Classification and the Treatment of the Patient

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If one thinks about what is the case and what is not the case seriously, intensely, and long enough, one seems either to drive oneself insane or to come to the conclusion that almost everyone else is or that we all are. . .
R.D. Laing, The Facts of Life

We are all born mad. Some remain so.
Estragon in Samuel Beckett's Waiting for Godot

The Rise of the DSM

In today's therapeutic settings the terms "diagnosis" and "treatment" are virtually inseparable. In clinical settings it has become quite popular to speak of the diagnosis as "driving the treatment plan," or of the caregiver "providing a proven treatment pathway" for the patient who suffers from a mental illness. But the link between diagnosis and clinical treatment has not always enjoyed such a prominent position. Our own classification system, or nosology, emerged separately from the work of clinicians within the therapeutic framework, and it even predated Freud's publications which first outlined the methods of psychoanalysis by over a half a century.

In the United States the need to collect statistical information for the census was the impetus behind gathering information on the prevalence of mental disorders. Obviously a facile task in its beginning, for the 1840 census consisted of exactly one category of mental illness: insanity. The number of mental illness categories leaped to seven by the 1880 census. In 1917 the Bureau of the Census began employing the efforts of the American Medico-Psychological Association (whose name changed to the American Psychiatric Association shortly thereafter) and charged the Association with the task of developing a nationally acceptable psychiatric nomenclature which would be included in the American Medical Association system of classification (DSM-IV, p. xvii).

But it wasn't until World War II that the nomenclature business began to boom. Shortly after the war the U.S. Army began developing a broad classification system to facilitate outpatient treatment of its servicemen and veterans. Concurrently, the World Health Organization (WHO) published the 6th edition of the ICD (International Classification of Diseases), which included for the first time a section dedicated to mental illnesses-- a section heavily influenced by the Veterans Administration nomenclature (DSM-IV, p. xxii). The ICD-6 included 10 categories for psychoses, 9

for psychoneuroses, and 7 for personality disorders. It was this version of the ICD that most heavily influenced the development of the DSM-I (*Diagnostic and Statistical Manual of Mental Disorders*), which was first published in 1952 by the American Psychiatric Association. What was unique about the DSM-I was that it was the first classification system of mental disorders to focus on clinical utility (DSM-IV, p. xvii). Historically speaking, the developers of the forerunners of today's major classification systems (the DSM and ICD) did not attempt to relate the classification of mental disorders (nosology) with the actual treatment of mental disorders (clinical application). Perhaps such a consideration at that time might have been viewed as malapropos for the doctor/patient relationship.

This distinction between classification and treatment can also be seen in the different approaches of Freud, the father of psychoanalysis, and Emil Kraepelin, the father of the psychiatric laboratory. Whereas Freud's theories focused on the etiological dynamics of mental illness, Kraepelin attempted throughout his career to classify, categorize, and describe mental disorders as discrete entities (Kirk & Kutchins, 1992, p. 5). These two approaches-- the former etiological, the latter nosological-- were united, or at least placed side by side, for the first time with the publication of the DSM-I.

The publication in 1968 of the DSM-II witnessed the addition of 76 new diagnostic categories (DSM-I contained 106 categories). Consistent with its predecessor, and despite the new additions, the DSM-II did not vary much in terms of its clinical usefulness-- practitioners appreciated its modest administrative practicality. But for researchers, the DSM-II was a nuisance. For this group, the DSM-II was vague, inconsistent, and theoretically clumsy (Kirk & Kutchins, p. 202). It was also during this time that American psychiatry underwent a number of scathing attacks from groups such as the humanists (including the "anti-psychiatry" movement) and behaviorists, as well as clinicians who were more inclined to view mental illness as entirely organic (a physiological perspective). As Kirk and Kutchins note:

> American psychiatry and the field of mental health were more fragmented and diverse than they had been in 1960. The developers knew that it was impossible to organize a classification system that would satisfy multiple constituencies with different views about etiology, prognosis, structure, severity, or relevant dimensions (axes). (Kirk and Kutchins, p. 203)

Faced with such pressing legitimation problems, the American Psychiatric Association set up the DSM-III Task Force in 1974 to oversee the development of a new manual. And in 1980 the DSM-III was published. The DSM-III heralded a number of important methodological changes over its predecessors, including "explicit diagnostic criteria, a multiaxial system, and a descriptive approach that

attempted to be neutral with respect to theories of etiology" (DSM-IV, p. xviii). This new manual boasted of "extensive empirical work" which attempted to resolve issues of reliability and validity, and provide consistent medical nomenclature for both clinicians and researchers (DSM-IV, p. xviii).

