On the Legacy of Ronald Laing

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At the outset, I think it is important to state that we need to maintain humility in the face of "schizophrenia." That is because it always manages to elude us. I recognise that many of my psychiatric colleagues were engaged, as I was, in scientific research on mental illness. Ever since the discovery of *Dementia Paralytica*, we have been searching similar explanations for schizophrenia (*Dementia Praecox*), in fact for its organic cause. However, it is frustrating to report that, after nearly a century of research, we have found no strong correlations that "pin down" such mental illnesses within a neurophysiological framework. Insanity, just like the mental patient, is elusive to our understanding. Within this context, I want to talk about the work of a colleague and friend, Ronald Laing, who abandoned quantitative research into mental illnesses in favour of qualitative research. He attempted a kind of phenomenology of madness in an effort to express what it. s like to have a mental illness. His aim was to recognise within the "patient" the problems of living in the light of the existential paradoxes that are common to humanity.

I want to talk about what Ronald Laing has left to us and I would like to avoid some of the biographical scandal that surrounded him during his life. Laing was the guru of the abandoned, rejected, depressed and lonely. He seemed deliberately to court high publicity and, as a shamanic leader of the sixties, could indulge in some of the most outrageous antics, usually involving sex and drugs. The period in which he wrote may be encapsulated in the popular slogan: "Don't change your mind, there. s a fault in reality." That disturbed the classical psychiatrist who couldn. t understand it. Surely reality is reality? Reality for Laing, though, referred to human despair, loneliness, insecurity and fear of the other. However, I wish to avoid the glare of scandal, even though it may be attractive, and dwell a little on the philosophical basis of Laing's thought in order to outline the major achievements and limitations of his own *Weltanschauung*. I also wish to explain the impact he had on my life.

My first introduction to the work of R. D. Laing was, typically enough, through some of my patients. It was typical in that I have learnt most of what I value in my working life through those people who were called my patients. They came to me with a book called *The Divided Self*. They encouraged me to read it. They told me that if I wanted to understand them, then here was a writer who had an inkling of what it was like to be mad. I must explain that at this time I was a profoundly scientific psychiatrist, engaged on highly respected research on the production of hormones in manic depressives and other patients who had a regular cycle of psychoses. But, at the same time, I was scientific enough to be open-minded and was willing to read anything that

might help me understand my patients and enable me to engage with them. This always seems to be the greatest difficulty for psychiatrists' engaging with people who are so highly defended that little seems to touch them.

I must be honest and say that reading *The Divided Self* was not an experience comparable to walking on the road to Damascus. But I can point to it and say that it was one of the influences that gradually changed my position, from being a physical scientist to a humanist thinker, when considering the problems of psychiatry. This was an influence that continued in my few meetings with Ronald Laing and further reading of his works. I was flattered that he said I was the only neuropsychiatrist with whom he could discuss.

But my first reaction to reading *The Divided Self* was, I think I have to confess, to find it a curious work. For it began with a completely new perspective for the psychiatrist. Our perspective, at the sharper end of psychiatric illness, usually dealing with psychosis was not to expect to understand the psychiatric patient. Indeed from Jaspers onward one of the characterising definitions of psychosis was that it was impossible to understand what the patient was saying. Thus every psychiatrist in the Western World would be bemused by the philosophical curiosities that could be found in their patients' discourse, but would not even try to attempt to understand them. They would try to treat them, with concern and understanding and would try to end the disruptions and broken relationships that the "illness" seemed to cause. But understanding a patient was like throwing away the book of signs and symptoms. It seemed unthinkable. After all, psychiatrists need their own defences and barriers.

