# The Affirmation of Experience*

## A contribution towards a science of social situations

Aaron Esterson

Phenomenology I take to be the study of experience. I am concerned with living experience, specifically with acting as a guide to those whose experience has become problematic to them. This practice I term existential phenomenological analysis. I contrast it with the practice of psychiatry.

Psychiatry styles itself the study and treatment of diseases of the mind, and claims to be a branch of scientific medicine. In practice, it functions to negate experience, and to invalidate those whose patterns of experiencing and being fall outside a narrow range. I see the matter as follows.

Experience may be defined as whatever I come to know in and through participating in the world, including how I come to know what I know. It is thus wider than consciousness or what is now called psyche or mind. It is the indivisible unity of a person intentionally acting, and by acting I mean to do, to know that I do, and to know in some measure what I do when I do it. Thus, as the study of experience, phenomenology is the study of personal agency, and as such it is the study of the differentia of the human.

The primary field of personal agency is the relationships persons make with each other. The phenomenological investigation of personal agency is the study of persons in their relationships with one another in and through the examination of their experience. This is the method of

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* **Note by Anthony Stadlen.** Aaron Esterson wrote this paper, dated December 1985, by invitation for the Symposium on Phenomenology and Psychiatry, subsequently renamed the Symposium on Psychiatry and Phenomenology, at the Simon Silverman Phenomenology Center of Duquesne University, Pittsburgh, Pennsylvania, on 6–7 March 1986. But Esterson withdrew it within two weeks of submitting it. For an investigation and explanation of his withdrawal, see my postscript, 'Quintessential Phenomenology', after this paper in this Journal. I gave the paper its first public reading at Inner Circle Seminar No. 196 on 29 September 2013 at Durrants Hotel, London, for the 90th anniversary of Esterson's birth.

understanding persons. We understand them through understanding their relationships, and we understand their relationships through understanding their experience.

Persons experience. The way they relate to each other and to the natural world is an expression of how they experience each other and that world. This can be formulated axiomatically as, behaviour is a function of experience.

The pattern of a person's relationships makes sense through elucidating the experience his behaviour expresses. Existential phenomenology studies the experience of persons in respect of their way of being in the world with others and with nature.

While behaviour is a function of experience, it is also true that experience is a function of behaviour. That is to say, there is a reciprocity between behaviour and experience.

Persons relate to other persons. They respond and their responses are a function of how they experience those others. Their experience of these others is a function of how the others act towards them. My experience of you is a function of how you act towards me. It is not necessarily an exact reflection. It may be an accurate perception, or it may be to a significant extent a function of an experience in phantasy unrecognized as such by me. Only empirical observation of your conduct towards me can reveal how much it is a function of that conduct. This requires direct observation of the relationship.

For instance, I may respond fearfully to a frown by you. My response may be excessive, or it may be justified. For you being the person you are may be expressing in that frown a hostile intent, but only knowledge of you through direct observation of your relationship with me can determine whether or not my response is excessive, whether it expresses an accurate perception or whether, for instance, it is significantly determined by phantasy.

My frightened conduct is, thus, a function of my experience of you, and my experience of you is a function of your conduct towards me.

But, the experience of persons interacting is always an inter-experience, and so, we must consider your experience of the relationship. Your frown may, indeed, indicate hostility, but your hostility may be a function of your perceiving me as having betrayed your confidence, which, however, I may not experience myself as

having done. Further, I may not realise that you see me as having done that, while you may or may not know that I do not see you as seeing me in this way. Unless our experience of each other is clarified a spiral of reciprocal fear, mistrust and misunderstanding will build up. Such clarification again requires direct observation of the relationship. This is the province of social phenomenology.

