

R. D. Laing and The Politics of Diagnosis

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We live in curious times. Before Sigmund Freud and Carl Jung, no educated person would have regarded a specialist in the mysteries of mental disorder as a preceptor to humanity at large. As the 19th century drew to a close, however, it slowly dawned on some people that the malaise experienced by mad and acutely neurotic individuals was different in degree, rather than in kind, from the suffering of relatively normal people struggling with the constraints and injustices of civilized life. Philosophy, art, literature, and drama all contributed to this emergent cultural awareness. Indeed, they created the climate of opinion that enabled Freud and Jung to become cultural icons.

Many objected strenuously to this fashionable new trend. Many still do. Some cling to an outdated rationalism that attempts to expunge irrationality in all its forms from our concept of the human. Others insist that the boundaries between normals and neurotics are not permeable, but distinct and intelligible to any clear-headed individual, although the authors of the DSM IV freely concede that it is often difficult to impossible to distinguish a disorder from a "non-disorder."

In any case, Freud and Jung heralded the emergence of a new cultural form at the turn of the century; the alienist or "head shrinker" as public intellectual. Although Adler and Rank tried, no doubt, no one else in the mental health professions achieved comparable public stature until the cold war era, when Bruno Bettelheim, Erik Erikson, Erich Fromm, and R. D. Laing became the pre-eminent examples of this new cultural trend. Indeed, by 1970, their fame rivaled or exceeded that of Freud and Jung because they spoke to issues, experiences, and ideals with which young people could readily identify in those turbulent times. Laing's place in this group is quite distinctive, however.

Freud said that neurosis and normality exist on a continuum, and therefore, that normal people succumb to acute neurotic conflict in certain circumstances. This assertion strikes many of us as self-evident, but was once considered a very radical idea. But like his contemporaries, and most of us, Freud thought of *psychotics* as having a very different existence from normals and neurotics . or "normal neurotics," as some prefer to call them. Unlike their more adapted contemporaries, said Freud, psychotics are not amenable to psychoanalysis because they cannot form a "transference," and by implication, a working alliance, with the therapist. Freud was not alone in this respect. Eugen Bleuler, who coined the term "schizophrenia," once remarked that when all was said and done, his patients were stranger to him than the birds in his garden. And in a similar vein, Karl Jaspers argued that an abyss of

understanding separates the schizophrenic from the non-schizophrenic. Echoing Freud, Bleuler and Jaspers, Carl Rogers said that schizophrenics are utterly incapable of forming meaningful human relationships, hinting that they were not merely deficient in this respect, but that they actively repudiate the bonds of human fellowship.

C.G. Jung, a student of both Bleuler and Freud, disagreed. Indeed, his differences with Freud on this point played a small but significant role in the controversies that precipitated Jung's resignation from the Presidency of the International Psychoanalytic Association, and the emergence in Zurich of Analytical Psychology (Hogenson, 1984). Jung believed that psychotherapy with psychotics is not always doomed to failure, and that psychosis represents an existential crisis, an attempt at a radical inner transformation which he termed *metanoia*, a term he borrowed from the New Testament, which is usually translated as "repentance." Being Jewish, and an atheist as well, Freud probably found this usage a bit distasteful, but conceded that the delusions and hallucinations of psychotics often symbolize an abortive attempt at self-cure in "Psychoanalytical Notes Upon An Autobiographical Account of A Case of Paranoia" (1911). But he remained thoroughly skeptical about the prospects of analyzing psychotics successfully . in principle, if not always in practice (Roazen, 2000).

Undeterred by Freud's pessimism, in the 1920s several psychiatrists began to explore the psychotherapy of schizophrenia here in the United States. Adolph Meyer, Richard Kempf, Harry Stack Sullivan, and later, Marguerite Sechehaye, and Frieda-Fromm Reichmann, were the most celebrated and successful. Despite minor differences in theoretical orientation, Sullivan and Fromm-Reichmann both stressed that to do effective therapy with psychotics, the therapist must be able to empathize with their states of mind by drawing on their own "psychotic potential." That means, in effect, that they must be in touch with their own psychotic core, while remaining firmly anchored in reality. This is arduous work at the best of times, and well beyond the capacity of the average psychiatrist or psychoanalyst. Coping with anguish, confusion and despair that intense, that annihilating, and doing it routinely, is more than most people . and most therapists, however dedicated and well-intentioned . can bear.

