Who Are You Calling Crazy?

Gary Greenberg On How We Define Mental Illness — And How It Defines Us

Zander Sherman

July 2016

IN AUGUST 2010, at the age of twenty-seven, my brother began showing psychotic symptoms: Buildings seemed taller. The ground appeared to undulate beneath his feet. Joshua had always been exceptionally healthy — a high-school track-and-field star who had recently completed a sixty-eight-day wilderness-survival course. He had been elected president of his college's student union and dreamed of becoming a musician like our father. Now he heard voices in his head.

I had just turned twenty-four and didn't know anyone with a serious mental illness; there was no history of it in my family. My knowledge of schizophrenia was limited to how it was presented in movies and the occasional story in The New York Times. I found myself in the middle of a nightmare scenario in which I was trying to help my brother while also preventing him from attacking our father. (Joshua was convinced that our father was hypnotizing him, and the only way to break the spell was to kill the hypnotist.)

A few months into Joshua's illness, I happened to speak with psychotherapist Gary Greenberg. I was working on a story about the anarchist John Zerzan and his friendship with Ted Kaczynski, the domestic terrorist known as the Unabomber. Greenberg was something of an expert on Kaczynski, having traded letters with him and written about their correspondence for McSweeney's in 1999. As the conversation shifted to Kaczynski's schizophrenia diagnosis, I made a note to talk to Greenberg about my brother someday.

When we had that second conversation, in December 2014, I learned more about mental illness in four minutes than I had in the four years since my brother had begun to show symptoms. Greenberg spoke carefully, even elegantly, often going back to make sure he hadn't lost me. He seemed both wise and averse to thinking of himself that way as he helped me understand mental illness and the challenges of discussing it.

In his writing Greenberg reveals the powerful political and economic forces behind psychiatry, as well as the effect the profession has on the way research is conducted, policy is drafted, and legal cases are tried. In the case of Kaczynski, for example, Greenberg believes the legal-defense team sought a diagnosis of schizophrenia to help their client avoid the death penalty, despite the fact that Kaczynski did not fit the criteria. Greenberg argues that, unlike most medical diagnoses, psychiatric disorders do not have a clearly defined basis in biology. Instead of making objective findings rooted in observed psychological conditions, the diagnostician must listen to the patient's account of his or her symptoms and decide which mental-illness category they best fit. The categories, in turn, are only assemblages of symptoms, their boundaries based on observation or tradition and therefore arbitrary, no matter how carefully rendered. Psychiatrists know this, Greenberg says, but when it comes time to explain diagnoses to patients and to the public — notably in the Diagnostic and Statistical Manual of Mental Disorders, or DSM, sometimes called the "bible" of psychiatry — they insist that the diseases are as verifiable as cancer or diabetes. This insistence often leads patients to feel defined by their psychiatric labels.

Greenberg received his undergraduate degree from Swarthmore College in 1979 and his master's from Southern Connecticut State University in 1983. He opened his first private practice in New London, Connecticut, the following year and earned his doctoral degree from Saybrook University in 1992. He has authored four books, including Manufacturing Depression: The Secret History of a Modern Disease and The Book of Woe, about the process of revising the fifth edition of the DSM. He is a contributing editor for Harper's and has written for The New Yorker and The New York Times, among other publications.

I spoke with Greenberg by phone several times earlier this year. He was at his farm in Scotland, Connecticut, where he lives with his wife and teenage son. When I called, he would often be busy feeding livestock or retooling some old farm machinery. Once, I interrupted him while he was blaring Grateful Dead songs and de-icing his windows.

Some of Greenberg's critics have suggested that he is "anti-psychiatry," a charge Greenberg dismisses. Although as a psychotherapist he cannot prescribe medications, as psychiatrists do, he says he is not against medicating patients. And he acknowledges evidence of a biological basis for disorders like schizophrenia. But he is calling for more introspection from psychiatrists about ideas they take for granted. After all, Greenberg suggests, psychiatry makes a point of analyzing us — isn't it time we analyzed it?

Gary Greenberg

Sherman: What is mental illness?

Greenberg: I don't know that the question can be answered. Maybe when I was younger I thought it could be. Maybe I even thought I knew the answer myself. But at this point I'm not sure the question is worth spending time on. You have to make so many huge assumptions about human nature, the nature of consciousness, and the nature of illness that I think you become wrong before you even begin. I don't mean to insult anyone who would try. I attempt to answer it myself every time somebody comes into my office to talk about what is bothering them.

Sherman: What assumptions about human nature are being made?

Greenberg: The main assumption is that we can understand the kind of suffering we call "mental illness" as some problem or pathology in the brain. And that notion is increasingly taken for granted. We have come to think of ourselves in mechanistic terms. We believe our thoughts and personalities are the product of neurotransmitters.

Sherman: Why is that a problem?