Social phenomenological analysis studies relationships directly. It does so primarily in and through the examination of the experience of all the relevant participants, including the participating observer. It examines the behaviour and experience of persons in relation to themselves, each other and the groups they comprise. It studies persons in their relevant social contexts, no matter how peculiar their behaviour and experience seem at first sight, and is concerned with the sense of their praxis, and that of their groups. In a microsocial situation it seeks to elucidate with the persons concerned the reciprocities between them and among them, and between them and their group, in and through elucidating the reciprocities between experience and action and between inter-experience and interaction.

Consequently, it suspends judgement on the rationality or otherwise of even bizarre-seeming behaviour and experience. Viewed in its relevant, current microsocial context, even the most mad-seeming actions and experience may be found to be an intelligible and even a reasonable response to an unreasonable social situation.

This is in contrast with psychiatry. It, too, is concerned with people's behaviour and experience – primarily with conduct that deviates from the social norm, without being illegal, and with experience it sees as aberrant. But it assumes the peculiarities to be ipso facto irrational, and assumes the more peculiar they seem the more irrational they must be deemed. And if they seem peculiar and disturbing enough they are diagnosed grossly irrational and mad.

This judgement is, thus, made without viewing the other in his relevant interpersonal context. In effect he is extrapolated from his social situation and viewed in practical isolation, reinforcing the appearance of peculiarity and unintelligibility. And while social and interpersonal factors may be seen to be present these are regarded essentially as secondary, as precipitating and/or aggravating.

Furthermore, psychiatry compounds its primary assumption with a second. The presumed irrationality is assumed to indicate a disease of the mind, analogous to a disease of the body, that causes the other to experience and act in the way he does. He is, thus, stripped of his personal agency, his experience and actions are invalidated, and their appearance of lack of intelligibility reinforced and sealed. Social phenomenology breaks this seal.

Social phenomenological analysis is a method of sampling microsocial situations, such as the family, through interviews conducted according to certain principles. It is investigative and demystifying. Philosophically speaking, it is in the Socratic tradition of *elenchos* – of dialectical or conjoint personal inquiry and learning through the discovery of what the other, in some sense, knows already without realising it or being able to formulate it.

The Socratic method involves as a first step formulating and examining what has hitherto been taken for granted.

Consider the case of Rosie Lander. She was an attractive young woman of 30 with three admissions to mental hospital and an established diagnosis of paranoid schizophrenia. She was the fourth of six sisters ranging in age from 25 to 35.

Her father had died of a heart attack when she was 11, and her mother had to expand her business to support her family full-time. She arranged for her own widowed mother to move in with her to keep house and care for the children. Five years later the grandmother died suddenly. Six months after that Rose had a breakdown. She was 16 years old.

She was admitted to hospital where she was described as confused, incoherent, inaccessible, agitated and saying things like, 'writing on the wall', 'Jesus is the answer', 'Grandma, Grandma'. From time to time she would burst into fits of simultaneous sobbing and laughing. During her stay she was said to be uncooperative and resistive, constantly screaming she was not ill. She was described as having violent outbursts and needing to be secluded in a padded room.

She was given deep insulin treatment and electroshocks. Over a period she settled down into a dull apathy with occasional outbursts of temper, but eventually she was said to be stable in mood, and after eleven months she was discharged as 'remitted without insight'.

She remained well according to the clinical record until she was 27, when she apparently had another breakdown. Once more she was said to be restless and agitated, noisy and inaccessible to questioning and deluded, claiming there was a plot and that she had been kidnapped. She was said to be aurally hallucinated, and to show affective-cognitive incongruence, crying and laughing together. Diagnosis was recurrence of paranoid schizophrenia.

Once more she was given electroshocks, and this time heavily tranquillised. During her stay she was said to be evasive without insight. She was described as gradually settling, and ten months after admission she was discharged, relieved.

On her third admission two years later the description was similar with further paranoid ideas noted, such as a claim that she was being poisoned. For the third time she was diagnosed paranoid schizophrenic.

Once more she was given tranquillisers, and also, what was described as psychotherapy. She was discharged six months later as remitted with little insight. Shortly after she was persuaded to see me by a young man who had contacted me, and who said he was her boy friend.