Ronald David Laing was cut from the same cloth as Sullivan, Sechehaye and Fromm-Reichmann. Born in 1927, he was raised and educated in Glasgow, and apprenticed in psychiatry in the British Army during the Korean war. In 1951, while stationed at the Royal Victoria Hospital at Netley, Laing read Sullivan, Fromm-Reichmann and Sechehaye with keen interest. There, and again at Catterick Military Hospital (Yorkshire), where he was stationed from 1952 to 1953, Laing spent as much time as possible in padded cells with the men placed in his custody. This kind of intensive immersion in the schizophrenic life-world was unheard of at the time. He found that

with enough patience and persistence he could eventually get on their wave length, and make sense of the peculiar speech and gestures that his colleagues found completely unintelligible (Laing, 1985).

When Laing left the British Army in 1953, he conducted similar experiments in civilian hospitals at Gartnavel and Southern General Hospital in Scotland, where his patients were generally women, for almost three years. Then in 1956, he set out for London, where he worked as a Registrar at the Tavistock Clinic, and trained at The Institute for Psycho-Analysis. Charles Rycroft was his training analyst, while D.W. Winnicott and Marion Milner were his clinical supervisors (Burston, 1996, chapter 3). Significantly, however, Laing was profoundly disenchanted with most analysts. closed-minded and dogmatic world-views, and their derogatory attitude toward psychotics (Burston, 1996, 2000). The Freudians and Kleinians in London, for their part, did not trust Laing because he committed the cardinal sin of taking Jung's notion of *metanoia* seriously. This was not yet evident in 1960, when he published *The Divided Self*. But it was vividly apparent in *The Politics of Experience*, published in 1967.

According to some critics, *The Divided Self* is Laing's best book. It attempted to make the process of going mad intelligible to ordinary people. Although couched in the idioms of existential-phenomenology, and quite critical of psychiatry and psychoanalysis, *The Divided Self* was relatively "low-key" in its criticism of mainstream society and politics. By contrast, *The Politics of Experience*, written in the midst of the Vietnam War, bristled with angry denunciations of psychiatry and psychoanalysis, of capitalism and imperialism, of family piety, schools and universities, and so on.

In between *The Divided Self* and *The Politics of Experience*, Laing published *Sanity, Madness and the Family* with Aaron Esterson (1964), *Reason and Violence* with David Cooper (1964) and *Interpersonal Perception*, with Phillipson and Lee (1966). Along with Esterson, Cooper and various friends and co-workers, Laing founded the Philadelphia Association, which he chaired from 1965 till 1982. The Philadelphia Association is chiefly a psychotherapy training organization now. But its original mandate was primarily the creation of therapeutic households or "safe houses" where disturbed individuals could undergo a metanoic journey free from the useless labels and coercive practices of mainstream psychiatry (Burston, 1996, chapter 4). Their most famous experiment, Kingsley Hall, ran from 1964 till 1970.

Nestled in the heart of London's east end, Kingsley Hall was a meeting place whose function and leadership were seldom clearly defined. It hosted training seminars, fundraising events and informal meetings with luminaries from the mental health field, new-left activists, rock stars, artists, writers and others. Some people reveled in

the alternating currents of carnival and of deep anger and confusion that animated the place. Others were shocked and dismayed. Other therapeutic households that followed it were less chaotic, and less accessible to the avid crowds of hippies, thrill seekers and celebrities who thronged to Kingsley Hall. As places of healing, they actually fared better, as a rule (Burston, 2000, chapter 4).

In any case, by 1969, Kingsley Hall and *The Politics of Experience* had gleaned so much media attention that they transformed Laing from a medium-size British celebrity, and the darling of the British left and artistic avant garde, into an international celebrity on a par with Sartre or Marshall McLuhan. It also conveyed the mistaken impression that Laing was positioning himself to assume some sort of leadership role in the anti-Vietnam, pro-disarmament, and counter-cultural movements, or indeed, had already done so.