But here at the beginning of *The Divided Self*, Laing analyses the words of one of Kraepelin's patients and begins to make sense of his utterances. It is not possible, says Laing, to see a patient as a bundle of symptoms or as an organism *and* to understand his existential position. The human being is a relating being made of I and thou (thus acknowledging his debt to Buber) and if he is treated as a separate mental apparatus he can then only be treated as the object or the *it* of the psychiatrist's medical concerns. If we try to understand the existential phenomenology of the person termed schizophrenic, it is no help to relate to the barriers he has put up to the world or within himself, with further barriers. Thus if someone describes himself as dead, he may be describing the truth of his existence as he experiences it. But this will not be acceptable to most psychiatrists. It is difficult, says Laing, to recognize the schizophrenic's "despairing aloneness and isolation" (Laing, 1965: 17).

Here Laing makes reference to the existential philosopher Kierkegaard and I think it is worth pausing for a moment to consider the contribution of Kierkegaard to Laing's philosophy. Indeed, it is important to recognise that Laing's ideas did not form as the result of some intellectual immaculate conception, they come from a long tradition

and culture of existential thought and European humanist philosophy. In Kierkegaard's work we see that the "self" is seen as a relationship: the relationship of a person to him or herself. Thus our despair, which according to Kierkegaard most of us spend much of our time avoiding, is not being able to accept ourselves, wishing to get rid of ourselves. This despair is like a living death:

> Despair is the sickness unto death, this tormenting contradiction, this sickness in the self; eternally to die, to die and yet not to die, to die death itself. For to die means that it is all over, while to die death itself means to live to experience dying . . . despair is exactly a consumption of the *self*, but an impotent self-consumption not capable of doing what it wants. But what it wants is to consume itself, which it cannot do, and this impotence is a new form of self-consumption, but in which despair is once again incapable of doing what it wants, to consume itself. This is a heightening of despair, or the law for the heightening of despair. This is the hot incitement or the cold fire in despair, this incessantly inward gnawing, deeper and deeper in impotent self-consumption. Far from its being any comfort to the despairer that the despair doesn't consume him, on the contrary this comfort is just what torments him; this is the very thing that keeps the sore alive and life in the sore. For what he- not despaired but- despairs over is precisely this; that he cannot consume himself, cannot be rid of himself, cannot become nothing. (48-9)

Laing describes this sense of internal division in terms of ontological insecurity, which is a sensation of easily being able to lose oneself, of not experiencing continuity of self as a single and separate being. This seems to show itself in two opposite ways either through isolation as though others are either going to engulf or literally petrify one, or to clamp on to somebody else, limpet-like and to let the other person define one. s personality. This can work well for a time but, normally a breach in this defence shows itself through separation and the original anxiety returns. As Laing sets out his explanation of ontological insecurity he sweepingly denies that any concept of the unconscious is going to help us. In this he keeps company with Sartre. There seem to be no sexual desires compelling the anxiety (as in Freudian theories). The greatest desire (and fear) which these patients demonstrate is their desire to be, or to cover up their lack-of-being with someone else's personality. This desire is hardly unconscious.

But what, we may ask, is the cause of this insecurity of existence? At this point in time, Laing gives us many clues but no answers. One patient who complained of a "vague but intense fear" attached this feeling to the fear of her parents. Nothing she could do was right for them. "If she did one thing and was told it as wrong, she would do another thing and would find that they still said that that was wrong. She was

unable to discover, as she put it - what they wanted me to be" (1964: 56). However, Laing still sees this information as the phantasies of his patient's parents.

Another patient did not complain of her parents' cruel treatment of her, but felt rather that her parents did not notice her. She spent the rest of her life trying to be significant to someone, which she could never be because she wasn't anyone to begin with. For this woman, as Laing puts it (following Berkeley), *esse* was *percipi*; (to be was to be observed), she had to be seen in order to feel she existed. If she looked in the mirror she was frightened that there was no-one there. Here we may see the importance for the child of being noticed, of being seen. We may also note the crucial effects of indifference on a child's development.

But how does a child survive in such a difficult situation? Here we come to one of Laing's key (but, as I will explain, flawed) theories, heavily influenced by the existential theory of the true and false self. Laing believed that any child growing up in difficult circumstances will construct a false self system as he is too frightened to reveal his true self to his parents. In such circumstances the child will seem extraordinarily well behaved or "as good as gold." Underneath this mask there may be the protoorganisation of the "real" self but this is something that the person will not test out with his parents because he is afraid of his parents' reaction. Thus the child hides his true self in order to protect it.