It is clear from these descriptions that whatever Rosie's problem might be, she and the psychiatrists were in disagreement about whether or not she was ill. When a psychiatrist makes an ascription of schizophrenia he acts as if there is present in the person a demonstrable internal dysfunction or disease that causes the person to experience and act in the apparently bizarre way he does. Yet, despite more than 70 years of research into the problem no one has demonstrated scientifically the presence of such a disease or dysfunction. By scientifically, I mean, a demonstration according to the criteria laid down by Virchow on which the whole of modern, scientific medicine is based, a branch of which psychiatry claims to be. Virchow's criterion was the presence of demonstrable histopathology later extended to pathophysiology. No disease of the cells, no disorder of function, no disease. These criteria have never been met with regard to what is called schizophrenia.

The view that there is a disease present that causes these people to experience and act in a disturbed and disturbing way has, therefore, at best only the scientific status of an hypothesis, while in practice it is

merely an assumption. Since repeated interventions based on this assumption had failed with Rosie it was time to question it. Was she behaving as she did because there was something inside her causing her to act so, or were her actions under her control? And if so, did she have reason enough to do as she did, or was she indeed deluded? And if she was deluded, did this necessarily mean she was suffering from a medical-type disease of the mind analogous to a disease of the body?

It is a long-held popular view that one can be driven crazy by the actions of others, yet curiously, psychiatry fails to recognise this possibility, or if it does in theory, it has no way of discovering it in practice. In assuming disturbed and disturbing conduct and experience are primarily the result of an inner dysfunction, psychiatry precludes itself from seeing social and interpersonal stresses as anything other than secondary and contributing.

How might one question, therefore, the clinical assumption scientifically? Popper's dictum is relevant. A proposition to have the status of a scientific hypothesis must be formulated in a way that is falsifiable. We need certain concepts. There are three – praxis, process and social intelligibility.

Praxis means the actions of an agent, the intentional deeds of a doer, whether the agent is a person or a group of persons acting in concert. But the praxis of a group acting together may be of a complexity that itself generates events that are unexpected, unintended and even undesired by any of the participants in the interaction. For instance, the size of a football crowd generates an unwieldiness and a complexity that might cause someone to be crushed, though no one in the crowd intends it. This unintended happening may be termed process because it gives the appearance of mechanistic inevitability to the activities of the group. We speak, for instance, of the bureaucratic machine. And, though the events generated cannot be attributed to the intentions of any particular person or persons, if what happens can be traced back to the pattern of interpersonal action showing the event to be the outcome of this, the happening becomes thereby socially intelligible.

The question to be asked, therefore, was, 'Is Rosie's peculiar behaviour and experience as unintelligible socially as the psychiatrists who made the diagnosis of schizophrenia assumed?' If their proposition is disproved the view that she is suffering a disease of the mind

becomes redundant and irrelevant (on the principle of economy of hypotheses) and her real problem would have a chance to come into view.

In addressing this question two issues have to be considered: the method to be used, and the general principles informing the conduct of the study.

The general principles first. Hitherto the attitude of those dealing with Rosie had been based on a presumption of illness. This is a particular kind of bias that evokes a certain type of behaviour from the patient; and it affects how those with the bias see him, and how they evaluate what they see. As Szasz has pointed out the presumption of illness by institutional psychiatry results in a method of approach that formally resembles the inquisitorial legal process typical of the police state, and developed historically by the medieval church against deviants such as Jews, heretics, witches etc. This results in institutional psychiatry functioning in our society as a means of social control of people whose behaviour and experience is unconventional, but not illegal. In a police state like Soviet Russia it is also an instrument of political control.

The main feature of the inquisitorial process is a primary presumption of guilt. The accused is put in the position of having to prove himself innocent. This is practically impossible to do. As soon as one is assumed guilty, even the most innocent action takes on a sinister cast, and tends to be seen as further evidence of guilt. No one can escape this psychological quirk, not even the most experienced judge. Our civil liberties are founded on recognition of this fact.