Greenberg: Because it's making a philosophical and possibly even religious claim about the nature of consciousness that ultimately can't be verified. The reason I recoil from the idea that our subjective suffering is "mental illness" is because I believe we become the people we think we are. The more we hear that "the brain does this and the brain does that," the more we think of ourselves as a product of brain chemistry, and that has profound implications for human agency.

At a more practical level, the idea that our subjective suffering is caused by mental illness has not yielded much fruit. Psychiatry simply hasn't proven to be the best way to understand psychic travail — at least, not yet. Even with a disorder like schizophrenia, which looks the most like a true disease, we don't understand the mechanism the way we do with the majority of other medical conditions. Mental illness is a function of consciousness, and consciousness is something we see through a glass darkly. We simply are not prepared to understand it with the same certainty that we are prepared to understand, say, liver disease. It's possible that by thinking of schizophrenia and depression as illnesses, we are going down the wrong path entirely.

Although I don't believe consciousness can be reduced to the brain, the brain is a necessary condition of consciousness. That means we have to pay attention to it. If I think a patient would do well to consult with a psychiatrist or physician about the possibility of medication, I might recommend it. But I also think we are indebted to history — and not just familial history, but cultural history, political history, and economic history — for our understanding of ourselves. Comprehending the way we're situated in the world helps us to comprehend suffering, come to terms with it, and maybe relieve it.

Let's say I'm talking to a young person who is struggling to figure out what to do with his life. I might talk about how that dilemma has changed over the last twenty-five to thirty years. I might let him know that the question didn't always create as much anxiety as it does now. Success today requires a narrower set of skills and talents and temperaments. It's gotten harder to establish yourself in a career. So his anxiety

is not caused just by his nervous system being on overdrive. It reflects a changing reality in which we all have to work harder than the next person to have a satisfying, meaningful, comfortable life. And if you're failing to do that, it isn't necessarily because you're feckless. It may be because your skills and talents aren't useful anymore. The classic case of this is the young man who struggles to get through college. Fifty years ago he might not have gone to college, because he could have gotten a well-paying factory job straight out of high school. Those jobs are disappearing.

Sherman: Where do you draw the line between mental health and mental illness?

Greenberg: Health and illness are on a spectrum. How you get from one to the other is dependent in part on whatever might be happening in your head, but also on the world in which you're living. There are plenty of people whose anxieties or odd beliefs do not impair their functioning, often due to their high position in the world. They're insulated by class or wealth from the consequences of their dispositions, and they don't experience the stresses that less-privileged people do.

Sherman: Does that mean that someone from a wealthy family who has schizophrenia wouldn't be diagnosed as mentally ill?

Greenberg: Someone from a wealthy family can certainly be diagnosed as mentally ill, but everything from that point on could be entirely different than it is for a poor person. There are recent studies showing that the social status of people diagnosed with schizophrenia does affect how well they do. If someone has an intact, caring social network, then that person is more likely to get better. A person from a wealthy family may have the money to spend a year and a half at Sheppard Pratt or another long-term treatment hospital. The old-fashioned asylums have been closed, but beneath the radar there are still places where it is possible for someone with a severe mental illness to live sheltered from the world for as long as necessary. Meanwhile prisons have become the new mental hospitals for the nonwealthy.

Clearly it doesn't always work this way, but, all other factors being equal, people who have more resources are better able to avail themselves of treatment.

Sherman: I think about that when I'm sending e-mails or making phone calls on my brother's behalf. I can navigate the bureaucracy pretty well and champion my brother's cause. Is that the kind of resource you're talking about?

Greenberg: Yes, and if you were truly wealthy, you could pay the twenty or thirty thousand dollars a month it takes to place him in a top-notch institution.

Sherman: You say that mental illness is hard to define, but is it possible that part of it is defined for us in our DNA?

Greenberg: There's a strong indication of some kind of genetic component to mental illness. People who tend toward anxiety often have parents who tended toward anxiety. It's the same with mood disorders and psychotic disorders. When hereditary predisposition has been examined scientifically, what's shown up is that particular illnesses, such as schizophrenia or depression, are not genetic, but their symptoms may be. There are genes or groups of genes that appear to be common in people who suffer from, say, delusions or anxiety.

Sherman: Can our upbringing determine our receptiveness to mental illness?

Greenberg: It's an interesting question. I would broaden the concept of "upbringing" to include forces beyond just the family. If Freud had come along at a different time and hadn't been so interested in the nuclear family, he might have widened his scope. That's one of the real shortcomings of all the dynamic therapies, which focus on a client's childhood, relationships, and feelings. The dynamic therapies are very articulate and accurate about the bourgeois family and its effect on us, but they aren't good at understanding the larger forces such as culture, society, politics, and power relations, all of which shape the family as well as the individual.

Sherman: How could the dynamic therapies better explore and understand those forces?