The diagnostic manual was revised in 1987 (DSM-III-R), and pitched once again in 1994 as the DSM-IV, the most current manual available as of this writing. In the last two decades, the DSM has become an indispensable tool for psychiatrists, psychologists, social workers, educators, and many others. Its reputation as the only authorized diagnostic manual of the APA is virtually sealed and guaranteed for years to come.

As the authoritative guidebook for psychiatrists and other mental health care practitioners, the DSM represents our current scientific understanding of mental illness. Arriving at such an understanding is no easy task. For even the developers of the DSM recognize the difficulties of delineating between the mental and physical spheres of illness:

> . . . the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute. (DSM-IV, p. xxi)

Of course, to do away with the term "mental" in its definition would in essence eliminate the entire domain of modern psychiatry and psychology, and, besides, would further muddy an already murky pond. The resolution of the problem for the developers of the DSM is to continue the work of clarifying what is meant by the term "mental disorder." It is to this end that they offer the following definition:

> In the DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress . . . or disability . . . or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior . . . nor conflicts that are primarily between the individual and society are mental

> disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. (DSM-IV, p. xxi-xxii)

Quite comprehensive! According to this definition, a mental disorder involves a basic dysfunction *in an individual regardless of etiology* . The diagnosis of a mental disorder for an individual relies upon the presentation of a marked level of impairment (distress, disability, increased risk of death, pain, etc.) or dysfunction for that individual and cannot be based upon culturally accepted or permissible patterns of behavior and/or expression. A mental disorder is a conflict in the individual person. In reference to its uses in forensic settings, the developers of DSM-IV explicitly state that "inclusion of a disorder in the Classification does not require that there be knowledge about its etiology" (DSM-IV, p. xxiii). The correspondence between diagnostic category and the individual's presenting problems (symptomatology) alone provide the ground for a diagnosis. These two fundamental premises of the definition of "mental disorder"-- that it is an individual event, and etiology is not a necessary component of the diagnosis-- is the *sine qua non* of our modern understanding of whole enterprise of the mental health profession. It is on this basis that both research and practice are carried out, directly affecting *what* is being researched and *who* is being treated.

Conquering Reliability

One striking and incontrovertable feature of the evolution of modern psychiatry through the revision of the DSM-IV is the exuberance and fanfare that accompanied it. After the publication of the DSM-III in 1980, Gerald Klerman, who was the highest ranking psychiatrist in the federal government, declared:

> In my opinion, the development of DSM-III represents a fateful point in the history of the American psychiatric profession. . . the judgment is in: DSM-III has already been declared a victory. There is not a textbook of psychology or psychiatry that does not use DSM-III as the organizing principle for its table of contents and for classification of psychopathology. (Kirk & Kutchins, p. 6)

Klerman was not alone in his views. In the pages of *The New Psychiatrists*, Gerald Maxmen proclaimed:

> On July 1, 1980, the ascendance of scientific psychiatry became official. For on this day, the APA published a radically different system for psychiatric diagnosis called . . . DSM-III. By adopting the scientifically based DSM-III as its official system for diagnosis, American psychiatrists broke with a fifty year tradition of using psychoanalytically based diagnoses. Perhaps more than any other single event, the publication of DSM-III demonstrated that American

> Psychiatry had indeed undergone a revolution. (1985, p. 35; as quoted in Kirk & Kutchins, p. 7)

With biopsychiatry making leaps and bounds in scientific journals, the publication of a diagnostic manual grounded in empirical research was surely a fresh source of enthusiasm and solidarity for psychiatry. Many psychiatrists welcomed this new nosology, for it provided an avenue for moving psychiatry closer to mainstream medicine; hence, closer to legitimacy.

