Chapter 5

The Schizophrenic Experience

Jones (laughs loudly, then pauses): I’m McDougal myself. (This actually is not his name.)

Smith: What do you do for a living, little fellow? Work on a ranch or something?

J: No, I’m a civilian seaman. Supposed to be high muckamuck society.

S: A singing recording machine, huh? I guess a recording machine sings sometimes. If they’re adjusted right. Mm-hm. I thought that was it. My towel, mm-hm. We’ll be going back to sea in about – eight or nine months though. Soon as we get our – destroyed parts repaired. (Pause)

J: I’ve got lovesickness, secret love.

S: Secret love, huh? (Laughs)

J: Yeah.

S: I ain’t got any secret love.

J: I fell in love, but I don’t feed any woo – that sits over – looks something like me – walking around over there.

S: My, oh, my only one, my only love is the shark. Keep out of the way of him.

J: Don’t they know I have a life to live? (Long pause)

S: Do you work at the air base? Hm?

J: You know what I think of work. I’m thirty-three in June, do you mind?

S: June?

J: Thirty-three years old in June. This stuff goes out the window after I live this, uh – leave this hospital. So I lay off cigarettes, I’m a spatial condition, from outer space myself, no shit.

S (laughs): I’m a real space ship from across.

J: A lot of people talk, uh – that way, like crazy, but Believe It or Not by Ripley, take it or leave it – alone it’s in the Examiner, it’s in the comic section, Believe It or Not by Ripley,
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Robert E. Ripley, Believe It or Not, but we don’t have to believe anything, unless I feel like it. (Pause) Every little rosette — too much alone. (Pause)

s: Could be possible. (Phrase inaudible because of aeroplane noise)

j: I’m a civilian seaman.

s: Could be possible. (Sighs.) I take my bath in the ocean.


s: I can quit whenever I feel like quitting. I can get out when I feel like getting out.

j (talking at the same time): Take me. I’m a civilian, I can quit.

s: Civilian?

j: Go my – my way.

s: I guess we have, in port, civilian. (Long pause)

j: What do they want with us?

s: Hm?

j: What do they want with you and me?

s: What do they want with you and me? How do I know what they want with you? I know what they want with me. I broke the law, so I have to pay for it. (Silence)*

This is a conversation between two persons diagnosed as schizophrenic. What does this diagnosis mean?

To regard the gambits of Smith and Jones as due primarily to some psychological deficit is rather like supposing that a man doing a handstand on a bicycle on a tightrope 100 feet up with no safety net is suffering from an inability to stand on his own two feet. We may well ask why these people have to be, often brilliantly, so devious, so elusive, so adept at making themselves un-remittingly incomprehensible.

In the last decade, a radical shift of outlook has been

occuring in psychiatry. This has entailed the questioning of old assumptions, based on the attempts of nineteenth-century psychiatrists to bring the frame of clinical medicine to bear on their observations. Thus the subject matter of psychiatry was thought of as mental illness; one thought of mental physiology and mental pathology, one looked for signs and symptoms, made one's diagnosis, assessed prognosis and prescribed treatment. According to one's philosophical bias, one looked for the aetiology of these mental illnesses in the mind, in the body, in the environment, or in inherited propensities.

The term 'schizophrenia' was coined by a Swiss psychiatrist, Bleuler, who worked within this frame of reference. In using the term schizophrenia, I am not referring to any condition that I suppose to be mental rather than physical, or to an illness, like pneumonia, but to a label that some people pin on other people under certain social circumstances. The 'cause' of 'schizophrenia' is to be found by the examination, not of the prospective diagnosee alone, but of the whole social context in which the psychiatric ceremonial is being conducted.*

Once demystified, it is clear, at least, that some people come to behave and to experience themselves and others in ways that are strange and incomprehensible to most people, including themselves. If this behaviour and experience falls into certain broad categories, they are liable to be diagnosed as subject to a condition called schizophrenia. By present calculation almost one in every 100 children born will fall into this category at some time.