Now, of course this notion of true and false self owes much to Sartre's ideas on bad faith in *Being and Nothingness* (Sartre, and, perhaps, even more to Heidegger's ideas of "authenticity" in the face of the knowledge of our death in *Being and Time*). But it does seem to be an extremely difficult and unwieldy concept. Nowadays we would find it more than difficult to discover what a "true" self is as we all have to live through negotiating compromises with others.

I would suggest that a more happy formulation would be a dichotomy between the "compliant" self and the "complicit" self. The compliant self only complies with his surroundings; he does not negotiate with them. Underneath this compliance of course may be a very rebellious self that brooks no contradictions. Unhappily, this total rebellion usually reveals itself as madness. But the complicit self works in a completely different way. The complicit self will work within the rules of an organisation in order to get the best out of it (even a Marxist like Lenin saw the pragmatic virtues of having to fit in) and does not necessarily feel that he is losing himself if he does have to compromise. Unfortunately, as Binswanger noted, the compliant self seems to recognise only "either/or" in the situation- either victory or defeat. However, the complicit self will play the rules of the game and will to some extent compromise on objectives in order to achieve the maximum success possible within any human situation.

Laing's analyst, D. W. Winnicott, also developed a theory of a "true self/false self" organisation within the personality. I don't wish to give precedence to any of these ideas, I am simply trying to explain the *Zeitgeist* from which Laing's ideas developed. If we understand the tradition from which Laing emerged, we can understand him as part of a developing movement within psychoanalysis and not as the lonely genius/iconoclast as he was portrayed, particularly by his enemies. Winnicott's formulation of the true/false dichotomy, owing just as much, I believe, to Heidegger's ideas of authenticity, were in some sense more dialectical and less romantic, in that he recognised that we all have to develop a persona in order to negotiate with others through the difficulties of life.[1] Indeed, by persuading a child to say "Thank you" before he is ready to feel gratitude, we make young hypocrites of the new generation.

There is one case in Laing's work, *The Divided Self*, which I found particularly expressive. It concerns a patient who Laing names - Peter- who suffered from the delusion that he stank, that his body gave off a noisome and noxious smell to himself and to others. Once again, as a child, Peter did not suffer from overtly cruel treatment. But his mother did not seem to see him. His only acknowledgment from his father was being called "a big lump of dough" which seems to be a euphemism for being called a "big lump of dung." As he grew up, this patient felt guilty for existing and tried to maintain a high-wire act of not existing and yet of "going through the motions" with other people. He came to understand his "smell" as an expression of having died and rotted within. We must recognise these life and death issues in psychiatry.

Having read *The Divided Self* I wanted to make contact with Ronnie Laing, because I suppose I was suffering from my own divisions. I was a reasonably successful research psychiatrist, profoundly chemical in my research outlook but at the same time I enjoyed existential philosophy. Thus I was bemused to find a psychiatrist who could employ existential philosophy to explain otherwise inexplicable symptoms. There then followed a friendship and an interchange of views that I think I can claim was mutually useful. At this time Laing had been shunned by the mainstream of psychiatry and, however rebellious he was, I think he enjoyed being able to discuss and argue and test out his views with a colleague from a very different persuasion. In fact, he never, in our arguments dismissed the scientific researches that I and many of my colleagues were engaged in. He only asked that our ideas be treated as scientific hypotheses yet to be proven, which of course, they have not yet been. I also found Ronald Laing to be quite helpful and critical when discussing our relationships with patients. As I described to him the way in which I tried to be friendly, kind and considerate to my patients he warned me to remember the superiority of my position as Professor. He said I was like an Admiral with all the ribbons and badges of office who tells an ordinary sailor in bell-bottoms to have a cigarette and talk "man to man."