Greenberg: Take the example I gave of the young man who is distraught because his talents and skills and education aren't suited to the modern world. Now, maybe he's got Oedipal problems, too. Maybe he has some kind of internal conflict about surpassing his father. I certainly wouldn't rule that out. But even under those circumstances, we still have to look at the effect of broad changes in our society.

Here's a different example: Somebody comes in who works in a defense plant making nuclear weapons, and she's feeling depressed and anxious. Therapy wouldn't typically delve into the moral quandary of spending her days making weapons of mass destruction, but maybe it should.

I don't believe I'm the only person stretching these boundaries. Most therapists do it at one point or another. But it isn't recommended in the books, and it's certainly not found in Freud or any of the dynamic therapies that I'm familiar with.

Sherman: Your most recent book, *The Book of Woe*, is about the *Diagnostic and Statistical Manual*. What is the DSM?

Greenberg: The DSM is a book in which mental disorders are named and defined, and it's used by all mental-health professionals to diagnose patients.

Sherman: Are there people who profit from the creation of new disorders?

Greenberg: Of course. In a capitalist system every disease creates a market. As soon as you allow medicine to become a commodity — and I don't mean medicine as in drugs; I mean the whole business of healthcare — you create incentives for people to convince others that they are sick and that medicine has the cure. The ones who profit from this are obviously the pharmaceutical companies, hospitals, and providers, which includes me.

Defining disorders in the DSM is one of the ways mental-health professionals exercise power. The main point of the DSM is to create and reinforce authority. Much, if not all, of what we do could be done without it. There's no reason you should have to have a diagnosis in order to be treated with a psychiatric drug. If the patient says, "I'm anxious," we like to think it matters whether the anxiety is a result of depression or an anxiety disorder, but, in fact, the drugs treat the symptoms, not the illness.

In some ways psychiatry is already being practiced in this fashion. I know psychiatrists who prescribe a drug or treatment based on their belief that it will help the

patient and then write down a diagnosis to fit. Maybe some think this diagnosis is what's driving the patient's illness, but it doesn't make a difference.

Sherman: In *The Book of Woe* you talk about the need to find labels for our suffering. "Give a name to suffering," you write, "and suddenly it bears the trace of the human. It becomes part of our story. It is redeemed."

Greenberg: It gives us great comfort to be able to name things. In the Bible God tells Adam and Eve to name the creatures in the Garden of Eden. What that myth might represent is the need to bring order to chaos. So when you're confronted with something as difficult and inexplicable as depression or schizophrenia, naming it could help you feel better.

The danger, however, is that a name can become a simplistic means of understanding the self. If a person identifies him- or herself as bipolar long enough, the term becomes a crutch. When people come to me and say, "I have ADHD," I ask, "What does that mean to you?" Then I'll follow up with "How is it valuable to see yourself that way? And how is it limiting you?" There's nothing wrong with having the label, so long as it doesn't encourage a superficial understanding of yourself. If your answer to the question "Who am I?" is "I'm bipolar" or "I have major depression," that forecloses other forms of self-identity.

The reason I recoil from the idea that our subjective suffering is "mental illness" is because I believe we become the people we think we are. The more we hear that "the brain does this and the brain does that," the more we think of ourselves as a product of brain chemistry, and that has profound implications for human agency.

Sherman: Isn't it useful for researchers gathering data to have a name for the disorder they're studying?

Greenberg: One legitimate reason to define disorders is to ensure that, for example, when different people write about schizophrenia, by and large they're all writing about the same phenomenon. Even if the way we define it is just some construct that doesn't have any scientific basis, it allows us to identify the set of symptoms we are talking about. In the prescientific era, everybody agreed that something called "black bile" caused people to be melancholy. It turned out it didn't exist, but that doesn't mean the observations made about melancholy back then weren't valuable. Of course, once you start assuming a construct is real, you're going down the wrong road.

It's becoming more apparent that different pathologies can lead to the same symptoms. The brain has many ways of making people delusional, for example. So those DSM categories are becoming less useful to researchers. The major funder of psychiatric research in this country, the National Institute of Mental Health [NIMH], has more or less abandoned the DSM. The NIMH is no longer requiring or even encouraging researchers to specify a DSM category as the subject of their research. Rather, it's looking for researchers to focus on narrow domains of consciousness, such as fear or arousal.

Sherman: I've heard you speak about an "anthropology of mental illness." What do you mean by that?

Greenberg: Like an anthropologist studying another culture, a therapist might try to isolate, observe, and describe a phenomenon with as few preconceptions as possible. There are philosophical debates about whether we can eliminate preconceptions entirely, but ideally we should try just to describe the thing as it actually occurs, which in this case means really listening to people.

Sherman: How does this differ from the process used by the authors of the DSM?