* See H. Garfinkel, 'Conditions of Successful Degradation Ceremonies', American Journal of Sociology, LXI, 1956, pages 420–24; also R. D. Laing, 'Ritualisation in Abnormal Behaviour' in Ritualisation of Behaviour in Animals and Man (Royal Society, Philosophical Transactions, Series B (in press)).
or other before the age of forty-five, and in the U.K. at the moment there are roughly 60,000 men and women in mental hospitals, and many more outside hospital, who are termed schizophrenic.

A child born today in the U.K. stands a ten times greater chance of being admitted to a mental hospital than to a university, and about one fifth of mental hospital admissions are diagnosed schizophrenic. This can be taken as an indication that we are driving our children mad more effectively than we are genuinely educating them. Perhaps it is our very way of educating them that is driving them mad.

Most but not all psychiatrists still think that people they call schizophrenic suffer from an inherited predisposition to act in predominantly incomprehensible ways, that some as yet undetermined genetic factor (possibly a genetic morphism) transacts with a more or less ordinary environment to induce biochemical-endocrinological changes which in turn generate what we observe as the behavioural signs of a subtle underlying organic process.

But it is wrong to impute to someone a hypothetical disease of unknown aetiology and undiscovered pathology unless he can prove otherwise.*

The schizophrenic is someone who has queer experiences and/or is acting in a queer way, from the point of view usually of his relatives and of ourselves. . . .

That the diagnosed patient is suffering from a pathological process is either a fact, or an hypothesis, an assumption, or a judgement.

To regard it as fact is unequivocally false. To regard it as an hypothesis is legitimate. It is unnecessary either to make the assumption or to pass judgement.

The psychiatrist, adopting his clinical stance in the presence of the pre-diagnosed person, whom he is already looking at and listening to as a patient, has tended to come to believe that he is in the presence of the 'fact' of schizophrenia. He acts as if its existence were an established fact. He then has to discover its cause or multiple aetiological factors, to assess its prognosis, and to treat its course. The heart of the illness then 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, whether genetic, constitutional, endogenous, exogenous, organic or psychological, or some mixture of them all.*

Many psychiatrists are now becoming much more cautious about adopting this starting point. But what might take its place?

In understanding the new viewpoint on schizophrenia, we might remind ourselves of the six blind men and the elephant: one touched its body and said it was a wall, another touched an ear and said it was a fan, another a leg and thought it was a pillar, and so on. The problem is sampling, and the error is incautious extrapolation.

The old way of sampling the behaviour of schizophrenics was by the method of clinical examination. The following is an example of the type of examination conducted at the turn of the century. The account is given by the German psychiatrist Emil Kraepelin in his own words.

Gentlemen, the cases that I have to place before you today are peculiar. First of all, you see a servant-girl, aged twenty-four, upon whose features and frame traces of great emaciation can be plainly seen. In spite of this, the patient is in continual movement, going a few steps forward, then back again; she

plaits her hair, only to unloose it the next minute. *On attempting to stop her movement*, we meet with unexpectedly strong resistance; *if I place myself in front of her with my arms spread out* in order to stop her, if she cannot push me on one side, she suddenly turns and slips through under my arms, so as to continue her way. *If one takes firm hold* of her, she distorts her usually rigid, expressionless features with deplorable weeping, that only ceases so soon as one lets her have her own way. We notice besides that she holds a crushed piece of bread spasmodically clasped in the fingers of the left hand, which she absolutely will not allow to be forced from her. The patient does not trouble in the least about her surroundings so long as you leave her alone. *If you prick her in the forehead with a needle*, she scarcely winces or turns away, and leaves the needle quietly sticking there without letting it disturb her restless, beast-of-prey-like wandering backwards and forwards. *To questions* she answers almost nothing, at the most shaking her head. But from time to time she wails: ‘O dear God! O dear God! O dear mother! O dear mother!’, always repeating uniformly the same phrases.*

Here are a man and a young girl. If we see the situation purely in terms of Kraepelin’s point of view, it all immediately falls into place. He is sane, she is insane: he is rational, she is irrational. This entails looking at the patient’s actions out of the context of the situation as she experienced it. But if we take Kraepelin’s actions (in italics) – he tries to stop her movements, stands in front of her with arms outspread, tries to force a piece of bread out of her hand, sticks a needle in her forehead, and so on – out of the context of the situation as experienced and defined by him, how extraordinary they are!