Furthermore, predicated as it was on empirical research, the new psychiatry was now apparently immune to the excoriating work of critics such as Thomas Szasz and R. D. Laing. Szasz's claims in the late 50s and early 60s struck the very foundation of psychiatry as a profession. Szasz argued that what constituted "mental illnesses" were in actuality merely socially devalued behaviors (Kirk & Kutchins, p. 20). These "problems in living" were no more akin to medical conditions than were issues of spirituality, thus undercutting an already weak link between psychiatry and modern medicine (no doubt the Achilles heel for modern psychiatry). R. D. Laing's bitter criticisms in the 60s and 70s attempted as well to turn modern psychiatry on its head by suggesting that "schizophrenia was an adaptive response to a chaotic and disordered society" (Kirk & Kutchins, p. 22). By attacking the claims of diagnostic validity and medical authority, both Szasz and Laing, among many others, almost succeeded in capsizing an already splintered and sinking vessel. Modern psychiatry, by the mid-1970s, was in a severe identity crisis.

For psychiatry, as well as its relatives in the mental health sphere (psychology, sociology, social services, etc.), the issues of validity and reliability were of major concern when it came to measurement and diagnosis. Simply put,

> Classification is, in the crudest way, a form of measurement, a method of determining whether phenomena have the particular characteristics for membership in a class. Questions about the meaningfulness of the concept of mental illness, just like questions about the substantive meaning of many relatively abstract concepts such as intelligence or anxiety, involve issues about the validity of scientific constructs. (Kirk & Kutchins, p. 29)

Construct validity is concerned with questions about the nature of the phenomena under investigation. In other words, the question is: are we in fact describing what we say we are describing? For example, intelligence testing is widely regarded as a useful tool, yet scholars and researchers have yet to agree upon what is being tested--namely, what is intelligence? There are still several camps who disagree on fundamental criteria for what is and what is not intelligence. Critics such as Szasz and Laing were addressing these fundamental issues of validity, and doing so with a force

and acumen not easily dismissed by those within mainstream psychiatry. The inability of researchers and practitioners to agree upon the nature of the object of study was a very real and stultifying problem.

Another focal point were the attacks on the credibility of the nosology of DSM-I and II, both by critics such as Szasz and Laing, *and by the new critics within psychiatry*. These new critics, including Robert Spitzer, who was a key consultant on DSM-II and senior architect of the DSM-III, succeeded in shifting the focus of attention from the question of validity to questions of reliability. This was no accident, for

> there is . . . one ironic advantage of problems of reliability: they make it possible to forget about the messy problems of validity. Preoccupation with the consistency of clinician's judgments about the presence of mental illness or about the types of mental illness in a particular group of patients has the attraction of avoiding the issue of the general conceptual definition and meaning of disorder. (Kirk & Kutchins, p. 31)

In their book, *The Selling of the DSM*, Kirk and Kutchins suggest that the first task of the new critics was to transform the problems of diagnostic reliability into *a technical difficulty requiring technical solutions* (Kirk & Kutchins, p. 35). According to Kirk and Kutchins, shifting the focus from the quagmire of validity to the technical and statistical difficulties of reliability had two major advantages. First, the issue of reliability appeared to be more solvable than the problems of validity. Second, the abrupt removal of the pertinent issues into a purely technical arena made matters more complex, and thus beyond competence of clinicians and the public alike (Kirk & Kutchins, p. 35). By focusing on a problem perceived as having a greater chance of success, and by confining this work to the realm of the expert (statisticians), this new group of critics succeeded in mystifying the psychiatric profession as well as the public at large.