This was not the case, however. In 1968 Laing became deeply disenchanted with leftist politics, and began divesting himself of political commitments and affiliations, turning inward, to Yoga and meditation, and fostering the proliferating network of therapeutic households the Philadelphia Association had by now created. Nevertheless, *The Politics of Experience* continued to sell, conveying to the world an image of an angry, politicized Laing that was already somewhat discrepant with the mellower, more retiring and essentially a-political person he was trying to become.

Fed up with the limelight, in 1970, Laing left for India and Ceylon, where he studied Buddhist mediation and Shiviite Yoga for 18 months. He returned a changed man. Unlike his former, angrier, radical self, the new R.D. Laing now enjoined a kind of gentle, Buddhist austerity as the best path to liberation, and expressed a great skepticism about the left's agenda and methods (Burston, 1996, chapter 5). Moreover, he no longer condemned the nuclear family or the use of psychotropic medication as a treatment of last resort, provided these drugs were taken voluntarily, with the patient's informed consent. He remained categorically opposed to electroshock and involuntary psychiatric treatment, and eager to explore alternatives to psychiatry. But he now rejected the "anti-psychiatry" label that others had placed on him, and made several conciliatory gestures toward his estranged psychiatric colleagues.

But Laing was not the only one who changed. In his absence, the world had changed too. When Laing returned from India, the Philadelphia Association was in turmoil, and many former colleagues who left the organization, like David Cooper, Aaron Esterson, Morton Schatzman and Joseph Berke, had published books and acquired followings of their own. Moreover, many old allies on the left who were wounded or puzzled by his retreat to Asian mysticism now turned on him. In the mental health field, for example, Peter Sedgwick, Joel Kovel, Giles Deleuze and Felix Guattari vigorously denounced him. And they were joined by a growing chorus of ambivalent

appraisals and abrupt dismissals by prominent feminists like Juliett Mitchell, Phyllis Chesler, Elaine Showalter, and others.

Despite the boos and brickbats of the early and mid-seventies, Laing retained some of his old cache, and could still draw a crowd almost anywhere he chose. But his creativity faltered, and his main book in the seventies, *The Facts of Life*, was a disappointing flop, commercially speaking, that alienated even many loyal fans. By the late seventies, the Left had truly and completely taken its leave of him, and the universities of the Anglo-American world were inundated by the wave of new French theory embodied in the works of Bachelard, Baudrillard, Deleuze and Guattari, Derrida, Foucault, Jacques Lacan, Lyotard, as well as feminist-Freudians (and anti-Freudians) like Kristeva, Cixous and Irigeray, and so on. They buried Laing -- in the universities, at any rate. And curiously enough, Laing played a significant role in facilitating this new trend to the English-speaking world.

In 1961, with the help of David Cooper, Laing edited the first English translation of Foucault's *Madness and Civilization* in a Tavistock series entitled "Studies and Existentialism and Phenomenology." Foucault had divorced himself from phenomenology some five years earlier, but Laing stubbornly insisted on regarding him as a phenomenologist (e.g. Laing, 1985, 1987). Laing's regard for Foucault never wavered (Laing, A., 1994). Indeed, Laing wept openly at the news of his death (see Hanja Kochansky, in Mullan, 1997).

Unfortunately, Laing's esteem for Foucault was never quite reciprocated. In 1975, when they finally met, Foucault's courtesy toward Laing was strained and ironic, and he seemed to regard Laing as an irrelevant has-been. That is certainly how most of his compatriots viewed him. Laing was no longer fashionable, and he knew it. And in all likelihood, though he seldom said so, he probably suffered from nagging doubts about the viability of the therapeutic communities he founded with the Philadelphia Association. Some were a singular success. But many floundered or folded, leaving a legacy of bitterness and disillusionment behind them.