A feature of the interplay between psychiatrist and patient is that if the patient’s part is taken out of con-

text, as is done in the clinical description, it might seem very odd. The psychiatrist's part, however, is taken as the very touchstone for our common-sense view of normality. The psychiatrist, as ipso facto sane, shows that the patient is out of contact with him. The fact that he is out of contact with the patient shows that there is something wrong with the patient, but not with the psychiatrist.

But if one ceases to identify with the clinical posture, and looks at the psychiatrist-patient couple without such presuppositions, then it is difficult to sustain this naïve view of the situation.

Psychiatrists have paid very little attention to the experience of the patient. Even in psychoanalysis there is an abiding tendency to suppose that the schizophrenic's experiences are somehow unreal or invalid; one can make sense out of them only by interpreting them; without truth-giving interpretations the patient is enmeshed in a world of delusions and self-deception. Kaplan, an American psychologist, in an introduction to an excellent collection of self-reports on the experience of being psychotic, says very justly:

With all virtue on his side, he (the psychiatrist or psychoanalyst) reaches through the subterfuges and distortions of the patient and exposes them to the light of reason and insight. In this encounter between the psychiatrist and patient, the efforts of the former are linked with science and medicine, with understanding and care. What the patient experiences is tied to illness and irreality, to perverseness and distortion. The process of psychotherapy consists in large part of the patient's abandoning his false subjective perspectives for the therapist's objective ones. But the essence of this conception is that the psychiatrist understands what is going on, and the patient does not.*

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H. S. Sullivan used to say to young psychiatrists when they came to work with him, 'I want you to remember that in the present state of our society, the patient is right, and you are wrong.' This is an outrageous simplification. I mention it to loosen any fixed ideas that are no less outrageous, that the psychiatrist is right, and the patient wrong. I think however, that schizophrenics have more to teach psychiatrists about the inner world than psychiatrists their patients.

A different picture begins to develop if the interaction between patients themselves is studied without presuppositions. One of the best accounts here is by the American sociologist, Erving Goffman.

Goffman spent a year as an assistant physical therapist in a large mental hospital of some 7,000 beds, near Washington. His lowly staff status enabled him to fraternize with the patients in a way that upper echelons of the staff were unable to do. One of his conclusions is:

There is an old saw that no clearcut line can be drawn between normal people and mental patients: rather there is a continuum with the well-adjusted citizen at one end and the full-fledged psychotic at the other. I must argue that after a period of acclimatization in a mental hospital the notion of a continuum seems very presumptuous. A community is a community. Just as it is bizarre to those not in it, so it is natural, even if unwanted, to those who live it from within. The system of dealings that patients have with one another does not fall at one end of anything, but rather provides one example of human association, to be avoided, no doubt, but also to be filed by the student in a circular cabinet along with all the other examples of association that he can collect.*

A large part of his study is devoted to a detailed documentation of how it comes about that a person, in being put in the role of patient, tends to become defined as a non-agent, as a non-responsible object, to be treated accordingly, and even comes to regard himself in this light.

Goffman shows also that by shifting one's focus from seeing the person out of context, to seeing him in his context, behaviour that might seem quite unintelligible, at best to be explained as some intra-psychic regression or organic deterioration, can make quite ordinary human sense. He does not just describe such behaviour 'in' mental hospital patients, he describes it within the context of personal interaction and the system in which it takes place.

