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Knotted:
R. D. Laing and Psychiatry

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Abstract

This paper focuses on R. D. Laing's published views on mental illness and the theme of clinicism within psychotherapy. It argues that Laing consistently avoided confronting the question 'Does mental illness exist?' and leaves the reader uncertain as to what his position is. It argues his position is less clear than is generally supposed, and considerably less clear than that of Thomas Szasz, for whom mental illness does not exist and whose position the author believes to be correct.

Key Words

R. D. Laing, clinical bias, mental illness, 'schizophrenia', process and praxis, agency, existential analysis, Thomas Szasz.

Introduction

To date, one author in this journal has written a personal account of an existential psychotherapist in training beginning to question, reflect upon, and give up entirely, his belief in the existence of 'mental illness' and its corollary, 'mental health' (see Bull, 2013). The author of this original paper chose to focus on his efforts whilst in training, at making sense of the difficulties which his own diagnosis entailed, and his attempt through further hard work and persistence to get out of the unexamined clinical bias that prior to training he had been trapped within. He gives only brief mention, however, to the professional dimension of training. His on-going practice as a psychotherapist and his intention to practice with persons similarly diagnosed are left untouched. He thus misses an opportunity to show how his personal insights informed professional practice.

More often than not, an individual will train as a psychotherapist primarily to understand something fundamental about himself. Usually it is related to family life and part of a quest for personal fulfilment. However, if this personal project includes making sense of involvement with psychiatry, it seems to me that a trainee must first demystify psychiatry if he is to achieve true professional as well as personal fulfilment.

R. D. Laing is one existential psychotherapist who addresses the topic of mental illness. But the legacy which he has left behind contains a high degree of confusion on this topic. Despite his influence, and - as I shall try to show in this paper - to a significant extent because of his influence, the notion of mental illness, the language

of mental illness and the presumption of non-responsibility it entails continue to be passed down from generation to generation of psychotherapists.

Clinical Non-Responsibility

The literature on psychoanalysis from Freud on is ambivalent as to whether psychoanalysis is a medical discipline. One would hope that analysts would be sufficiently aware that to make an assumption of illness would be seen by them as irrational. However, nowhere that I can find is the prior assumption of illness expressed as an example of countertransference. Yet this is a privilege given to most unexamined assumptions which hinder the professional life of a psychoanalyst and remain despite personal analysis. A 'full analysis' does not appear to include analysis of this habitual deception about the true nature of illness.

What can be found instead are references to 'the clinic', 'clinical work', 'clinical skills', 'clinical thinking/opinion' and 'clinical assessment' by 'clinicians'. If an author cannot make either a scholarly or a personal point about his work he may say that 'clinical experience' tells him/dictates to him his conclusion (see in particular Schwarz, 2005). In state-funded settings where time and resources are limited, if 'clinical assessment' and 'clinical opinion' have not provided a successful 'clinical outcome', 'clinical need' is appealed to if further sessions are to be granted, not the expressed need of the client or therapist. Thus, a third force emerges at points where responsibility stops, leaving the non-clinical challenge implicit in Laing and Esterson's (1970 [1964]: 27) statement unmet:

'We believe that the shift in point of view that these descriptions both embody and demand has a historical significance no less radical than the shift from a demonological to a clinical viewpoint three hundred years ago'.

Mis-behaviour and Mis-experience

When therapist and client are pickled in the unexamined false assumption that human behaviour is a medical problem, it is common for both to talk as if 'brains' and 'persons' are interchangeable. An example of this fusing of persons and brains is existential analyst and psychoanalyst Arno Gruen (2007 [1992]: 22) when he writes:

'[…] autonomous drives tend to conceal themselves in symptoms of pathological otherness.'

This is a poor example to follow. If a client is consulting a psychotherapist with the

aim of questioning his psychiatric diagnosis it is likely he is trying to survive in a family in which intentionality is mis-attributed to 'illness' but not to persons. In this pickle, he will only find his confusion mirrored.

In similar vein, a recent advertisement for a conference intended for psychotherapists and given by psychotherapists, entitled 'Distress or Disease?' appears, at first sight, to address this confusion about human behaviour head on. The aim of the conference as stated in the promotional material, is to 'study […] the experience and needs of the African Caribbean person suffering from extreme mental distress', with reference to 'the African Caribbean experience of psychotherapy' (Distress or Disease 2015). The main source of distress for this 'client-group' as stated in the promotional material, is that 'illness' is misdiagnosed. Nowhere in the promotional material is the presence of 'disease' put into question, as the title suggests. Thus, what appears in the title to be a question is not. Nowhere is the assumption of 'disease' considered to be one of the 'unconscious expectations', or 'risks of misunderstanding' which 'persist' in the 'therapist', or one of the 'strains of migration' which this client-group will have to contend with in the new country. Thus, the question of 'disease' is ignored.