The movement of the debate into the realm of the expert and the attempts at solving the problems of reliability successfully pushed the earlier critiques of validity entirely out of the picture. Variations on the "expert" theme are also evident. In the late 60s and early 70s mainframe computers came on the scene, forever altering the methods of statistical analyses. But unlike today's personal computing environment, computers then were the domain of large institutions, and controlled by experts trained in the use of statistical programming software. With the introduction in 1967 of kappa, a statistical formula used to calculate diagnostic agreement rates, new avenues were developed in the hopes of conquering the reliability dilemma. What the new critics wanted was a classification system built on empirical data, analyzed by modern statistical methods, and for this system to be proven to be more successful at inter-rater diagnostic agreement than either DSM-I or II. The DSM-III would be the vehicle

in which to accomplish these goals. The first Task Force for the development of the new manual was created in 1974: a massive army of more than one hundred members working in fourteen specially designed task force subcommittees, its 265 separate diagnoses based on field trials involving over 450 clinicians evaluating over 800 patients -- adults, adolescents, and children. Six years later came the publication of the manual itself: the DSM-III.

But the so-called proof is in the pudding. Was the reliability of the new DSM-III, published in 1980, greater than either of its predecessors?

Kirk and Kutchins answer with a resounding "No!" Their analysis of the entire literature of research involved in assessment of the reliability for the new diagnostic system found no significant improvement in reliability-- in some categories it was worse! Kirk and Kutchins use as their standard of evaluation the .70 standard used in Spitzer and Fleiss's earlier work. a standard by which Spitzer and others discredited the earlier versions of the DSM (Kirk and Kutchins, p. 142). Using this standard, the results of the field trials that formed the basis of the new manual are appallingly low. For example, on Axis I not a single major diagnostic category achieved the .70 standard (Kirk & Kutchins, p. 143). On Axis II, only one of the seven individual kappas reached the .70 level; none of the overall kappas in Axis II did (Kirk & Kutchins, p. 143). In almost each and every diagnostic category Kirk and Kutchins discovered similar scores, leading them to claim:

> Given that even the combined overall reliability for axes I and II did not reach the self-imposed .70 standard and that there were other reliability problems in various categories, one would expect serious concerns to have been raised about the reliability, and therefore the validity, of the classification system. But they were not. Instead, the data were interpreted liberally and inconsistently. (Kirk & Kutchins, p. 147)

In addition, not only were these statistics based on field trials with very small numbers of participants, what constituted diagnostic agreement was sometimes frighteningly lenient:

> if one clinician judged a series of patients to be suffering from Agoraphobia with Panic Attacks and another clinician thought all the same patients suffered from Obsessive Compulsive Disorder, their diagnoses would be considered in perfect agreement on the diagnostic class of Anxiety Disorders and the kappa coefficient would be 1.0 (Kirk & Kutchins, 148)

And this was considered far greater improvement in diagnostic reliability by the developers of the DSM-III! At each and every turn in their analysis, Kirk and

Kutchins fail to discover the "scientific evidence" proving that the DSM-III is more reliable or valid than its antecedents I and II.

Having studied the entire enterprise of the manufacturing and selling of APA's diagnostic manual, Kirk and Kutchins offer four points to consider. First, none of the revisions of the manual have ever been stimulated by clinicians demanding a new classification system. *New systems have been initiated by the census, by the army, by medical groups, and by researchers in the field of psychiatry-- never by those who practice psychiatry.* Secondly, the whole arena of diagnostics is now more complex than ever, with ever increasing layers of political involvement. Third, *new diagnostic categories are added or changed with the belief that it is "better science"-- and no evidence is actually produced to support these claims.* Fourth, a visible cycle of "denigration, enthusiasm, denigration" is at work, where the old system is seen as antiquated and a new system necessary (with new gadgets, case books, and other supplies) (Kirk and Kutchins, pp. 214-215). What we are left with is a monolith of mental health practices, theoretically based on a scientific "grounding" lacking in real evidence, but rich in rhetorical justification. And this supposedly constitutes progress.

The current DSM-IV contains over 300 diagnostic categories. In its first 10 months on the market, the DSM-IV reportedly brought in $18 million in revenue for the American Psychiatric Association (Kirk & Kutchins, 1997, p. 247). What do its developers say about it?