... there is a vicious circle process at work. Persons who are lodged on 'bad' wards find that very little equipment of any kind is given them – clothes may be taken away from them each night, recreational materials may be withheld, and only heavy wooden chairs and benches provided for furniture. Acts of hostility against the institution have to rely on limited, ill-designed devices, such as banging a chair against the floor or striking a sheet of newspaper sharply so as to make an annoying explosive sound. And the more inadequate this equipment is to convey rejection of the hospital, the more the act appears as a psychotic symptom, and the more likely it is that management feels justified in assigning the patient to a bad ward. When a patient finds himself in seclusion, naked and without visible means of expression, he may have to rely on tearing up his mattress, if he can, or writing with faeces on the wall – actions management takes to be in keeping with the kind of person who warrants seclusion.*

It is on account of their behaviour outside hospital,

* E. Goffman: op. cit., page 306.
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however, that people get diagnosed as schizophrenic and admitted to hospital in the first place.

There have been many studies of social factors in relation to schizophrenia. These include attempts to discover whether schizophrenia occurs more or less frequently in one or other ethnic group, social class, sex, ordinal position in the family, and so on. The conclusion from such studies has often been that social factors do not play a significant role in the 'aetiology of schizophrenia'. This begs the question, and moreover such studies do not get close enough to the relevant situation. If the police wish to determine whether a man has died of natural causes or has committed suicide, or been murdered, they do not look up prevalence or incidence figures. They investigate the circumstances attendant upon each single case in turn. Each investigation is an original research project, and it comes to an end when enough evidence has been gathered to answer the relevant questions.

It is only in the last ten years that the immediate inter-personal environment of 'schizophrenics' has come to be studied in its interstices. This work was prompted, in the first place, by psychotherapists who formed the impression that, if their patients were disturbed, their families were often very disturbing. Psychotherapists, however, remained committed by their technique not to study the families directly. At first the focus was mainly on the mothers (who are always the first to get the blame for everything), and a 'schizophrenenogenic' mother was postulated, who was supposed to generate disturbance in her child.

Next, attention was paid to the husbands of these undoubtedly unhappy women, then to the parental and parent-child interactions (rather than to each person in the family separately), then to the nuclear family group of parents and children, and finally to the whole relevant
network of people in and around the family, including the grandparents of patients. By the time our own researches started, this methodological breakthrough had been made and, in addition, a major theoretical advance had been achieved.

This was the 'double-bind' hypothesis, whose chief architect was the anthropologist Gregory Bateson. This theory*, first published in 1956, represented a theoretical advance of the first order. The germ of the idea developed in Bateson’s mind in studying New Guinea in the 1930s. In New Guinea the culture had, as all cultures have, built-in techniques for maintaining its own inner balance. One technique, for example, that served to neutralize dangerous rivalry, was sexual transvestism. However, missionaries and the occidental government tended to object to such practices. The culture was therefore caught between the risk of external extermination or internal disruption.

Together with research workers in California, Bateson brought this paradigm of an insoluble 'can't win' situation, specifically destructive of self-identity, to bear on the internal family pattern of communication of diagnosed schizophrenics.

The studies of the families of schizophrenics conducted at Palo Alto, California, Yale University, the Pennsylvania Psychiatric Institute, and at the National Institute of Mental Health, among other places, have all shown that the person who gets diagnosed is part of a wider network of extremely disturbed and disturbing patterns of communication. In all these places, to the best of my knowledge, no schizophrenic has been studied

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whose disturbed pattern of communication has not been shown to be a reflection of, and reaction to, the disturbed and disturbing pattern characterizing his or her family of origin. This is matched in our own researches.*

In over 100 cases where we† have studied the actual circumstances around the social event when one person comes to be regarded as schizophrenic, it seems to us that without exception the experience and behaviour that gets labelled schizophrenic is a special strategy that a person invents in order to live in an unlivable situation. In his life situation the person has come to feel he is in an untenable position. He cannot make a move, or make no move, without being beset by contradictory and paradoxical pressures and demands, pushes and pulls, both internally, from himself, and externally, from those around him. He is, as it were, in a position of checkmate.