Similarly, once a person has been diagnosed or assumed to be mentally ill, ordinary human quirks come to be seen as signs of a malignant internal process which confirms the prior assumption.

Another inquisitorial feature is that the charge is implicit and general – witchcraft, heresy, treason, anti-Soviet activities and so on. The accused is not given specific details of his supposed crime: what, where, when, how. Nor is he allowed to confront his accuser. His actions are extrapolated from their relevant social context, while he is held in an ambiguous situation of menace, and given enough rope in the belief that sooner or later he will hang himself. And, in practice, if he fails to do so, he has, in fact, done so, since failure to hang himself

simply shows how stubborn he is or cunning or both. He is damned if he does and damned if he does not.

The institutional psychiatric examination is formally similar.

There is the primary presumption of inner dysfunction.

The diagnosis is always a generality like 'mental illness', 'schizophrenia', and so on. The person is never told precisely what he is supposed to have said and done to demonstrate, in the eyes of the psychiatrist, mental disorder.

His actions are examined in isolation from their relevant social context, so that it is impossible to evaluate how, and to what extent, the source of his distress lies primarily in what others are doing to him, rather than in something 'gone wrong' inside himself – in other words, whether he is screaming with pain because there is a disease process, or because someone is twisting his arm.

He is not allowed to question the psychiatrist, or anyone else who says he is ill. As with the inquisitional examination any attempt to question the credentials of the heresy- or witch-hunter (or any attempt to refute him) is taken as a sign of guilt, so any attempt by the putative patient to question or refute the psychiatrist is seen as confirmation of illness. It is usually labeled paranoia and lack of insight into the 'fact' that he is ill.

The principles on which the psychiatric examination should be based are, in my opinion, analogous to those of the accusatory system of due process which hold in our Western open societies. Its features include the following:

– The person is presumed innocent until proven guilty. He has the right to know in specific detail the crime of which he is accused.

– He has a right to confront his accusers in a controlled situation, namely one in which he and they are treated as equals by the representative of justice. He is entitled to question and to seek to refute them, and to test their credibility; they are obliged to respect his questions and reply to them. In the course of questioning he is entitled to establish the context in which the alleged act(s) occurred, and to establish the kind of relationship obtaining between himself and the hostile witnesses. It is a dictum of the accusatory process that circumstances alter cases.

My examination of Rosie's case was guided by similar principles. These included:

1. A primary stance that what was being investigated was not a case of mental illness or madness, but a case of a complaint by one party that another was mentally ill. A type of social situation, rather than a person, was to be studied in the first instance.

2. A presumption that Rosie's peculiar behaviour was intelligible and even comprehensible in terms of her relevant current social situation, provided that it was studied by an appropriate method. The burden of proof of unintelligibility is on those attributing it, including the examining psychiatrist.

3. The right of Rosie to know what label had been ascribed her, and to know in specific detail what the others said she had said and done which led them to this conclusion. This included the right to be told the basis of the psychiatrist's opinion.

4. The right of Rosie to confront, question and seek to refute those who are calling her irrational. This included the right to confront and refute the psychiatrist or examiner, in this case me.

5. The provision of a proper situation in which those attributing irrationality are expected to take Rosie's questions seriously, and to answer them.

6. The provision of a referee who also unravels the complexities of their relationships, while helping them clarify points at issue between and amongst them.

We may now turn to the question of method. How do we test the clinical hypothesis? To discover whether and to what degree Rosie's actions make sense in the context of her current family situation I had to sample the family in a way that did justice to the complexities of the reciprocities of the interaction and inter-experience of its members. I had to observe at one and the same time each person in the family, the reciprocities between these persons and the family itself as a system.

The method I used involved observing the relationships of the members of the family in all their permutations. I have described this in detail elsewhere.

People relate differently in different interpersonal contexts. A daughter in the presence of her father may act differently from the way she acts with her mother and, perhaps, differently again with them both.