It was a useful warning and helped me in my attempts to be less patronising to my patients.

Thereafter Laing worked a lot with Bateson, the famous anthropologist and psychologist who coined the "Double Bind" theory, and the therapists and psychologists working with Bateson and family therapy, including Haley and Searles. Thus more and more, Laing worked upon a theory of schizophrenia as a rational expression of the way that so-called schizophrenics were treated by their group. He noticed that in certain ways they seemed to be driven mad or that the patient's madness seemed to be a particularly heightened expression of the dysfunction of the families they were in. For this insanity of communication Laing, with his colleague Esterson, used terms such as "untenable situations" for those moments where an adolescent was expected to be independent but in an environment that was highly controlled by one or more members of the family. Although Laing was criticized for "blaming the parents" he was trying to show that madness did not only arise within the individual, but arose as part of a social mechanism. But this is a part of his work that I believe is under elaborated.

And here, it is important to recognise the limitations of Laing's work and ideas which I think can be best exemplified by his establishing of a community for schizophrenics and those suffering psychotic breakdowns in a place called "Kingsley Hall." In many ways it was a brave and exciting adventure. It was true to the experiment of "anti-psychiatry," a term which Laing rejected, but which refers to the belief that psychiatry did more harm than good and that simply to remove the medical hierarchy and conditions would, at least, do less harm to the patients, than sending them to a psychiatric clinic. Kingsley Hall, for a few years, became a kind of *centre* for the alternative culture where theatre groups, writers, musicians, and artists could visit. But, like many other communal projects of this era, the energy dissipated after a few years and Laing's interests moved elsewhere. And this is where, in particular, I want to draw attention to Laing's less impressive achievements. For Laing, unlike Basaglia of Italy, did not have a social context within which to understand the difficulties of the mad and therefore, working co-operatives, involving people in practical projects, did not become part of his vision. Unfortunately, we have come to know that Laing blocked the translation of Basaglia's work into english and this rejection also represents a great *lacuna* in Laing's theories.

While Basaglia pursued a social and political strategy with the aim of returning the problems of society back to the society which engendered them (Basaglia, 1985: 51), Laing, for the most part, ignored social policy and thus could not bridge the gap between individual and universal. In fact, his understanding of the schizophrenic always veered between the personal and the mystical and there was little room for a practical social policy of involving mental patients in our society. Although Kingsley

Hall had some spectacular "cures" for its inmates (notably Mary Barnes with Joseph Berke) we have to admit that even for Laing, "cures" of schizophrenics were few and far between, and he, like the rest of us, achieved limited practical success in helping people live with their problems. In fact, Laing, in a later work, poses our problem very clearly:

> If a violinist in an orchestra is out of tune and does not hear it, and does not believe it, and will not retire and insists on taking his seat and playing at all rehearsals and concerts and ruining the music, what can be done? If all persuasion fails, is there anything else to do than to have him or her removed, by physical force, against his or her will. . . ? (Laing, 1986: 3)

For this is the difficulty of *our* situation. If I am honest, which perhaps I can afford to be now I am retired, I have cured very few people of schizophrenia and those people who got well under my care and seemed to improve their own lives (or as we say "get better") recovered often almost spontaneously or as a result of life events. Certainly, I could not pin down any improvement to something I had done. In the same way, apart from the notorious stories, Ronald Laing effected very few cures. But perhaps the very word "cure" coming from our medical model leads us back into the old traps. I think we have to recognise and respect the mental patient's difference and distinctness and respect his need to maintain his separateness. Then all we can do is "invite him to the table" and ask him to communicate with us. Even if to admit this is to confess to our own impotence, we must recognise that an individual's willingness to engage with us and with our society must remain his own responsibility and choice.

Endnotes

[1] *[Editor:* Actually, so did Laing. Laing, however, noted that the "false self" of the normal ontologically secure person can be shed, and therefore does not preclude authentic self disclosure (in essence, real intimacy) in favorable circumstances. D.B.]

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