This state of affairs may not be perceived as such by any of the people in it. The man at the bottom of the heap may be being crushed and suffocated to death without anyone noticing, much less intending it. The situation here described is impossible to see by studying the different people in it singly. The social system, not single individuals extrapolated from it, must be the object of study.

We know that the biochemistry of the person is highly sensitive to social circumstance. That a checkmate situation occasions a biochemical response which, in turn, facilitates or inhibits certain types of experience and behaviour is plausible a priori.

The behaviour of the diagnosed patient is part of a

† Drs David Cooper, A. Esterson and myself.
much larger network of disturbed behaviour. The contradictions and confusions ‘internalized’ by the individual must be looked at in their larger social contexts.

Something is wrong somewhere, but it can no longer be seen exclusively or even primarily ‘in’ the diagnosed patient.

Nor is it a matter of laying the blame at anyone’s door. The untenable position, the ‘can’t win’ double-bind, the situation of checkmate, is by definition not obvious to the protagonists. Very seldom is it a question of contrived, deliberate, cynical lies or a ruthless intention to drive someone crazy, although this occurs more commonly than is usually supposed. We have had parents tell us that they would rather their child was mad than that he or she realize the truth. Though even here, it is because they say that ‘it is a mercy’ that the person is ‘out of his mind’. A checkmate position cannot be described in a few words. The whole situation has to be grasped before it can be seen that no move is possible, and making no move is equally unlivable.

With these reservations, the following is an example of an interaction given in The Self and Others* between a father, mother, and son of twenty recovering from a schizophrenic episode.

In this session the patient was maintaining that he was selfish, while his parents were telling him that he was not. The psychiatrist asked the patient to give an example of what he meant by ‘selfish’.

**S**ON: Well, when my mother sometimes makes me a big meal and I won’t eat it if I don’t feel like it.

**F**ATHER: But he wasn’t always like that, you know. He’s always been a good boy.

MOTHER: That's his illness, isn't it, doctor? He was never ungrateful. He was always most polite and well brought up. We've done our best by him.

SON: No, I've always been selfish and ungrateful. I've no self-respect.

FATHER: But you have.

SON: I could have, if you respected me. No one respects me. Everyone laughs at me. I'm the joke of the world. I'm the joker all right.

FATHER: But, son, I respect you, because I respect a man who respects himself.

It is hardly surprising that the person in his terror may stand in curious postures in an attempt to control the irresolvably contradictory social 'forces' that are controlling him, that he projects the inner on to the outer, introjects the outer on to the inner, that he tries in short to protect himself from destruction by every means that he has, by projection, introjection, splitting, denial and so on.

Gregory Bateson, in a brilliant introduction to a nineteenth-century autobiographical account of schizophrenia, has said this:

It would appear that once precipitated into psychosis the patient has a course to run. He is, as it were, embarked upon a voyage of discovery which is only completed by his return to the normal world, to which he comes back with insights different from those of the inhabitants who never embarked on such a voyage. Once begun, a schizophrenic episode would appear to have as definite a course as an initiation ceremony - a death and rebirth - into which the novice may have been precipitated by his family life or by adventitious circumstances, but which in its course is largely steered by endogenous process.

In terms of this picture, spontaneous remission is no problem. This is only the final and natural outcome of the total process. What needs to be explained is the failure of many who embark upon this voyage to return from it. *Do these encounter*
circumstances either in family life or in institutional care so grossly maladaptive that even the richest and best organized hallucinatory experience cannot save them?*

I am in substantial agreement with this view.

A revolution is currently going on in relation to sanity and madness, both inside and outside psychiatry. The clinical point of view is giving way before a point of view that is both existential and social.

From an ideal vantage point on the ground, a formation of planes may be observed in the air. One plane may be out of formation. But the whole formation may be off course. The plane that is ‘out of formation’ may be abnormal, bad or ‘mad’ from the point of view of the formation. But the formation itself may be bad or mad from the point of view of the ideal observer. The plane that is out of formation may be also more or less off course than the formation itself is.

The ‘out of formation’ criterion is the clinical positivist criterion.

