his verbosity, that he sometimes gets this way when he is excited, and to please excuse him,

he doesn't have much control over it, nor does he want to control it because it's an ecstatic state—that person is capable of metacommunicating about his state of mind.

On the other hand, if the same person is either incapable of describing that state, or of relating to another person who does not join him in that state, then that person is, by definition, in an extreme state of consciousness. He is missing the ability or the inclination to metacommunicate about the state itself. He has no high ground from which to be aware of what he is doing, what is happening to him or how he is affecting those around him.

The Question of Therapy

Laing did not believe that people in extreme states of consciousness were ill, nor did he believe that they needed therapy. He believed that what was required was a helper who herself had an experiential familiarity with the states she presumed to help others into and out of. More important than therapeutic skill was a belief in the reality and importance of these states, and the confidence that return was possible, given faith in its possibility and proper guidance.

Laing, during a particular phase of his life, devoted himself to providing an environment in which people with schizophrenia could complete their journeys. He trained a staff of helpers who were sympathetic to the difficulties faced by the schizophrenic "patient" and who could devote great quantities of time and energy to accompanying their schizophrenic clients on their journeys. He used no psychotropic drugs for sedating these people; he believed that the process should not be interfered with, lest the patient be unable to complete his or her journey.

The effort was immense in terms of time, energy and money. The experiment ended without the method being accepted by mainstream psychiatry. Today's psychiatry is largely interested in restoring patients to a more "normal" state through the use of psychotropic drugs, rather than helping patients complete the experiences which are typical of their extreme states.

Laing's Legacy

What remains from Laing's initial project is a legacy of belief in the meaningfulness of mental illness. Although this belief was present in the work of his predecessors, Laing's courage enabled him to put his views into radical action. It is one

thing to believe that a schizophrenic's ravings and trances are meaningful; it is quite another to take the same person out of the psychiatric clinic and into an environment where everyone is equal, where everyone has the same rights and privileges, and where no person's experiential reality is considered any truer or more valuable than anyone else's.

This legacy has been carried forth by Stanislav Grof, John Weir Perry and other pioneers. It has borne such fruits as Perry's therapeutic community, Diabasis, in which schizophrenics were treated with psychotherapy but no drugs, and Grof's Spiritual Emergence Network (SEN) which is devoted to providing people throughout the United States with access to helpers who know and respect extreme states.

There have been other experiments in the United States as well as abroad. They have, in general, led to more understanding and the potential for more humane treatment than has been provided by traditional psychiatry, with its emphasis on pathology, institutionalization and chemotherapy.

Despite these efforts, psychiatry is resolutely marching forward in its attempt to develop illness-specific chemical treatments for all manner of extreme states of consciousness. The current belief is that these states are produced by a biochemical disorder and can only be treated effectively by intervening in that chemical system.

Co-Existence of Contrasting Paradigms

The benefits of the chemical approach to extreme states of consciousness cannot be denied; over the past thirty or so years, periods of institutionalization have become shorter; people who were virtually imprisoned for long periods of time are now able to function in jobs, schools and home situations. Does the efficacy of chemicals at improving social functioning mean that the states which they are trying to treat are themselves meaningless?

To believe so would be to subscribe to the theory that extreme states of consciousness have but a single cause, and that the content of these states is an epiphenomenon of a more fundamental disorder. To subscribe to this theory is to say that our experience of these states is less true or less valid than their biochemical nature.

The biochemical theory supports some elements of empirical observations of extreme states of consciousness, but fails to explain others.

It supports the observation that certain measurable parameters of social functioning, interpersonal relationship and the like, show statistically significant improvement under chemical therapy.

There are certain other aspects of extreme states of consciousness which are not so clearly supported by the biochemical theory. These include the aspects to which Laing was referring, and to which Mindell's work has addressed itself.

1) Extreme states are relative to a "base" or consensus state of consciousness. This base state is not universal; it is the "normal" state for the social framework out of which the extreme state emerges. For example, a person living in a totalitarian state rife with government informers might have to develop a degree of suspicion of her fellow human beings which would brand her as clinically paranoid in a more democratic social system. With the collapse of the Soviet Union and the rapid transition to democratic process in the former Soviet satellite nations, people have not found it easy to relinquish old habits of caution acquired during a lifetime of repression. Has suspicion suddenly become an illness because of a change of governmental form?