> It is our belief that the major innovation of DSM-IV lies not in any of its specific content changes but rather in the systematic and explicit process by which it was constructed and documented. More than any other nomenclature of mental disorders, DSM-IV is grounded in empirical evidence. (DSM-IV, p. xvi)

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What Kirk and Kutchins revealed in their analysis of the statistical results of the DSM field trials can be summarized as follows: clinicians are today no more likely to agree upon a particular diagnosis than they were a half century ago. And not only are clinicians unable to agree upon general diagnostic categories, clinicians cannot agree upon *the criteria* for basing a diagnosis, putting into question once again the issue of validity in the current nosology as a whole.

The foregoing warrants further discussion in at least three related areas: first, the definition of "mental disorder" used by the developers of the DSM; second, the significance of this understanding of "mental disorder" for clinical practice; and lastly, the question of alternative approaches in today's current mental health climate. It is

with these thoughts in mind that I now turn to a discussion concerning the theoretical approach of R. D. Laing.

In 1959 Ronald D. Laing published his first book titled *The Divided Self*. In 1961 he produced *Self and Others*, and in 1967 he published the widely read and critically acclaimed *The Politics of Experience*. All three books (as well as his research with families of schizophrenics) helped to establish Laing as a respected critic of modern psychiatry alongside such notable thinkers as Harry Stack Sullivan, Thomas Szasz, Michel Foucault, and Ivan Illich. Laing. s polemical style has yielded comparisons to such leftist thinkers as Herbert Marcuse and social critic Paul Goodman. His later books, which include *The Facts of Life* (1976), *The Voice of Experience* (1982), and *Wisdom, Madness and Folly: The Making of a Psychiatrist* (1985) did not sell as well as his work from the 1960s; this turn in Laing's popularity was partly because of a radical shift in his subject matter. During the 70s and 80s, Laing was preoccupied with the influences of intra-uterine experience on development. This interest and the deepening theoretical contradictions within his own work were unappealing to most of Laing's more critically minded readers.

Even so, prior to the publication of the DSM-III in 1980, Laing and critics of psychiatry enjoyed some success in challenging popular assumptions concerning the role of the psychiatrist and of classification systems. Remember at this time the question of validity was paramount (Kirk and Kutchins, 1992, p. 28), and psychiatry's Achilles heel provided an opportunity for public debate and criticism. Laing was one of the first critics to attack modern psychiatry for its failure to show universal validity for its diagnostic categories.

The issue of whether or not there actually *is* such a thing as a "mental disorder" was a basic theoretical conundrum for Laing, and one that he did not take lightly. With his dislike for conventional psychiatric approaches to treatment and his deeply philosophical background, R. D. Laing expended much of his energy trying to understand what we mean by "mental disorder."

As noted earlier, there are two main assumptions in the DSM's definition of "mental disorder." The first premise states that a mental disorder is a strictly individual event. The second premise asserts that the etiology of the disorder should not be a factor when a clinician forms a diagnostic impression. What we have then is an individual *with* a disorder that can be identified on the basis of a particular set of criteria. The individual is said to have the "disorder" if that person meets the descriptive criteria as set forth by the diagnostic manual.

To give a brief example: if you were to present to your clinician symptoms such as insomnia and low energy, each of which lasted most of the day for at least two years,

without any relief, you would qualify for a diagnosis of 300.4 Dysthymic Disorder (note: several other minor features must also be accounted for, but these are primarily negative, i.e. symptoms you do not exhibit at the time of the diagnosis.) (DSM, p. 349). The diagnosis is based only upon what you, the patient, present to the clinician during your interview together. The DSM even offers to clinicians "structured interview" forms to aid in this information gathering process.