The ‘off course’ criterion is the ontological. One requires to make two judgements along these different parameters. In particular, it is of fundamental importance not to confuse the person who may be ‘out of formation’ by telling him he is ‘off course’ if he is not. It is of fundamental importance not to make the positivist mistake of assuming that, because a group are ‘in formation’, this means they are necessarily ‘on course’. This is the Gadarne swine fallacy. Nor is it necessarily the case that the person who is ‘out of formation’ is more ‘on course’ than the formation. There is no need to idealize someone just because he is labelled ‘out of formation’. There is also no


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need to persuade the person who is ‘out of formation’ that cure consists in getting back into formation. The person who is ‘out of formation’ is often full of hatred of the formation and fears about being the odd man out.

If the formation is itself off course, then the man who is really to get ‘on course’ must leave the formation. But it is possible to do so, if one desires, without screeches and screams, and without terrorizing the already terrified formation that one has to leave.

In the diagnostic category of schizophrenic are many different types of sheep and goats.

‘Schizophrenia’ is a diagnosis, a label applied by some people to others. This does not prove that the labelled person is subject to an essentially pathological process, of unknown nature and origin, going on in his or her body. It does not mean that the process is, primarily or secondarily, a psycho-pathological one, going on in the psyche of the person. But it does establish as a social fact that the person labelled is one of Them. It is easy to forget that the process is a hypothesis, to assume that it is a fact, then to pass the judgement that it is biologically maladaptive and, as such, pathological. But social adaptation to a dysfunctional society may be very dangerous. The perfectly adjusted bomber pilot may be a greater threat to species survival than the hospitalized schizophrenic deluded that the Bomb is inside him. Our society may itself have become biologically dysfunctional, and some forms of schizophrenic alienation from the alienation of society may have a sociobiological function that we have not recognized. This holds even if a genetic factor predisposes to some kinds of schizophrenic behaviour. Recent critiques of the work on genetics* and the most

recent empirical genetic studies, leave this matter open. Jung suggested some years ago that it would be an interesting experiment to study whether the syndrome of psychiatry runs in families. A pathological process called 'psychiatrosis' may well be found, by the same methods, to be a delineable entity, with somatic correlates and psychic mechanisms, with an inherited or at least constitutional basis, a natural history, and a doubtful prognosis.

The most profound recent development in psychiatry has been to redefine the basic categories and assumptions of psychiatry itself. We are now in a transitional stage, where we still to some extent continue to use old bottles for new wine. We have to decide whether to use old terms in a new way, or abandon them to the dustbin of history.

There is no such 'condition' as 'schizophrenia', but the label is a social fact and the social fact a political event.* This political event, occurring in the civic order of society, imposes definitions and consequences on the labelled person. It is a social prescription that rationalizes a set of social actions whereby the labelled person is annexed by others, who are legally sanctioned, medically empowered, and morally obliged, to become responsible for the person labelled. The person labelled is inaugurated not only into a role, but into a career of patient, by the concerted action of a coalition (a 'conspiracy') of family, G.P., mental health officer, psychiatrists, nurses, psychiatric social workers, and often fellow patients. The 'committed' person labelled as patient, and specifically as 'schizophrenic', is degraded from full existential and legal status

as human agent and responsible person, no longer in possession of his own definition of himself, unable to retain his own possessions, precluded from the exercise of his discretion as to whom he meets, what he does. His time is no longer his own and the space he occupies is no longer of his choosing. After being subjected to a degradation ceremonial* known as psychiatric examination he is bereft of his civil liberties in being imprisoned in a total institution† known as a 'mental' hospital. More completely, more radically than anywhere else in our society, he is invalidated as a human being. In the mental hospital he must remain, until the label is rescinded or qualified by such terms as 'remitted' or 'readjusted'. Once a 'schizophrenic' there is a tendency to be regarded as always a 'schizophrenic'.