2) Extreme states are defined in part with respect to a mainstream and often unconscious definition of truth. Schizophrenia, for example, is considered to be a disorder of thought. Schizophrenic thought is considered disorganized or even chaotic; it is deficient in "reality testing." Visual and auditory hallucinations are examples of disordered thinking; they refer to inner representations of things which "aren't really there." But "what is really there" is very much a matter of culture. "Talking to God" in the form of prayer is considered normal behavior as long as it is done in the right place at the right time. But if I begin to carry on a conversation with God in the midst of an oral examination on constitutional law at a university, I had better be willing to admit that God wasn't "really" talking to me nor I to she, lest I be suspected to be hallucinating and therefore psychotic. It is for this reason that psychiatry is so susceptible to being misused as an instrument of social repression. Mainstream culture establishes what is real, and, historically, has often depended on psychiatry to incarcerate or chemically alter those who do not subscribe to this standard.

3) Extreme states of consciousness are judged in part through differences of communication style. Each culture and subculture carries with it a

largely unconscious set of communication protocols. The more conscious of these are formulated as rules of courtesy and politeness. Those of which we are less conscious establish a kind of mood or atmosphere which emerges in reaction to those whose communication style conflicts with the mainstream norm. People who are by nature shy or introverted may be thought to be seriously depressed by adherents to a mainstream communication style which favors loud and spontaneous verbal interaction. Conversely, in a cultural framework which is marked by little body movement and soft speech, a person who speaks loudly and gesticulates may be thought manic.

Laing's program for the understanding and treatment of mental "disorders" was an attempt to take into account factors such as these, in addition to those which could be accounted for by the biochemical theory of mental illness. Having laid out these positions, I wish to consider why Laing's model was not picked up more enthusiastically by mainstream psychiatry, and to show how Mindell's approach promises to preserve Laing's basic intent while building a more durable bridge between the two paradigms.

Process and state:

madness in sanity, sanity in madness

Despite the evident truth of many of its observations and assertions, Laing's program has not had the sort of impact on mainstream psychiatry for which we might have wished. Laing seems to have viewed extreme states of consciousness as a "separate realm" to which people "journeyed" in the course of a psychotic episode. In *The Politics of Experience* he repeatedly uses the metaphor that psychosis is a journey to a distant realm. This realm, he claims, is inaccessible to people in consensus states of consciousness. He likens the journey into this realm as comparable to breaking through a fifty-foot thick concrete wall. The experience of an extreme state of consciousness has something of violence to it. This is in keeping with the common experience that there is something sudden, violent, disturbing, destructive and final about many episodes of extreme states of consciousness. This experience seems to lead people to characterize such states as pathological.

Despite Laing's claim that extreme states of consciousness are not pathological, we often experience them as such. When we are confronted with someone in a state of consciousness which

differs strongly from our own, it is difficult to escape the feeling that something is wrong with that person. A shift in our own state of consciousness is necessary before we can see the other person as simply partaking of another version of reality different from our own. The fact that the other person frequently appears to suffer in her or his state reinforces our belief that the other person is sick.

Laing's approach depathologizes extreme states in principle but does not deal with the fear and hopelessness that these states engender in both those who experience and those who observe them. He asks, instead, for a radical and probably unattainable shift in mainstream consciousness. He wishes a majority to shift its experience and perception to conform to that of a minority which it fears and often despises. As essential as this shift may be, the chances that it will ever occur on a large scale are negligible. Like many well-intentioned programs for social transformation, Laing's approach does not address how it can be implemented without first destroying all the social structure and process which preceded it. The theory does not consider the backlash that inevitably comes by denying the verity of the consensus or mainstream mode of perception.

To put the matter more strongly, Laing's model sets the stage for a serious split between itself and psychiatry. It sets up polar opposites which are so disparate that the chances of finding a metaposition which encompasses both positions and allows their adherents to communicate with one another are as good as nil. It also stops short of attempting to mediate a rapprochement between those two positions.

Laing's theory, on one hand, and mainstream psychiatry, on the other, form two poles of a continuum which neither recognizes as such. While they obviously disagree on most of the important issues in psychiatry, such as the existence, genesis and treatment of psychiatric disorders, they share one important point in common: both see extreme states of consciousness as binary or polar phenomena. They are two-state theories, in which a person occupies either one state or another. Both would agree that this separation of states is radical and tenacious. Neither would put much emphasis on these states as the extremes of a continuum of experiential process.