The first aspect of this definition of "mental disorder" assumes that "mental illness" is a strictly individual event. Laing, as well as many other theorists, would simply object to such a gross oversimplification. Laing, coming out of an existential-phenomenological framework, suggested that there is *no such thing as an individual*. We are all being-in-the-world-with-others, as Martin Heidegger would say. We cannot, for scientific or theoretical purposes, simply excise the individual from his or her enveloping social context. Laing makes this point quite clear in his discussion of schizophrenia in *The Politics of Experience*:

> 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. (Laing, 1967, p. 103)

It is the "whole social context" that forms the horizon within which interpersonal relations are enacted and experienced. To take the "individual" out of his or her context is, ontologically, a mistake. "Whether we exist in a close, distant, complementary, or adversarial relationship, self and other are always reciprocally constituted" (Burston, 1996, p. 178). Any attempts to isolate the individual from his/her surroundings, their context, is to neglect an entire field of meaning. There is no self without the other; the other is always implied. In *Self and Others* Laing writes:

> we cannot give an undistorted account of "a person" without giving an account of his relation with others. Even an account of one person cannot afford to forget that each person is always *acting* upon others and *acted upon* by others. The others are there also. No one acts or experiences in a vacuum. (Laing, 1961, pp. 81-82)

The second problem with the current definition of "mental disorder" is its avoidance of clinical concern over etiology, or the course of the illness. This approach naturally assuages the ofttimes temperamental disputes between different theoretical factions within psychiatry (e.g. psychoanalytic vs. physiologically oriented professionals), but

in so doing effaces the entire cultural, historical, and familial context from which the person emerges. It is not unlike the proverbial throwing the baby out with the bathwater. Because we cannot understand individuals outside of their context (and one's history is a very important part of one's context), ignoring the history of a particular illness is a dangerous affair. Such temerity on the part of the clinician not only promotes an alienating attitude toward the patient, it prevents the clinician from actually coming to know the patient. For Laing, this ahistorical, atomizing attitude toward the patient often resonates with the very attitudes that produced the psychological distress that drove that patient to therapy in the first place:

> Psychotherapy consists in the paring away of all that stands between us, the props, masks, roles, lies, defenses, anxieties, projections and introjections, in short, all the carryovers from the past, transference and countertransference, that we use by habit and collusion, wittingly or unwittingly, as our currency for relationships. It is this currency, these very media, that re-create and intensify the conditions of alienation that originally occasioned them. (Laing, 1967, pp. 46-47)

But even concern for the etiology of the illness is not enough for Laing, for our modern scientific and medical model approach to mental illness is itself ontologically skewed. Laing's thought on this matter is as follows:

> 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 too often 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," all that is the outcome of process, then resides outside the agency of the person. That is, the illness, or process, is taken to be a "fact" that the person is subject to, or undergoes, whether it is supposed to be genetic, constitutional, endogenous, exogenous, organic or psychological, or some mixture of them all. This, we submit, is a mistaken starting point. (Laing, 1964, p. 18)

It is not that the medical model approach itself is mistaken, but our use of it in trying to understand the psychological landscape of suffering persons fails to bring us closer to an understanding of their world. It is, quite simply, *a narrow approach*. It is an approach that fails to view persons *qua* persons, and degrades them to the status of "objects." Such an understanding of a "mentally disordered" person precludes a deeper understanding and appreciation of a world in conflict. "It is tempting and facile to regard -- persons-- as only separate objects in space, who can be studied as any other natural objects can be studied" (Laing, 1967, p. 23).

According to the developers of the DSM, the role of the psychiatrist or clinician is to observe the patient's symptoms and to correlate these symptoms with a proper diagnosis. In fact, a good psychiatrist is one who works diligently at perfecting the art of diagnostics. However, in *The Divided Self*, Laing points out that this approach actually prevents the doctor from understanding the patient, let alone promoting the process of recovery. Laing viewed diagnostic criteria as a form of *reification*. In his own words:

> Natural scientific investigations are conducted on objects, or things, or the patterns of relations between things, or on systems of "events." Persons are distinguished from things in that persons experience the world, whereas things behave in the world. Thing-events do not experience. Personal events are experiential. Natural scientism is the error of turning persons into things by a process of reification that is not itself part of true natural scientific method. (Laing, 1959, p. 62)

The psychiatrist who approaches his "subject" from an "objective" perspective ("natural scientism") fails to understand his/her own involvement or relationship with the "who" under investigation. This mode of depersonalization, or objectification, Laing suggests, "although conducted in the name of science, . . --yields false . knowledge. " (Laing, p. 24). In neglecting to see the uniquely human relationship between doctor and patient, between an I and a Thou, the traditional models can only view a person's behavior as "signs" of a "disease" and, more important, forego the possibility of seeing such "behaviour as expressive of his existence" (Laing, p. 31).