She may also experience herself differently in each of these situations, and no one way of experiencing and acting is necessarily more 'her' than any other. Not only may she experience herself differently in these different situations, she may remember different things, express different attitudes – even quite discordant ones – imagine and fantasy in different ways, and so on.

There is no way of knowing a priori the relationship between the pair she makes with her father, the pair with her mother, and the trio with both together. And similarly with the parents.

The family has to be systematically sampled to provide a comprehensive view. In a three person family (father, mother and daughter) it means seeing each person individually, then mother and daughter, father and daughter, mother and father and then mother, father and daughter, though not necessarily in that order. In a four person family (father, mother, son, daughter) again each is seen separately, then each pair, each threesome and all four together. And, if there are others (whether kin or not) who are regarded by members as contributing to the nexus, they must be included in the study, too. In Rosie's case this included her boy friend and her landlady.

Any or all of the permutations can be repeated until a picture emerges that demonstrably answers the question of the social intelligibility of the behaviour and experience under study. In Rosie's case it was the following picture.

Mrs Lander and her family said they were happy, united and close with no significant disharmony apart from Rosie. She was the odd one out who puzzled and alarmed them, her behaviour seemed so peculiar. The core of her peculiarity was that she had left her mother and rented a room of her own, even though she was still unmarried. This seemed bizarre to the point of perversity. They termed it unnatural.

This view was held by them all, including the three daughters who did live away from their mother, but they were married and that was different. They had added members to the family.

Just how close they were could be seen by the fact that Rosie's married sisters each phoned their mother twice a day and visited at least once weekly, while they phoned each other twice a week. They told me, too, they would never have dreamt of leaving home before they

were married. Rosie's two younger sisters, who still lived at home, agreed.

Rosie, however, saw matters rather differently. She agreed the family was close and united, but she found its closeness intolerably restricting, and its unity closely controlling, allowing no room for being separate and individual. This, according to her, was largely due to the tight control exercised by her mother and grandmother over the children.

Against this control Rosie had constantly rebelled. Until puberty she had been quiet and biddable like her sisters, 'a lovely girl', her mother said. With the onset of puberty she had begun to rebel, and from then on she was a changed girl, 'naughty', said her mother. She continually complained of lack of privacy, of intrusiveness by her mother and grandmother and of lack of washing facilities – there was no running hot water and no bath. She insisted, too, on doing things her own way, for instance on going to the public baths more than once a week. She complained also of the others borrowing her clothes, and she rejected the clothes chosen for her by her mother and grandmother. She protested, too, about her mother's cooking.

Rosie's complaints were met with blank incomprehension, none of her sisters had objected. She was characterised as obstinate, bad-tempered, over-particular and always wanting to be different. This view of her was adopted by her sisters, too.

Now, none of this is very different from what goes on in many families with an independent-minded child and rather restrictive parents. And it might have continued indefinitely until Rosie was old enough to make her own way, but unfortunately, her grandmother died, reinforcing her mother's emotional dependence on her children.

Mrs Lander was very insecure personally and financially. She saw her family as a refuge in an uncaring world. It was important for it to remain absolutely intact. The death of her husband when Rosie was eleven was a great blow emotionally and economically. She was left with six children to support. She fell back on her mother.

Her mother had always been a tower of strength, and Mrs Lander had always deferred to her. When Mrs Lander had to start working full time after her husband's death her mother stepped into the breach. She moved in with her daughter and took over running the household.

Five years later when Rosie was sixteen, she and her grandmother had a furious row. It was over Rosie rejecting a dress her grandmother had chosen. The quarrel was more intense and prolonged than usual, and ended with the grandmother giving Rosie 'a good hiding', as Mrs Lander put it – a beating. A few days later the grandmother collapsed and died. Mrs Lander was upset and bitter, and reproached Rosie for so distressing her mother. Rosie, upset too, by her grandmother's death, was shocked and withdrew emotionally. But Mrs Lander thought to herself defiantly, 'Well, she had upset her.'