Greenberg: Take a diagnosis like major depressive disorder. The DSM lists nine symptoms for it, but you have to have only five of them to qualify for the diagnosis, which tells you right away that it's bad science. It's possible for two people to each have five of the nine symptoms but to have only one symptom in common, yet we presume both people are suffering from something called "depression."

For schizophrenia the diagnostic criteria are tighter, but still there's a leap being made from the observation that "a group of people are suffering in this way" to the assumption that they're all suffering from the same anomaly in the brain.

Sherman: The Broad Institute of MIT and Harvard recently discovered a "schizophrenia gene." What do you make of that?

Greenberg: If you look at the fine print, you'll see that what they found is this gene increases your chance of developing schizophrenia by 25 percent. For the general population the chance of schizophrenia is, what, 1 percent?

Sherman: Less than 1 percent.

Greenberg: Let's round up to 1 percent. That means 1.25 percent of the people who have this gene develop schizophrenia. What does that prove?

Psychiatrists have done a decent job of organizing suffering into categories, but I think they fundamentally misunderstand the nature of those categories. They are much closer to the tentative categories of the social sciences than they are to medical diagnoses.

Sherman: How did you come to write *Manufacturing Depression*?

Greenberg: I started my therapy practice in 1983, and around 1990 clients started showing up to my office with diagnoses of depression and prescriptions they'd received from psychiatrists or family doctors for Prozac. My first thought was: I didn't realize there were so many people with depression. Maybe I had missed something.

Watching the trend unfold and gather strength and become a juggernaut was disturbing to me. A lot of critics thought it was bad for so many people to be taking antidepressants, but that's not what bothered me; I have no problem with people taking drugs to feel better. My concern was that, in order to get a prescription, you had to have an illness, and a diagnosis like depression shapes people's understanding of themselves.

We get our idea of what kind of people we should be from our social surroundings. We can see this clearly in the shift that occurred during the eighteenth-century Enlightenment, when people in the Western world started to emphasize the importance of individual liberty. They believed that each person should be free to, as the Declaration of Independence puts it, "pursue happiness." And that understanding is still with us today. It comes to us from our parents, our political and religious leaders, our culture, and, increasingly, the providers of consumer goods that might help us find happiness. All of those sources have the power to shape our sense of self.

The flip side to the pursuit of happiness is the belief that, if you aren't fulfilled or happy, you have failed in some respect. And if you turn to a drug to make you happy, then you are still failing by not being self-reliant, which is another trait our culture values highly. But there is one situation in which you can rely without guilt on an agent outside yourself: when you are sick. Illness grants relief from the injunction to achieve happiness on your own.

A drug company can't just sell Prozac as a product that will make you feel better — let alone change your personality (even though that is pretty much what it does) — because that would violate our ideal of who we are supposed to be. But if you can persuade people that their malaise is an illness, a biochemical imbalance no different in some respects from diabetes, then you can also persuade them to take drugs for it without violating that tenet of self-reliance. This has profound implications, not only for how we understand our suffering, but also for how we understand what it means to be human. The medical industry is using its power to shape us into not only consumers of drugs but also people who think of consciousness as a function of brain chemistry.

Now, I don't think drug-company executives or doctors are gleefully rubbing their hands as they turn us into pill-popping zombies. Most are genuinely trying their best to relieve suffering. But they are shaped by the same historical forces as the rest of us. We're all sailing our ships on the same currents, some of us on yachts and some of us clinging to scraps of flotsam.

Sherman: So the pharmaceutical companies are telling us depression is a disease.

Greenberg: Yes. The pharmaceutical industry — and, to some extent, the medical industry — says it's an imbalance of neurotransmitters, similar to not having enough insulin in your system. If you're depressed, they say, you don't have enough serotonin, and they sell you a drug that's going to release more serotonin. This theory has been discredited, but doctors still present it to patients to make them more comfortable with the idea of taking antidepressants.

Sherman: Should medication be a last resort?

Greenberg: I wouldn't put it that way. I would say that taking medication is something you need to do with your eyes open, recognizing that if the drugs make you feel better, you may want to keep taking them. And then you'll be left to wonder whether it's you or the drugs speaking. You're introducing another variable into your understanding of what's going on inside you. That's not necessarily a bad thing, but it's not a decision to take lightly.

Sherman: In *Manufacturing Depression* you write about your own diagnosis of clinical depression — a diagnosis you sought in order to participate in a drug trial in 2007. What did that experience do for you?

Greenberg: Participating in that trial changed my understanding of the way a diagnosis works psychologically on the patient. When somebody in a position of authority tells you that what's going on inside your mind is caused by an illness, you end up thinking it might be true.

Sherman: What was your motivation for participating in the trial?

Greenberg: My motivation was to write about it. Clinical trials had helped shape the idea of depression as a biological disease: When a trial offers proof that the drug works, it also seems to prove that the diagnosis was correct in the first place. In other words, if you feel better after taking the drug, then you were sick to begin with. In the back of my mind was the thought that clinical trials for antidepressants were at best troubled and at worst rigged.