Laing situates his critique of traditional models of "mental disorders" in the technical language used to describe "mental states," and more specifically in its overwhelming tendency to reify its "subject matter." Within the technical vocabulary trapped in the "anachronism" of a dualistic framework (terms such as "mind/body," "psyche/soma," etc.), what is uncovered, Laing suggests, is "an entity not essentially 'in relation to' the other and in a world" (Laing, p. 19). As such, the technical language falls short of describing existentially a unitary phenomenon that reflects the totality of the "original experience of oneself in relationship to others" (Laing, p. 19).

Laing was quite aware of the radical shift in thinking that his theory required of the clinician. Consider the following statement:

> *We believe that the shift of point of view that these descriptions* [of families of schizophrenics] *both embody and demand has a historical significance no less radical than the shift from a demonological to a clinical viewpoint three hundred years ago*. (Laing, 1964, p. 27)

Laing knew that his work with schizophrenic families, which had an existential-phenomenological orientation, required a radical shift in our conceptualization of the human being. Ontologically speaking, one's relation to oneself is an ambiguous situation. There is a sense in which I can recognize my identity, yet at the same time I am not who/ what I say I am. Following Heidegger, Laing would say that our being is always in question, that it is always at issue. These ontological themes were the focus of both Sartre's *Being and Nothingness* and Martin Heidegger's *Being and Time* , two classics of existentialism, and both influenced Laing's own theoretical orientation.

By establishing his perspective as existential-phenomenological, Laing is able to offer a re-orientation to the problems and incongruities encountered when trying to understand "mental disorders." Laing's re-orientation is not a classification system of the possible "signs" and "symptoms" of a pathological "disease," but an acknowledgement of our own limitations to "totalize" the existence of other persons. Laing here describes such a situation:

> There are therapists-- whether they're Freudian or Jungians, or whether they call themselves one thing or another, or simply psychotherapists-- who don't treat people as objects and as things, and who don't feel it is their job to impose their numbers and their scenarios and their values on the patient, but rather see therapy as a reciprocal undertaking and just don't have that impulse to depersonalize and reify the patient. (Charlesworth, 32)

But how does Laing understand persons who are traditionally labeled with a "mental disorder?"

> 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*. (Laing, 1967, p.121)

Most of Laing's published work dealt with so-called "schizophrenics." This raises the question of whether or not Laing's critique can be applied to diagnostic categories as a whole (i.e. our current nosology). Once again, at this point in our consideration, history can be of some service. Recall that for over one hundred years the classification of mental illness as a discrete entity and the clinical practice of psychiatry and psychology were two separate enterprises. Classification, properly understood, was viewed primarily as an *administrative duty*, not an edict of what does or does not constitute proper treatment. This is a crucial distinction to bear in mind, for it brings to light key differences between the two approaches. *In classification we seek to concentrate or group data according to similarities. In caring for another person, we seek to open up a world that is already all too constricted and indifferent to their individuality.* With one we sharpen our focus and induce structures, with the

other we look for freedom where it appears there is little or none. Classification systems such as the DSM are the products of political and historical processes. These processes valorize tacit prescriptions for what is or is not considered "sane" or "normal." Such global prescriptions and categories become literally of no use for a clinician sitting face-to-face with a person whose history, present situation, and future are entirely unique and, perforce, ambiguous. Again, recalling the observations of Kirk and Kutchins, the work of creating, maintaining, and perfecting a classification system has at no time in our history been initiated by working clinicians. Why? Because good clinicians are aware that no matter how many diagnostic categories one can hang around the neck of a patient, healing takes place in a realm without judgments, in a forum in which the clinician comes to simply understand the patient. It is in this forum that persons get better, and lives are changed.

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