The Radical Polarization is Only Apparent

Mindell and others have found, however, that the split between extreme and "normal" states of consciousness is not as radical as we tend to imagine. Careful observation shows that each state carries with it a vestige or trace of the other.

Laing's metaphor of the "concrete wall" which separates normal consciousness from the state of consciousness found in schizophrenia highlights the experience that the change of state from one to the other is radical and complete. Everything that existed in the normal state is cast asunder when the person embarks upon a schizophrenic episode.

If we believe this is so, and the dramatic quality of many extreme states supports this belief, we are unlikely to look any further for bridges between the two realms of experience. But if, following Mindell, we approach the person in an extreme state with a "beginner's mind," we often find that these realms are not as completely separated as we initially believed them to be.

It is unusual nowadays for a psychotherapist to encounter someone in a floridly psychotic state; the ethics and practice of psychiatry require people deep in extreme states of consciousness to be medicated and brought back to more normal states as rapidly as a diagnosis can be reached and a treatment plan can be formulated and implemented. Psychotherapists who work with people subject to extreme states of consciousness will most likely work with them when they are in a more "normal" or consensus state of consciousness, either as a result of remission of their symptoms, or through the use of psychotropic drugs. Because of this binary model of states of consciousness, both the psychotherapist and the psychiatrist may believe that the client's extreme states of consciousness are inaccessible to psychotherapy, and that psychotherapy can only serve as a supportive measure between the client's more extreme episodes.

Mindell's experience suggests, however, that a person in the most extreme hallucinatory or paranoid state of consciousness retains a vestige of ability to metacommunicate about her or his state. In order to find this trace of metacommunicative ability the therapist needs first to believe in its existence, and then to have the perceptual tools to locate and amplify it until it crosses the client's threshold of awareness.

Conversely, the person who is in remission between episodes of an extreme state will show evidence of that state as a secondary process (in the process work sense), namely, as disturbing perceptions, projections and other manifestations with which he or she does not identify. Again, it is up to the therapist's awareness and willingness to perceive these manifestations as perturbations of the client's more normal state. I will illustrate this situation through the example of a brief interaction I had with a so-called paranoid patient at a large state psychiatric hospital.

Clarence's Story

Clarence, a forty-nine year old man, was brought to the admissions conference suffering from apparent delusions that he was being poisoned. He delivered a monologue to the staff psychiatrist, social workers, mental health workers, psychologists and nurses present at the meeting.

CLARENCE: "They're putting that old Nazi stuff in the water at the camp. They're trying to poison me, they've been putting that stuff in the water for years, down at the camp...did you find the poison?"

The staff psychiatrist tells Clarence that they haven't found any evidence of poison in his blood.

CLARENCE: "Yeah, but it shows up in the eyes, you see my eyes (holds his eyelids up so that the staff can see the whites of his eyes)...you see it? Are you sure you have the right reagents to test for that old Nazi poison? Not all labs have the right stuff to do the test. My brother-in-law is head of the laboratory at the National Institute of Health, if the hospital doesn't have the right chemicals, I'll talk to my brother-in-law and make sure you get them..."

His monologue went on and on in this vein, repeating the same basic thoughts in several variations, as the psychiatrist questioned him and made notes. Clarence was duly sent back to the ward, and the staff continued to discuss his case. No anomalies had been detected in his lab reports; his suspicion of poisoning was therefore thought to be a paranoid delusion. He was deemed schizophrenic and needed to be medicated. The trouble was, because he felt he was being poisoned, he refused to take his medication, and the staff was pessimistic about being able to reduce the level of

his paranoia and bring him back to a more normal state of consciousness.

Binary Logic

Clarence is clearly in an extreme state of consciousness: he cannot talk about his impression that he is being poisoned. When presented with evidence that no poison could be detected in his system, he seamlessly integrates this by saying that it is the hospital which is faulty. He appears to be totally identified with his experience of being poisoned. This absolute and airtight conviction, not subject to modification by argument, is one of the characteristics that makes him seem mad. There is only one state to his thinking, and although it runs counter to our own convictions, there is no way to loosen his hold on it.

But the psychiatric framework in which Clarence is being evaluated suffers from a similar difficulty. Its job is to decide whether or not Clarence is psychotic, and if so, in what way. Its further task is to pry Clarence loose from his psychotic state and restore him to a normal state of consciousness. In doing so, it largely ignores the content of Clarence's story, listening and looking mainly for diagnostic indices which confirm one diagnosis or another.