Sherman: What do you mean "rigged"?

Greenberg: News had come out that antidepressants had not really shown much of an advantage over placebos in clinical trials, and the Food and Drug Administration [FDA] doesn't approve a drug unless it shows an advantage over a placebo. As it turned out, in more than half the clinical trials conducted for the new generation of antidepressants — mostly the selective serotonin reuptake inhibitors, or SSRIs, such as Celexa and Prozac — the placebo did better than the drug. My feeling was that these results didn't necessarily mean that the drugs had no effect. It was hard for me to imagine that you could change your serotonin metabolism and not experience a change in consciousness.

Sherman: So how was the process rigged?

Greenberg: All a pharmaceutical company has to do to win approval is show that its drug outperforms the placebo in two independent trials, and there's no limit on how many trials the company can run. If you test enough, you can eventually squeak out two narrow victories. So there is little incentive to design a methodology that determines what a new drug actually does. The trial is done not to investigate the effects of the drug but to create a rationale for bringing the drug to market, so it can then be prescribed for all sorts of maladies. This is exactly what happened with the SSRIs.

There is some evidence that what SSRIs do is change people's personalities — make them more resilient, less sensitive to rejection, more confident, et cetera. But that's the last thing the drug companies wanted to prove. How could you market that product

to a society allergic to the idea of altering consciousness with drugs? If you look at antidepressant ads, many go out of their way to assure you that the drug is treating an illness, not changing who you are. Methinks the lady doth protest too much.

Obviously this is a system that's looking to be gamed. So I wanted to get into the game and see how it actually worked.

Sherman: Did you fake your depression?

Greenberg: No. What happened is that I tried to join a trial for mild depression, which they were calling "minor depression" at the time. I didn't have to lie, because the criteria for minor depression were so loose. You had to experience a period of two weeks or more in which you were feeling low or sad and have one other symptom of depression from the list of nine in the DSM. This was in 2007. George W. Bush had been president for six years. Everyone I knew was minorly depressed. [Laughs.] So I went to be tested, thinking I would probably qualify. The funny part is, they told me I didn't have minor depression; I had *major* depression. Instead of that trial, I ended up going into another, for omega-3 fatty acids as a treatment for major depressive disorder.

Sherman: After you published an article about your experience, many people accused you of faking your way into the trial.

Greenberg: When I debated psychiatrists on the radio, that was the first thing they would say. It isn't true, of course. What's interesting to me is that, if I had faked my way into the trial, there would have been no way for the researchers to know it. The whole system of diagnosis depends on self-reporting. If depression really is a disease like diabetes, then you shouldn't be able to fake having it.

Sherman: Tell me about your experience of the drug trial.

Greenberg: What surprised me was that, during the course of the trial, I started to feel better. I began to think maybe there really was an illness called depression, and I had it. It was a disconcerting experience.

At the end of the trial, the doctor who was treating me told me I was a "good responder," and that in return for my participation I would receive a year's worth of omega-3 supplements. She seemed sure they were working. But I had held back the last dose and sent it away to a lab to be tested. It turned out that I was on the placebo.

Sherman: Your first published article was about your correspondence with Ted Kaczynski, also known as the Unabomber. Can you talk about how that correspondence started and what you learned from it?

Greenberg: My involvement with the Unabomber was in part an attempt to make a name for myself by writing about someone famous, but I also thought an injustice had been done at his trial. It might sound odd to talk about injustice when it comes to a convicted murderer like Kaczynski, but my sense was that psychiatrists had misused their power, saying that he was schizophrenic when that was clearly not the case. There may be other disorders Kaczynski had or has, but I am sure he is not schizophrenic and never has been.

The only reason his lawyers were interested in portraying him that way was that it made him less likely to be executed. They did this even though Kaczynski repeatedly told them he did not want to be labeled as mentally ill merely to save his life; he would rather have been dead than diagnosed. So the members of his defense team were driven by political opposition to the death penalty rather than by their client's wishes.

Sherman: What are the official criteria for a diagnosis of schizophrenia?

Greenberg: You have to have two of five symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and "affective flattening" — a lack of emotion. The symptoms have to persist for at least six months, and you can have one month in which they fluctuate. You also can't be suffering from another disorder or from substance abuse.

Kaczynski didn't meet the criteria, and the psychiatric report is relatively transparent about that fact. But psychiatrists have always been free to diagnose a disorder even if the patient doesn't meet the criteria. It's part of clinical judgment. In Kaczynski's case the defense suggested he had a delusion that technology was controlling all of us. One of the features of schizophrenia, especially paranoid schizophrenia, is the tendency to see the world as an organized place where everything is connected. When an airplane flew overhead, Kaczynski took it personally — not because he believed the CIA was spying on him, which is your classic paranoid-schizophrenic delusion, but because it represented the intrusion of technology into his life. And that's what allowed the psychiatrist for the defense to diagnose Kaczynski with paranoid schizophrenia, even though few people would deny that technology is an intrusive factor in our lives.