Now why and how does this happen? And what functions does this procedure serve for the maintenance of the civic order? These questions are only just beginning to be asked, much less answered. Questions and answers have so far been focused on the family as a social subsystem. Socially, this work must now move to further understanding, not only of the internal disturbed and disturbing patterns of communication within families, of the double-binding procedures, the pseudo-mutuality, of what I have called the mystifications and the untenable positions, but also to the meaning of all this within the larger context of the civic order of society – that is, of the political order, of the ways persons exercise control and power over one another.

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Some people labelled schizophrenic (not all, and not necessarily) manifest behaviour in words, gestures, actions (linguistically, paralinguistically and kinetically) that is unusual. Sometimes (not always and not necessarily) this unusual behaviour (manifested to us, the others, as I have said, by sight and sound) expresses, wittingly or unwittingly, unusual experiences that the person is undergoing. Sometimes (not always and not necessarily) these unusual experiences that are expressed by unusual behaviour appear to be part of a potentially orderly, natural sequence of experiences.

This sequence is very seldom allowed to occur because we are so busy 'treating' the patient, whether by chemotherapy, shock therapy, milieu therapy, group therapy, psychotherapy, family therapy – sometimes now, in the very best, most advanced places, by the lot.

What we see sometimes in some people whom we label and 'treat' as schizophrenics are the behavioural expressions of an experiential drama. But we see this drama in a distorted form that our therapeutic efforts tend to distort further. The outcome of this unfortunate dialectic is a forme frustre of a potentially natural process, that we do not allow to happen.

In characterizing this sequence in general terms, I shall write entirely about a sequence of experience. I shall therefore have to use the language of experience. So many people feel they have to translate 'subjective' events into 'objective' terms in order to be scientific. To be genuinely scientific means having valid knowledge of a chosen domain of reality. So in the following I shall use the language of experience to describe the events of experience. Also, I shall not so much be describing a series of different discrete events but describing a unitary sequence, from different points of view, and using a
variety of idioms to do so. I suggest that this natural process, which our labelling and well-intentioned therapeutic efforts distorts and arrests, is as follows.

We start again from the split of our experience into what seems to be two worlds, inner and outer.

The normal state of affairs is that we know little of either and are alienated from both, but that we know perhaps a little more of the outer than the inner. However, the very fact that it is necessary to speak of outer and inner at all implies that an historically-conditioned split has occurred, so that the inner is already as bereft of substance as the outer is bereft of meaning.

We need not be unaware of the 'inner' world. We do not realize its existence most of the time. But many people enter it - unfortunately without guides, confusing outer with inner realities, and inner with outer - and generally lose their capacity to function competently in ordinary relations.

This need not be so. The process of entering into the other world from this world, and returning to this world from the other world, is as natural as death and giving birth or being born. But in our present world, that is both so terrified and so unconscious of the other world, it is not surprising that when 'reality', the fabric of this world, bursts, and a person enters the other world, he is completely lost and terrified, and meets only incomprehension in others.

Some people wittingly, some people unwittingly, enter or are thrown into more or less total inner space and time. We are socially conditioned to regard total immersion in outer space and time as normal and healthy. Immersion in inner space and time tends to be regarded as anti-social withdrawal, a deviancy, invalid, pathological per se, in some sense discreditable.
Sometimes, having gone through the looking glass, through the eye of the needle, the territory is recognized as one's lost home, but most people now in inner space and time are, to begin with, in unfamiliar territory and are frightened and confused. They are lost. They have forgotten that they have been there before. They clutch at chimeras. They try to retain their bearings by compounding their confusion, by projection (putting the inner on to the outer), and introjection (importing outer categories into the inner). They do not know what is happening, and no one is likely to enlighten them.

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

The person who has entered this inner realm (if only he is allowed to experience this) will find himself going, or being conducted – one cannot clearly distinguish active from passive here – on a journey.

This journey is experienced as going further 'in', as going back through one's personal life, in and back and through and beyond into the experience of all mankind, of the primal man, of Adam and perhaps even further into the being of animals, vegetables and minerals.