The psychiatric approach to Clarence's story is binary in nature, attempting to assign Clarence's perceptions and experiences to one state of consciousness or another. In doing so it runs the risk of missing nuances of content which would add depth and even meaning to an otherwise mad-sounding story.

Experiential Logic

The logic of experience is less concerned with a statement's objective truth than with its place in the person's total world of experience. In the realm of experiential logic, a statement cannot be false; it is always an expression of an aspect of the speaker's experience. Although we may not share that experience, the experiential view makes this at most a matter of relationship, rather than of objective fact. If another person's experience doesn't make sense to us, we can only say that it is false in light of our own experience, rather than saying that it is objectively false.

Whereas the binary logic of objective truth is a state-oriented logic, experiential logic is process-oriented logic. When people speak about their experience, they are speaking about an ongoing process of perception and awareness. It is only

later, in conceptualizing this experience, that we turn it into a state.

Whether we hear people's stories and view their nonverbal communication as a description of a process or of a state depends on our own attitude toward experience. If we ourselves are attuned to the binary logic of state-oriented diagnosis, we are apt to hear people's stories as signs of permanent states of being; we are left with the choice to either let them be or to attempt to heal them by changing their states. If, on the other hand, we are interested in the logic of their experience as an ongoing process, then we have at our disposal a range of techniques and attitudes which are useful for unfolding the person's experiential process and helping it to find its own completion.

I believe that this process orientation toward experience in all of its forms, including extreme states of consciousness, can carry Laing's vision a necessary step further in two ways.

1) It can reduce the radical division that Laing's vision produced in the psychiatric community by building a bridge of experiential process between the two poles of medical intervention and social transformation.

2) It provides, in addition to a unified and evolving theoretical background, a whole spectrum of interventions and attitudes for helping extreme experiential processes to complete themselves. Under the theory and methods of Process Work, the immediate state of the client (medicated or unmedicated, in remission or in an episode) is less important than the therapist's openness, awareness and skill in finding and processing traces of all of the client's experiential states in his or her immediate situation. Put more simply, it may not be necessary for a person to go mad in order to process the states which that madness would otherwise produce.

Working with Clarence

We left Clarence as he posed a dilemma for the treatment team at the hospital. How can you medicate someone who is afraid that everything he ingests may be poisonous?

This is a dilemma born of binary logic. It is only daunting if one's goal is to change Clarence's state. Clarence is clearly in the middle of an extreme state of consciousness. His fear that he is being poisoned is very real and immediately present. As we have seen, it is so pervasive that it permits no relativization through objective "fact." The hospital's failure to find any poison is

evidence to him that the hospital itself is "sick" and needs to be healed.

Experiential logic leads us to try to determine the totality of Clarence's experience, not just the part with which he is strongly identified. Using awareness skills of the sort which Mindell has described in *City Shadows*, my approach was to listen carefully to find the vestiges of experience in Clarence's story with which he did not identify, with the idea that these would form the elements out of which he could eventually assemble the ability to metacommunicate about his experience.

Viewed from an experiential standpoint, Clarence's description of both the Nazi poison (and, presumably the Nazis who produced or placed it) as well as his offer to have his brother-in-law check out and properly stock the hospital laboratory, are instances of secondary processes. An immediate goal of Process Work with people in extreme states, who are totally identified with one element of their experience, is to get them to identify, if only for a moment, with other aspects of their experience. Mindell has found that if this happens, the person does not simply "flip" into the other state, but often is able to metacommunicate about both states for a longer or shorter period of time.

One method which seems effective for getting someone to identify with a secondary process while they are in an extreme state is to join them in that state, to congruently partake of the same experience with which they are identified and to share that experience with them. With the permission of the chief psychiatrist, I went on the ward and met Clarence. I went up to him and said, "They're trying to poison me too!" To my utter astonishment, he looked at me, smiled, put his arm around my shoulder and said, "Don't worry, it won't kill you."

This is an exceptional response from someone who is supposedly in the midst of a paranoid schizophrenic episode. In that moment, he was very related to me—I experienced a great deal of warmth of feeling when he put his arm around me. He became, for an instant, "normal" in the sense of speaking about the experience of being poisoned, instead of simply acting like the victim of that poisoning.

Clarence then began speaking in detail about the poisoning process. He said that I should call the Army, because people in the Army had the antidote to the poison. He refused, in fact, to

speak to me any more until I contacted the Army to secure the antidote. We then each went our separate ways.