In any case, in the late seventies, Laing entered what might be construed as a protracted mid-life crisis. His second marriage had deteriorated, he suffered from chronic writer's block, and almost abandoned his once flourishing private practice in favor of group marathons based on improbable ideas about birth traumas and intrauterine experience. Meanwhile, every rumor and breath of scandal that emanated from his circle and his increasingly turbulent life was circulating freely -- including the deathless rumor that he had finally "flipped out." As it happens, he did not, though his personal conduct and public appearances became more volatile and erratic, and many people had more trouble distinguishing between Laing the skeptic, scholar and psychotherapist and Laing the cynic, sybarite and publicity hound. His attempts at re-

packaging himself as a lay preacher, poet, and producer of movies and musicals during the late 70's only deepened that confusion. Worse still, his frequent lapses into silliness, sadism and self-aggrandizement shortly before and after his second divorce in 1984 were used to discredit the ideas and causes he championed (Burston, 1996, chapter 6).

In the books and papers that appeared between 1976 and his untimely death in 1989, one sometimes saw flashes of the old brilliance. But by the time he recovered his footing, more or less, his health was failing fast. Shortly before Laing's death, Andrew Feldmar and Kirk Tougas in Vancouver released a video entitled "Did You Used to Be R. D. Laing?" documenting a group co-run by Laing and Feldmar in the spring of '87. The title of the video was culled from a question addressed to Laing by someone vaguely familiar with his work or reputation who probably thought he was already dead -- another widespread rumor at the time.

Although nonsensical on the face of it, the question "Did you used to be R.D. Laing?" can be construed as a covert statement. In effect, the questioner was saying: "I suspect that you are someone who used to *be* somebody." In other words: "Hey man, you're history!" And indeed he was, in most people's estimation. Mention Laing nowadays and most people can dimly conjure up a flamboyant rebel of the psychedelic era, a chum of Tim Leary, Ram Dass, and Allen Ginsburg -- which he was, of course, off and on. But press them to describe what he stood for, what he actually thought or said, and you'll only elicit a trickle of platitudinous sound bites, proving that serious reflection on his work has virtually halted. The lasting fame that Freud and Jung achieved, and that some predicted for Laing, eluded him, and the recent stream of books about him, (my own included), have done nothing to change that.

My first book on Laing, *The Wing of Madness*, appeared in 1996, and since then many people have asked me why Laing's credibility declined so dramatically over the years. By way of a reply I generally rattle on about his internal contradictions, his inability to follow through and finish his various projects, his flamboyant and provocative gestures, and so on. All true, up to a point. Laing must shoulder some of the responsibility for his current neglect -- something he was apparently unwilling or unable to do. But on further reflection, the reasons for his brief fame and rapid decline are much more complex, and have less to do with his enigmatic personality than with changing climates of opinion. Let me explain.

The Divided Self was published in 1960. At the time, and for another decade afterwards, psychiatry had little evidence to support -- much less prove -- the view that schizophrenia is basically a neurological disorder. Indeed, many critics -- including many psychiatrists -- freely concede that the extant theories of schizophrenia (and evidence in their support) were astonishingly flimsy at the time.

That being so, Laing's eloquent appeal to treat the schizophrenic as an anguished, despairing person, rather than a bundle of irksome neuropathology, struck a deep and responsive chord in and out of the mental health field, particularly in view of the coercive atmosphere, and the pervasive apathy, anonymity and indifference of most mental hospitals, and the horrifying side-effects of drugs, lobotomy and electroshock.

Since the mid-seventies, however, numerous breakthroughs in the brain-imaging field demonstrate that there are significant correlations between certain varieties of brain disorders and certain schizophrenic symptoms. A clear cut etiology for any single form of schizophrenia is still quite elusive, but the newer drugs and psychosurgical techniques are more effective and less disabling or disfiguring than their predecessors. So there is progress of a sort going on here.

But even now, despite manifold improvements, compliance rates among diagnosed schizophrenics in the United States are still quite low -- as low as 20%, by some estimates. That means that about 80% of mental patients do not take their medication as prescribed; some take it episodically, and some not at all. This says something about the culture of psychiatry, and the pervasive mistrust that has grown up among psychiatric patients (and ex-patients). Beyond the self-serving rejoinder that patients mistrust psychiatrists (and therefore do not comply) because they are "ill" or "incompetent," what else may account for this striking climate of non-compliance, psychologically speaking?