What happened to Kaczynski is an example of how we sometimes try to grapple with a philosophical problem by using medical categories. He wrote a manifesto in which he raised philosophical questions: What is nature? Is technology inherently evil? Kaczynski's team of psychiatrists and lawyers placed those difficult questions into a medical framework because they wanted to save his life, but by doing so they took away any need to consider the answers. Kaczynski's being diagnosed with paranoid schizophrenia is just a particularly heinous example of something that happens all the time in the field of psychiatry.

Sherman: Could you cite another example?

Greenberg: Take that German copilot who intentionally flew a commercial airliner into the Alps. Everybody wanted to blame it on depression or mental illness instead of considering that he might have had a motive. Another example is actor Robin Williams. After his suicide, talk shows had experts on to discuss his depression, but it turned out he'd also had dementia related to Parkinson's disease. So it was more complicated. We use psychiatric labels to jump to conclusions.

Sherman: What would be a better way of handling it?

Greenberg: We need to think about these things in a more comprehensive, less medicalized way. It's too easy just to say, "Oh, he had a disease. If only he had gotten treatment." It's much more frightening to think that someone might wake up one day so pissed off at the world that he's going to fly his airplane into the ground.

Sherman: Some people who were reviled during their time as delusional became revered later on — for example, the biblical prophets Jonah and Ezekiel. What accounts for such a change in perspective?

Greenberg: They were proven right. In the case of Ezekiel, he was warning the children of Israel about their impending destruction, and the next thing you know, they were exiled to Babylon. The problem is, when you're confronted by someone who sounds crazy, you don't know whether to believe that person. I think one of the reasons we call such people "crazy" is because we don't want them to be right.

Sherman: How do you distinguish between someone who just sounds crazy — say, Donald Trump — and a paranoid schizophrenic who imagines there's a vast, secret conspiracy against him?

Greenberg: I'm not sure it's useful to think of Donald Trump as crazy. Many have said he has narcissistic personality disorder, but psychiatric diagnoses can distract us from much more troubling realities. The reality of Donald Trump is much more disquieting than a diagnosis of mental illness would suggest. He's a menace, an amoral clown, a mean, power-hungry bully — and apparently a perfect fit for these times. He doesn't even sound crazy to me. He sounds like a horrible human being. His rise in the polls begs for all sorts of analysis — historical, sociological, economic, political. But not psychiatric.

Getting back to your question of how we can distinguish between someone who only seems crazy and someone who really is: In a way that's exactly the question the psychiatrist in the Kaczynski case was up against. And the answer is, you use the DSM. But instead of doing that, we should be looking at why that question is being asked in the first place. Usually it's because there's a treatment decision that needs to be made, or there's a legal mess that needs to be unraveled, and you want some authoritative clarification of whether or not this person is just different or really crazy.

Sherman: My brother's psychosis was triggered by recreational drug use: he smoked a lot of pot. How big of a role do recreational drugs play in triggering mental illness?

Greenberg: The research on the connection between cannabis and schizophrenia or other psychotic disorders shows a correlation, but it's ambiguous as to causality: we don't know whether people who are predisposed to psychotic illnesses are more likely to smoke a lot of weed, or whether smoking too much weed increases the risk of psychosis.

We need better drug education in this country. Virtually none of what we tell children about drugs is useful. We create an allure around drugs by making such a big deal about them, and then we tell kids, "Don't do drugs." It's looking for trouble.

I think drug use is like driving: it's something you have to learn how to do, and if you don't learn how to do it right, you're probably going to get hurt or hurt somebody else. You wouldn't let a sixteen-year-old get behind the wheel of a car without proper instruction. It doesn't make any sense to do that with drugs either. Recognize that kids are likely to "drive," and tell them about the hazards.

Psychiatrists have done a decent job of organizing suffering into categories, but I think they fundamentally misunderstand the nature of those categories. They are much closer to the tentative categories of the social sciences than they are to medical diagnoses.

Sherman: Are we moving too slowly to legalize marijuana?

Greenberg: I think all drugs should be immediately decriminalized. A regulatory scheme should be put into place not unlike what we have for tobacco and alcohol.

As near as I can make out, the war on drugs has done nothing to alleviate the problem of drug abuse. Instead it's created mass incarceration. The harm it's caused to the African American population in this country — and, to a lesser extent, the Latino population and the poor — is a crime against humanity. And it's in part due to the war on drugs that we can't talk to kids about drugs in more-helpful ways.