Her other daughters were upset, also, with Rosie, and though they said nothing, Rosie felt the pressure of their disapproval in their manner. Mrs Lander, aware of the atmosphere, made ostensible attempts to mitigate it, but in her ambivalence she made things worse, for she told the others she did not think one could die of giving a child a beating.

For the next six months Rosie struggled alone with the sense of guilt and confusion generated by the family's implicit, unvoiced, unavowed and denied reproaches. Eventually it became too much, and she spoke to a friend in her office who was a committed Christian. Her friend spoke of Jesus forgiving sin, and briefly Rosie toyed with the idea of conversion. But how could she hurt her mother and her family, all observant, Orthodox Jews? In desperation she tried to confess to her mother, but Mrs Lander, barely comprehending, was shocked and reproachful. Rosie broke down in despair, laughing and crying all at once. The doctor was called, and she was taken into hospital. She was terrified.

Eleven months, nineteen insulin comas, three courses of electroshocks and numerous confinements in a padded room later Rosie was discharged. She returned home a shadow of her old self. Her spirit seemed crushed. To her mother, however, she seemed to be her biddable little girl again. But her spirit was not dead.

Her mother's part in having her sent away, combined with the psychiatric assault, had functioned to absolve her of her guilt over her grandmother's death. Nevertheless, it took years to recover from the effects of the psychiatric treatment. But gradually she began to reassert herself, and to start making complaints again about her mother's control at home.

But her family’s attitude had changed. Her conduct formerly seen as naughty or bad was now seen as illness. This generated confusion in them, and further conflict with her, because she disputed that she had ever been ill. This strengthened her wish to leave home.

She got herself a job, and eventually, when she felt strong enough, she did leave and rented a room. She was twenty four.

She did not cut herself off from her mother. She visited at least once weekly and telephoned frequently, but Mrs Lander’s refuge had been shaken again. Shocked, puzzled and bitter she constantly pressured Rosie to return, and she enlisted the help of her other daughters. She continually told Rosie how difficult it was to live on one’s own, how much of a strain it was to manage financially, and how bad it would be for her health. She constantly offered unsolicited advice on how she should spend her money, while reproaching her for spending it unwisely, as she saw it, on clothes or scent or jewellery or even on presents for her and the family.

She told her, too, that people thought it wrong for an unmarried girl to live on her own, and that she would never get a husband. She told her she was shaming her family, and indeed her family was ashamed, so much so, that whenever she went out with her younger sisters to a dance, say, they introduced her as a cousin.

Meanwhile, Rosie fell in love with a young man, Benny, who lived with his parents. They went out together. Two or three years later she fell pregnant by him. They kept it secret from their families and arranged an abortion. Shortly after certain things happened.

Rosie had been feeling guilty over her sexual relationship, and guilty over deceiving her mother. These feelings were compounded by gilt and deception over the pregnancy, and further compounded by guilt and deception over the abortion.

She felt unworthy and unattractive, and since she had gained weight, she decided to diet. She consulted her doctor. He advised her and prescribed appetite control pills. These she took under supervision. She also began to refuse the meals her mother offered when she visited, saying they were fattening. Her mother was upset.

Rosie began to lose weight. This alarmed her mother, who started badgering her to eat more, saying she would make herself ill. Rosie refused, and her mother started phoning the doctor, complaining Rosie

was wasting away, and claiming his pills were harming her. He dismissed her complaints as groundless.

Mrs Lander made another move. Benny's parents had recently moved further away, and Benny with them. He was unable to see Rosie so often. Rosie, already emotionally vulnerable over the abortion, was upset. More important, Mrs Lander had been telling her that Benny was not the marrying kind. She now sought him out secretly and warned him off. He began to see Rosie even less often. Mrs Lander never told her she had seen Benny.