The following day, I ran into Clarence in a hallway in the hospital. He looked well-groomed and showered (in contrast to his disheveled appearance the day before) and recognized me immediately. He smiled and asked me how I was doing.

Accessing the Inner Healer

I was able to follow Clarence's case in the coming months. He was soon discharged from the hospital, only to re-enter several weeks later. But on his re-admission, he was very cooperative with the staff, and told them what drugs had worked for him in the past. They provided him with this medication, which he took without resistance. His symptoms abated, and he was able to leave the hospital in a few days.

Clarence had a good deal of inner knowledge of how to deal with his own extreme state. It was, however, knowledge that was largely inaccessible to him in his "normal" state. This knowledge was represented in his extreme state in the story of the brother-in-law who worked for the government and could heal the hospital's difficulties. It was also represented in his story of the Army personnel who had an antidote for his poison. Why is this state of affairs "extreme"?

It is an extreme state relative to mainstream North American culture. In other cultures, it would not be considered extreme at all. In the worldwide traditions of trance shamanism, practitioners are always going into deep trance states and coming back with information about healing. Despite some modern attempts to romanticize and popularize shamanism, the true shaman seldom has an easy time of it. Many shamans are called to their vocation through near-death experiences, spiritual crises and other terrifying and harrowing rites of passage. The success of the shaman's calling often depends on having a trusted elder who knows the perils of the journey through first-hand experience and can use this experience to offer support and guidance to the suffering and endangered apprentice. How would someone with a genuine shamanic calling fare in a social setting without elders who had trod the same path before her?

Here we get a hint of the picture which Laing is trying to reveal to us. Is Clarence considered mad because there is something wrong with his biochemistry, or because he has a shamanic calling

but lacks an elder to guide him along the arduous path which lies before him?

I suspect that these paradigms do not, at their root, conflict with each other. I cannot escape the lurking suspicion that the very same biochemical disposition which will earn one a label of "mad" in one society may be the prerequisite for a life of sacred healing in another.

Processing the Inner Healer

What are some possible goals for psychotherapeutic work with Clarence in his extreme state? The acute ward of a psychiatric institution, with its complex and restrictive legal and administrative constraints, is an unlikely setting for psychotherapeutic treatment of people in extreme states of consciousness. Triage, diagnosis and short-term treatment are the functions of this system. Even if it were thought that psychotherapy could be of positive value in working with people in extreme states of consciousness, the gap between the patient load and the available therapeutic resources make the whole question seem absurd.

Experiences like the one I have described with Clarence occupy a kind of middle ground; they are not psychotherapeutic in the sense of providing healing through a "psychological" channel, nor are they psychiatric in the sense of (necessarily) producing a lasting and measurable change in the client's state of consciousness or level of functioning. Rather, they are aimed at addressing the client's total world of experience in the moment with the intent of temporarily restoring the client's capacity for metacommunicating about the totality of that experience.

This seems to serve at least two functions. In the event that the client is capable of and interested in gaining insight into his or her psychological processes, it may be possible, once the person can metacommunicate, to work on the person's relationship to the extreme state of consciousness. In Mindell's and others' experience, people are frequently able to widen the boundaries of their lives to include the disavowed experience implicit in the extreme state. Through embracing the disavowed and nearly inaccessible experiences locked up in those states, people discover callings as teachers, healers, spiritual leaders and even politicians.

Other clients are less interested in personal growth, or are less privileged in their access to resources for pursuing self-knowledge. For them, Process Work may not be explicitly therapeutic,

but can, in such cases, serve to elicit the experience which drives their states, and bring it to the attention of the collective consciousness as an instrument of social change.

Conclusion

Stories like the one I have told here show a direction for Process Work with people in extreme states of consciousness. This direction pays homage to Laing's original vision, but with an added ingredient. It emphasizes the experiential aspect of Laing's approach to extreme states while remaining open on the question of just whose experience we are talking about, and what ought to be done to make the whole extreme state experience less painful and less destructive. Process Work adds the element of a Taoistic approach which encourages all participants in an experiential process to unfold their experience, regardless if they are momentarily identified as healer, patient or bystander.

This work demands an extreme degree of flexibility and creativity from the therapist. At times the therapist must act like a physician. At other times, as golden-tongued Aaron spoke for a barely coherent Moses, the therapist must be the ambassador bringing the message of divinely inspired chaos from the back wards of psychiatric hospitals to a depressingly normal and often suicidal mainstream culture.

References

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