Sherman: In a recent issue of *The New Yorker* journalist Michael Pollan writes about an organization called MAPS, the Multidisciplinary Association for Psychedelic Studies, which advances the use of psychedelics and marijuana in the treatment of both physical and mental illnesses. You've also written favorably about your own experiences with psychedelics. Are they good for us?

Greenberg: Before LSD was made illegal, research found strong evidence that using it and psilocybin and, to some extent, mescaline as adjuncts to psychotherapy was helpful. A study of psilocybin out of Johns Hopkins reports that — big surprise — if you give people drugs that open up their minds, it changes their lives. To me that's a pretty obvious conclusion.

As for using them to treat specific mental disorders, I'm skeptical, if only because I'm skeptical of the idea of mental disorders. MAPS is using psychedelics to treat ailments that are the most amenable to them, because that's the best way to get the drugs back into use for clinicians. It's gaming the system the way every pharmaceutical company does. But MAPS is a chartered nonprofit, so I'd rather have it gaming the system than one of the pharmaceutical giants. And once psychedelics are actually approved, there will be off-label uses for them. In other words, even if they are approved for terminal cancer or PTSD, you won't have to have these illnesses to get them.

In the long run we should no more look to Ecstasy or LSD or psilocybin as a cure for mental disorders than we should look to Prozac, because mental disorders don't exist the way that diseases that respond to drugs exist.

Freud said that psychoanalysis is a "cure through love," and I think that is essentially correct. The love is conveyed not so much in the content as in the form: the rapt attention of someone who cares enough to interrogate you. The love stows away in the conversation.

Sherman: The physician and author Jeffrey Lieberman has called you a writer of "anti-psychiatrist screeds." How do you answer the accusation that you are attacking the psychiatric profession?

Greenberg: I don't. Psychiatry is an embattled profession. It has been for its entire existence. At this point there are those who feel that anybody who criticizes it is attacking it.

Some smart people — people who have done much more research than I have — have described in responsible and articulate ways what's wrong with psychiatry. But psychiatrists in positions of authority don't listen to these critiques. This refusal prevents them from improving their own profession.

Sherman: Who are some prominent critics of psychiatry?

Greenberg: In the 1960s there were people like Thomas Szasz, a psychiatrist who claimed that mental illnesses were really just the problems of living, and although those were important to address, it wasn't really helpful or honest to treat them as medical illnesses; and philosopher Michel Foucault, who said that calling people "mentally ill" was just an excuse to discipline them for being different; and sociologist Erving Goffman, who had a whole theory of how social stigma caused people to be classified as mentally ill. None of these critics denied the possibility that there was such a thing as mental illness, but they were more interested in what we *could* know about, such as how a particular form of suffering is a way of living, or how people suffer due to the workings of power in society. They thought it was more fruitful to look at it this way than through these fabricated categories in the DSM.

The critic I agree with the most is one not many people have heard of: Peter Sedgwick. He argued that all categories of illness depended on the workings of society. To call anything an illness was not so much to identify it as a biochemical problem as to give the patient access to resources. Drugs that alter consciousness are a resource you're legally allowed to get only if you're declared ill. And other resources — compassion, understanding, accommodation, support — are more freely given when the person who is suffering has a disease.

Sherman: You advocate a "self-doubting" psychiatry that goes back to its Freudian roots. Could you elaborate?

Greenberg: One of the problems with psychiatry is that it doesn't have an internal check on its power. The Freudian idea of countertransference — that, as an analyst,

you have to consider your own prejudices and neuroses when treating other people — acknowledged that the analyst's perspective was flawed and reminded us to be careful when mucking around with other people's minds. Countertransference wasn't the best safeguard, but it was better than nothing. As psychiatry has evolved away from psychoanalysis, it's also moved away from this built-in check. Now, when a psychiatrist tells a patient, "You have a chemical imbalance, and this drug is going to treat that," there's no recognition of fallibility.

Sherman: How would that recognition help the profession?

Greenberg: It would encourage psychiatrists to be more humble; to say to the patient, "I really don't know exactly why you're suffering, but my experience tells me that this drug may help." Critics of this approach underestimate how many patients would be fine with it.

Sherman: In your most recent book, *Scotland*, you write, "Community is a response to the prolonged emergency of being alive." What role does community play in mental illness, and what role could it play in the future?

Greenberg: It's probably too simplistic to say that one reason we have so many mental disorders is that our communities are fragmented, but in a way it's true. We're isolated from each other and from any transcendent sense of goodness and how we should live. This creates great stress for many people. The political polarization in our society today is another source of stress for many. Conservatives and progressives have radically different ideas about how our communities should be. Nobody's going to win. We've lost track of the fact that we're in this together.

Sherman: You have advocated for the creation of communities for mentally ill people. What would that look like?