Rosie was now very unhappy, and it showed. Her family were convinced she was getting ill. Her mother wondered if it was because Benny was not the marrying kind, and she urged Rosie to eat to keep up her strength. Rosie refused this advice. Her mother then began calling on her with food. Rosie became increasingly exasperated. One morning she awoke to find her mother and eldest sister at her bedside with a meal. They had persuaded her landlady to admit them. She began to laugh and cry and scream. Alarmed, they called the doctor. When she saw him she was terrified and fell silent, withdrawing into herself. He had her admitted to hospital, her second admission.

Ten months later she was discharged. Rosie had maintained throughout she was not ill, and so her mother was given charge of a supply of tranquillisers. She was to see Rosie took them, but Rosie refused, and some weeks after she was back with her former landlady and working in a new job. She also made contact with Benny again, who was guilt-stricken. They began going out once more.

But the pressure from her family gradually built up. Her mother was constantly trying to get her to take the tranquillisers, without success. She ground up a tablet, and persuaded one of her other daughters to put the powder in the food she offered Rosie when she visited. Rosie was furious. She accused them of trying to drug her. They told her she was imagining it.

Rosie decided to lose weight again. And then she caught 'flu and was off work for about a week. Her mother visited her and once again tried to make her eat. When Rosie refused she called on the landlady and asked her to persuade her. Rosie heard voices whispering outside her door, but when she opened it only the landlady was there. Her mother had slipped into another room. When Rosie asked the landlady whom

she had been speaking to, the landlady said, ‘No one’, but Rosie remained suspicious.

A week later, Rosie, now convalescing, visited her mother, looking rather wan and thin. She accused her of plotting with the landlady. Her mother denied it. She then produced a meal of fried gefilte fish which Rosie refused. Mrs Lander became very alarmed indeed. She knew Rosie was getting ill because, she said, this used to be her favourite dish. She decided to act.

She was sure it was worry over her job that was making Rosie ill, and that she was going back too soon because she needed to pay for all those living expenses she had saddled herself with. She was sure, too, that her worry was caused by an unpleasant supervisor who Rosie had once said got on her nerves.

Without telling her daughter, Mrs Lander called at the office and spoke to her boss. She told him Rosie was ill. It was the supervisor’s fault and he should control his staff better. He was angry and Mrs Lander flounced out. The following day when Rosie returned to work she was told to quit.

She was shattered. She went home and wept. She took a pill to help her sleep, but she woke in the night and, in a daze, she phoned her mother. Alarmed, Mrs Lander phoned Rosie’s doctor and demanded he visit at once. He refused. She demanded a tranquilliser for her, and insisted on calling on him at three o’clock in the morning for it. She then phoned the landlady who told her to come at seven o’clock. Promptly at 7 a.m. she and her eldest daughter called. They entered Rosie’s room, and she awoke to find her mother and sister standing over her once more, pressing on her a glass of milk. She screamed at them to go away and accused them of plotting to kidnap her again. Shocked, they called the doctor. She screamed at him he was in the plot too. Once again she was taken to hospital.

What has happened, you might ask, to all those signs of madness, all those so-called clinical features of schizophrenia? In my view, Rosie was never mad. She was being driven frantic with despair. Psychiatry cannot discriminate between being mad and being frantic as if one is mad. I am not saying there is no such occurrence as madness. I am not claiming all behaviour deemed mad is a rational or socially intelligible response to how others are acting towards one. In my experience, some

people are mad by any test I know. But, what has this to do with a disease of the mind, in the psychiatric sense, if there is no demonstrable, relevant tissue damage or dysfunction? In far more cases than is generally recognised, if these people are studied in their relevant, current social and interpersonal contexts by a phenomenologically appropriate method, it will be found that they are being invalidated and driven mad, albeit unwittingly, or driven frantic as if they are mad, by others including, I regret to say, psychiatrists themselves.