This brings us to a very peculiar problem. For reasons that are not yet clear, some people are actually quite relieved when they are told that their anguish, confusion and despair, their sense of helplessness, futility and self-loathing, and so on, are simply the by-products of neurological dysfunction. This verdict gives them palpable hope for improvement, and they are only too glad to tinker with dosages and to try new medications till the right one materializes, eventually. For these people, the loss of dignity, of self-command and of hope that they suffer while symptomatic are viewed as temporary setbacks, to be conveniently erased when their neurological integrity is restored, more or less. Patients like this are a boon to biological psychiatry -- their greatest, most grateful and most loyal fans, who are not easily disappointed or deterred by mishaps or mistreatment of one sort or another.

Other patients are averse to this whole approach. They feel that this way of construing things trivializes and demeans them, that it defines and deforms their experience in ways that are at variance with their deepest, though often groping and inarticulate sense of who they *really* are. Whether they know it or not, people like these are often looking for something akin to a religious experience as a solution to their difficulties - an new experience or a fresh perspective that will elicit or confer deeper meaning on their suffering, giving it some ennobling *raison d'être*, assuring them it is actually *in*

aid of something. It doesn't take much insight to see why. They feel that their lives have been hijacked or derailed somehow. They don't just want their suffering to *stop*, or to see some light at the end of the tunnel. They desperately want that tunnel to be a necessary rite of passage to a new and better place than the one they left behind, one which they are loathe to return to.

In addition to patients (or prospective patients) like these, there are people who shun conventional psychiatric remedies because they feel shattered by the blows of life, and look to the psychotherapist to address their deep sense of victimization at the hands of others, to enable them to clarify and cope with it more satisfactorily than they can at present. If the psychiatrist isn't listening, or isn't helpful in this respect, they will not stay the course.

Finally, many candidates for a psychiatric diagnosis have *both of* the aforementioned tendencies in extremely pronounced form. Being told that what they feel or experience is purely the result of a disordered brain is quite distressing for them, and prompts deeper self-doubt and/or distrust of others. In Laing's terminology, they feel "invalidated" by a summary appraisal like this, and fear that their mental-health worker is colluding with all the others who neglect or oppress them, despite their overt or conscious intentions. Rightly or wrongly, then, they are likely to experience the standard treatment approach as disrespectful and coercive, and they've had quite enough of that already, thank you very much. As a result, they are far more likely to go astray with conventional psychiatric treatment. And their numbers are legion.

Laing drew attention to these and other features of work-a-day psychiatry long ago, but many things have changed since *The Politics of Experience* created such a sensation. The general public isn't as moved by the plight of these people as they were in Laing's day. And though Laing was far more effective with people like these than the average clinician in a one-on-one setting, he never developed a workable alternative to the conventional mental hospital. In the absence of such an alternative, people in distress are inclined to rely on the devil they know. Besides, really good psychotherapy is time and labor intensive. It requires a substantial emotional investment from the therapist as well as the patient. It is not cheap and not fast, and in the recent climate of fiscal restraint we want a quick fix: something clean and cost-effective, not messy and time consuming.

OK. But let's not kid ourselves. These new drug treatments do not work for everyone, not even those who *do* comply with their physician's advice. And while drug companies minimize their side-effects -- they always do -- their long term repercussions may come back to haunt those whose treatment was "successful" in the first instance.

Another reason Laing is neglected now is that we are weary of the culture of victimization. And rightly so. We are all so frightfully fed up with people making lurid careers of their victimization that we try to ignore them, and in our state of numbed inattention, we need to be reminded of how nauseated we actually are by this cultural state of affairs. Only a lucid appreciation of our impatience and disgust enables us to distance ourselves from these almost reflexive feelings sufficiently so that we may remember that many mental patients really *are* profoundly victimized by those who claim to be their nearest and dearest, and that they often have no form of redress, and no way of explaining or calling attention to themselves. Even when they do have the means, they often lack the ability to make themselves heard, because life has robbed them of the confidence and clarity they need to address us on *our* terms, and in a language *we* readily understand. The most that many of them can manage, finally, is to let their symptoms do the talking, and hope vainly that someone, somewhere will "hear" their strange, disembodied voices.