Greenberg: Let's just say that, by some unfortunate accident, this whole business of a chemical imbalance is true for some people. It has to be possible. Everything else can go wrong with us — why not that? So let's say we can identify who those people are, which we can't yet. The next question is: What do we do with them?

The impetus behind the asylums of the nineteenth century — at least, some of them — was to provide a safe place for the mentally ill to live out their lives. It didn't work. There was abuse. There was warehousing. People were committed who didn't belong there. There was little attempt to help patients get better. There were all sorts of terrible problems. But I don't see a problem with the basic idea that the mentally ill should have someplace to go and someone to take care of them.

Sherman: What do you worry about the most for the future of psychiatry?

Greenberg: I worry that psychiatrists will remain entrenched and continue to insist that they know things they don't. The biggest problem psychiatry faces is finding a way to admit what it doesn't know without torpedoing the profession. The arguments over revising the DSM, which I chronicled in *The Book of Woe*, were a sign of a profession scrambling to maintain its authority in the face of the obvious weakness of its claims.

Sherman: Psychologist James Hillman critiqued mainstream psychology for being too literal. Do you agree?

Greenberg: Hillman lived through the rise of psychopharmacology and was disturbed by the way that approach to mental suffering eclipsed the transcendent aspects of the self. To focus on brain chemistry was, in his view, to turn away from what makes us human. In the book he coauthored with Michael Ventura, *We've Had a Hundred Years of Psychotherapy — And the World's Getting Worse*, he argued that the mental-health professions had taken a wrong turn when they'd become a branch of medicine.

Sherman: Hillman also felt that therapy's preoccupation with feelings led to a decline in political engagement.

Greenberg: I agree that's a problem, but I'm not sure there's a solution. Almost by definition, therapy must focus on the individual, and that focus is bound to contribute to the hyperindividualism in our society. What I think therapists can do is ask how the larger social dynamics affect the client. We therapists are always choosing which to attend to out of the hundreds of cues a client gives: words, images, stories, gestures, body language, and so on. I think if you studied which cues therapists choose to focus on, you'd find that social factors are low on the list. That's why we have feminist therapy: because the idea that you would attend to sexism as a factor in a mental disorder was so novel it gave rise to its own discipline. It's important to introduce social questions into the therapeutic conversation as often as possible.

Sherman: Hillman said, "The world is in a terrible, sad state, but all we're concerned with is trying to get our selves in order." What's a better reaction, do you think, to the "sad state" of world affairs?

Greenberg: I really have no idea. I once went to New York City to see Laurie Anderson perform *Homeland*, her evisceration of post-9/11 American culture, Wall Street, and the Iraq War. Afterward I walked into the Manhattan evening, where everything her show had been about was apparent, and I wondered why we weren't all just heaving trash cans through shop windows. I guess there will come a point when enough of us will find the conditions of our existence intolerable, and then we will do something. Why it hasn't happened yet, I don't know.

As critical as I am of my own profession, I don't think we can hang this one on psychotherapy. It is not an inherently pacifying force. It can even be an empowering force on an individual level. But in a culture as dedicated as ours is to distraction and disavowal, I don't think we stand a chance of making the changes we need.

Sherman: What are your goals as a psychotherapist?

Greenberg: I want to help people face who they are and figure out what to do about it. This shouldn't be complicated, but there's a lot that gets in the way. We are at least as good at evading ourselves as we are at finding ourselves.

Sherman: Do you see, or have you seen, a therapist yourself?

Greenberg: I've been in and out of therapy a number of times, and I've always found it to be valuable. Even when it didn't seem to help all that much, I still learned something about myself. I will keep the specifics private. There is something sacred about the therapy space, and part of that sacredness hinges on the privacy of it.

I also no longer write about my clients. Using their stories, no matter how well-intentioned I am, is a violation of their trust. And if I disguise them sufficiently — meaning to the extent that they won't recognize themselves — then it's fiction, and I'm lying to the reader. Even for a careful writer, it's almost impossible to convey what actually happens in therapy. *The New York Times* runs a feature called "Couch," in which therapists and patients alike write about their experiences in therapy. Reading it almost always makes me cringe, in part because the authors so often seem to be presenting a trivial personal insight as some kind of universal life lesson. The really valuable part of therapy isn't what you learn about the effects of what your parents did to you, your conflict with your boss, or your broken heart. Freud said that psychoanalysis is a "cure through love," and I think that is essentially correct. The love is conveyed not so much in the content as in the form: the rapt attention of someone who cares enough to interrogate you. The love stows away in the conversation. Most therapy stories simply don't do justice to that phenomenon.

People come to therapy because their life circumstances have somehow disrupted the story they tell themselves about who they are. But even then the healing isn't only about the new story we fashion. It's about the intimacy.

A critique of his ideas & actions.

Zander Sherman
Who Are You Calling Crazy?
Gary Greenberg On How We Define Mental Illness — And How It Defines Us
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