In my view, psychiatry as a branch of medicine is a snare and a delusion. I believe its methods, based on this delusion, are completely misconceived. In my opinion, we need to start afresh, and look again at the people who come within the purview of psychiatrists. We need a new science, a science of persons and social situations. And we need a new profession of existential analysts, counsellors and guides that subsumes and depasses psychiatry. This profession should systematically study and seek to understand the structure of human experience, the nature of misexperience and the intricacies of human relationships. And it should espouse appropriate principles and develop appropriate methods. This paper is intended as a contribution towards that end.

# ‘Quintessential phenomenology’
## On Aaron Esterson’s ‘The Affirmation of Experience’

Anthony Stadlen

Aaron Esterson died on 15 April 1999. Among his papers was the typescript ‘The Affirmation of Experience’ (see the preceding article) and associated correspondence. On 9 July 1985 he was invited to read a paper at the Simon Silverman Phenomenology Symposium of 6–7 March 1986. On 3 December he posted the typescript, well before the deadline, 1 January. But on 16 December he withdrew it.

Why?

His paper was far more radical than most papers on phenomenology and psychiatry. Most offer ‘phenomenology’ as a ‘technique’ within the medical ‘discipline’ ‘psychiatry’.

But Esterson *contrasts* phenomenology with psychiatry. Phenomenology, he says, studies experience, but psychiatry ‘negates’ experience. Psychiatry is ‘a snare and a delusion’. Its methods are ‘completely misconceived’. We need ‘a new science, a science of persons and social situations’ and ‘a new profession of existential analysts, counsellors and guides’.

Few psychiatrists or even phenomenologists could see his point. Many people called this great existential phenomenologist ‘not existential’, ‘not phenomenological’. Even though he was used to being patronised or dismissed, he intended to go to the symposium.

But then he received a letter dated 9 December from Dr Richard Rojcewicz, co-director of the Phenomenology Center. It began:

‘Thank you for your letters of Nov. 17 and Dec. 3 and for the copy of your paper. I daresay your talk will be well received, having read it.’

Esterson replied on 16 December:

‘I have received your letter of the 9th December. In view of the extraordinary attitude of your opening lines I think it would be best if I withdrew from your Symposium.’

Rojecwicz’s second sentence did seem gauche and backhanded. But did Esterson, or I, understand American English?

In 2000 I telephoned the Phenomenology Center. Its then Chair, Fr. David L. Smith, remembered the Esterson episode well. They had concluded he was mad.

I telephoned Rojcewicz. He remembered Esterson, with feeling. He was mystified by his withdrawal. His paper had been really interesting, a fine case study. 'Yes,' I said, 'but …' – and I read his 'I daresay' sentence back to him. 'Exactly,' said Rojcewicz.

'In English English that sounds backhanded,' I said. 'But I'm an anglophile,' he said. 'I love Shakespeare, Keats, Sherlock Holmes, P. G. Wodehouse. I was expressing myself in an *English* way. Understated.' 'I see,' I said. I rang off. How could he think…?

The minute I put the phone down I saw it. I rang back. 'When you said P. G. Wodehouse – were you being … *Jeeves*?' 'That's it,' he said. 'I see,' I said.

Rojcewicz is a superb translator of Heidegger. His book *The Gods and Technology: A Reading of Heidegger* is outstanding.

Esterson, by some miracle, had found his ideal reader, had he only known. This was a mis-meeting between two of the world's finest phenomenologists. A simple question from either to the other could have made it a meeting.

In October 2013, I questioned Rojcewicz again. Did he still recall the paper? 'Yes. It showed how what looks like disturbance in one person can make sense if it's studied in its social context.' Did he keep a copy? 'No.' So he had understood the heart of it, and remembered it, having had it in his hands for only a few days twenty-eight years ago. Had anyone else read it? 'No.' Had anyone else ever withdrawn? 'No.' Had he read all papers submitted for all thirty-one annual symposia – one hundred and twenty-four papers plus Esterson's? 'Yes, except for a couple which came in late. But I heard them all.' How did he rate Esterson's paper? 'Quintessential phenomenology.'