This is a hard nut to swallow. Most mental health professionals are trained to believe that diagnosis entails the accurate identification of a disease entity or some discrete form of psychopathology situated in the body, brain or unconscious of the patient/client. The corollary assumption at work here is that until the disorder in question is correctly diagnosed, an appropriate treatment cannot be prescribed. However, Laing argued that labeling the individual often has little to do with accurate assessment of the patient's real problems, and that the remedial interventions mandated by a specific diagnosis often serve complex *social* functions by equilibrating extant social-systems, i.e. maintaining the status quo. In short, clinicians frequently locate the cause of the disturbance in individuals to divert attention from the processes that actually engendered their disturbed behavior. If they did not, they would often construe the "signs and symptoms" of these diagnostic entities as intelligible responses to what Laing termed "unlivable situations" -- ones which the patient can neither understand, nor tolerate, nor change effectively.

Laing often told a story about a weeping mother who came to inquire about her teenage son, "Julian," who had just been diagnosed schizophrenic. She would spare no expense to avoid the standard psychiatric zombification doled out to troubled teenagers like him. When asked about the initial onset of Julian's problems, she said that some months previously, he started to insist that the man his mother married was not his real father. That was only the beginning, unfortunately. Soon other delusional fantasies, charges of conspiracy and deception, appeared. But this was the central or core complaint, which he never relinquished, and which was driving her and her husband to distraction.

After seeing the boy once, Laing informed the mother that he might be able to help her son if she would level with him. *Was* her husband truly the boy's father? After

beating around the bush, the mother finally confessed that he wasn't. In fact, Julian was conceived during a premarital fling she had hidden from her husband all these years. Laing then informed the mother that he could not help her or her son unless she was honest with herself and her husband about his real paternity. So long as she and her husband construed his suspicions as delusional, Laing noted, the psychiatrists she engaged to treat Julian would act as unwitting but thoroughly obliging accomplices to a sustained family cover-up. At some cost to herself, no doubt, the mother eventually leveled with her son and her husband, and in a few months, the boy was back to normal.

Cases like these, which were not uncommon in Laing's practice, suggest that there is often much literal as well as symbolic truth in the (real or alleged) delusions of schizophrenics, and that an honest attempt to discern and to validate those truths may be indispensable, therapeutically speaking. It also indicates that people who are deeply disturbed and disturbing to others need not be suffering from brain damage or the ravages of repression, regression and/or other specifically internal disturbances. They may be reeling from the effects of what Laing termed *interpersonal defenses*, which are subtle, silent and usually unconscious tactics designed to silence and/or discredit a prospective patient who may very well recover his or her sanity when these collective defenses are exposed. Far from being an act or expression of medical *gnosis* -- or of "knowledge," as the Greek roots suggest -- the act of diagnosing may be the perfect cover for ignorance, perhaps willful ignorance: a way of *not* knowing the patient, as Laing would say.

In such circumstances, the treatment patients receive, however well intended, often compounds the damage they've suffered, rather than reversing it. And this is especially so when the diagnosis of schizophrenia -- or some other grave mental disorder -- is rendered in ignorance of the deeper levels of the patient's experience and social surround.

Endnotes

For more on Laing the DSM, see "R. D. Laing in Austria," by Theodor Itten, below, p. 69, and "Classification and the Treatment of the Patient," part 2, p. 191.

2 For more on the origins and development of the Philadelphia Association, see "Remembering Ronnie: a three way conversation," below, p. 29.

3 For a frank discussion of the damage wrought by all the publicity and hoopla that surrounded Laing, see "Remembering Ronnie: a three way conversation," below, p. 29.

4 For more on this point, see "Classification and the Treatment of the Patient," part 2, p. 191.

5 For more on this point, see "The Case of Edgar," part 2, p. 214.

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