In this journey there are many occasions to lose one's way, for confusion, partial failure, even final shipwreck: many terrors, spirits, demons to be encountered, that may or may not be overcome.

We do not regard it as pathologically deviant to explore a jungle, or to climb Mount Everest. We feel that Columbus was entitled to be mistaken in his construction of
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what he discovered when he came to the New World. We are far more out of touch with even the nearest approaches of the infinite reaches of inner space than we now are with the reaches of outer space. We respect the voyager, the explorer, the climber, the space man. It makes far more sense to me as a valid project — indeed, as a desperately urgently required project for our time, to explore the inner space and time of consciousness. Perhaps this is one of the few things that still make sense in our historical context. We are so out of touch with this realm that many people can now argue seriously that it does not exist. It is very small wonder that it is perilous indeed to explore such a lost realm. The situation I am suggesting is precisely as though we all had almost total lack of any knowledge whatever of what we call the outer world. What would happen if some of us then started to see, hear, touch, smell, taste things? We would hardly be more confused than the person who first has vague intimations of, and then moves into, inner space and time. This is where the person sitting in a chair labelled catatonic has often gone. He is not at all here: he is all there. He is frequently very mistaken about what he is experiencing, and he probably does not want to experience it. He may indeed be lost. There are very few of us who know the territory in which he is lost, who know how to reach him, and how to find the way back.

No age in the history of humanity has perhaps so lost touch with this natural healing process, that implicates some of the people whom we label schizophrenic. No age has so devalued it, no age has imposed such prohibitions and deterrents against it, as our own. Instead of the mental hospital, a sort of re-servicing factory for human breakdowns, we need a place where people who have travelled further and, consequently, may be more lost
than psychiatrists and other sane people, can find their way further into inner space and time, and back again. Instead of the degradation ceremonial of psychiatric examination, diagnosis and prognostication, we need, for those who are ready for it (in psychiatric terminology often those who are about to go into a schizophrenic breakdown), an initiation ceremonial, through which the person will be guided with full social encouragement and sanction into inner space and time, by people who have been there and back again. Psychiatrically, this would appear as ex-patients helping future patients to go mad. What is entailed then is:

(i) a voyage from outer to inner,
(ii) from life to a kind of death,
(iii) from going forward to a going back,
(iv) from temporal movement to temporal standstill,
(v) from mundane time to aeonic time,
(vi) from the ego to the self,
(vii) from being outside (post-birth) back into the womb of all things (pre-birth),

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

I shall leave it to those who wish to translate the above elements of this perfectly natural and necessary process into the jargon of psychopathology and clinical psychiatry. This process may be one that all of us need, in
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one form or another. This process could have a central function in a truly sane society.

I have listed very briefly little more than the headings for an extended study and understanding of a natural sequence of experiential stepping stones that, in some instances, is submerged, concealed, distorted and arrested by the label ‘schizophrenia’ with its connotations of pathology and consequences of an illness-to-be-cured.

Perhaps we will learn to accord to so-called schizophrenics who have come back to us, perhaps after years, no less respect than the often no less lost explorers of the Renaissance. If the human race survives, future men will, I suspect, look back on our enlightened epoch as a veritable age of Darkness. They will presumably be able to savour the irony of this situation with more amusement than we can extract from it. The laugh’s on us. They will see that what we call ‘schizophrenia’ was one of the forms in which, often through quite ordinary people, the light began to break through the cracks in our all-too-closed minds.

Schizophrenia used to be a new name for dementia praecox – a slow, insidious illness that was supposed to overtake young people in particular, and to be liable to go on to a terminal dementia.

Perhaps we can still retain the now old name, and read into it its etymological meaning: Schiz – ‘broken’; Phrenos – ‘soul or heart’.

The schizophrenic in this sense is one who is broken-hearted, and even broken hearts have been known to mend, if we have the heart to let them.

But ‘schizophrenia’, in this existential sense, has little to do with the clinical examination, diagnosis, prognosis and prescriptions for therapy of ‘schizophrenia’.