It is rare to find psychotherapists facing the aforementioned non-clinical challenge posed by Laing and Esterson and, having given up on the psychopathological view of human behaviour without reservation, sharing their achievements in their writing. Laing is attempting to do so however, when early in his career in his case notes, he tentatively wrote (Laing, 1954, cited in Beveridge, 2011: 213):

'One could perhaps define 'illness' in terms of what they [?] do to others i.e. in terms of what others do to them – have done [my italics]. Patients tend to regress not to their past but to what others have done to them. [A schizophrenic] does not regress only to her infancy but to her mother's 'unconscious' (unacknowledged) attitude towards her in infancy. Her 'illness' is a persisting response to this, or, otherwise put: - What has been repressed is 'the bad mother' – it is she who returns, overwhelms the 'ego'.'

Laing's use of quotation marks around the term 'illness' shows he was starting to question the existence of mental illness. So why the impersonal and noncommittal: 'One could perhaps'? Doing something to another person is not an illness. It is a behaviour. Persons interfere with and intrude upon other persons, not 'illness'. Whereas Gruen lacked insight but not commitment, Laing has insight without commitment.

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Praxis vs Process

Throughout Laing's chaotic personal life, he insisted that a person is always an agent. He often compared psychotherapy and psychotherapists to mountaineering and mountaineers for this reason. Both, he thought, were of the view that if one of us falls then we all must fall. What he meant by this was that most clients are far too caught up in determinism to change, but that it ought not to be the case that the therapist 'lose track' in the same way. The therapist ought to be on the side of the solution and not swayed by the client's perception of the problem. He must cut the rope! Thus, in a review of Karl Jaspers' General Psychopathology, Laing (1964: 592) wrote:
'Jaspers' use of process indicates that he fails to understand the dialectics of the person's life before the supposed alien, meaningless intrusion occurs. It is because he has lost track long before, that the person's experience finally loses all meaning to Jaspers, and process is then invented.'
Laing is saying that 'because' Jaspers has 'lost track', and he has lost track of the ways in which he has 'lost track', process is 'then invented'. Untangling this confusion, of process and praxis, is characteristic of Laing. He is continually bringing his reader's attention to the vast difference that exists between a being who experiences himself as a victim of impersonal alienated non-human forces ('process'), and a being whose actions are the result of intentions ('praxis') (Laing, 1965: 350). The aim of psychotherapy for Laing, is to convert process ('what is going on') back into praxis ('who is doing what to whom') (Laing and Esterson, 1970 [1964]: 22), whereas Jaspers has unreflectively converted praxis into process, action into event.

The Experience of Intrusion vs The Intrusion of Experience

In Esterson's (1970: 99) case study of the Danzigs, a family with a daughter diagnosed as 'schizophrenic', he observed:
'The lavatory was the only place in the […] home where each member of the family was entitled to be physically alone after a certain age.'
Laing and Esterson (1970 [1964]: 120), writing of the same family, note in contrast the lack of bedroom privacy in the home:

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'[…] unannounced intrusions into … [the daughter's] bedroom when she was undressed […] Her father insisted […] on his right to enter her bedroom whenever he wanted.'

Within this family, intrusion into the bathroom symbolised violation of the utmost privacy of the person. And yet, the intrusion of a disease-type illness of the mind and not of a person, was believed by the family to be causing the daughter to suffer, and interfering with the perceived harmony in the home. The source of intrusive experience was assumed by the family to be an internal dysfunction of unknown and unknowable biological and psychological origin within the daughter (process), not the intrusive behaviour the father was displaying (praxis). The family simply attributed to process, praxes of the daughter of which they disapproved.

Persons intrude upon and interfere with other persons, not 'illness'. In Sanity, Madness and the Family Laing is much clearer about this simple fact than in his case notes cited above. Laing (Laing and Esterson, 1970 [1964]: 149) wrote, in a footnote of the same book:

'It is a curious feature of psychiatric theory […] We have clinical terms for disturbed, but not for disturbing persons'.

Cutting the Rope

Most 'psychotherapists' today designate human experience and behaviour as 'pathological' when they judge it to be a) senseless and b) experienced by either themselves or their client as if a natural event. When Laing writes about mechanical processes, he is perfectly clear. His starting point is where most 'psychotherapists' today stop. In his discussion of psychoanalytic 'defence mechanisms' for example, Laing (1967 [1981]: 30) states emphatically:

'There is thus some phenomenological validity in referring to such 'defences' by the term 'mechanism'. But we must not stop here. [my italics] They have this mechanical quality, because the person as he experiences himself is dissociated from them. He appears to himself and to others to suffer from them. They seem to be processes he undergoes, and as such he experiences himself as a patient, with a particular psychopathology.

But this so only from the perspective of his own alienated experience. As he becomes de alienated he is able first of all to become aware of them if he has not already done so, and then to take the second, even more crucial, step of progressively realizing that

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these are things he does or has done to himself. Process becomes converted back to praxis, the person becomes an agent.'

Laing's point is that the person, as he is experiencing himself, may feel himself to be a victim of a disease-like process from which he is passively suffering, but this is so only from within his alienated experience. It is possible, if he so wishes, for him to retrace back the 'twofold violence' which he has committed upon himself, and to return himself to himself, so to speak. Laing (1967 [1981]: 30) continues:

'Ultimately it is possible to regain the ground that has been lost. These defence mechanisms are actions taken by the person on his own experience. On top of this he has dissociated himself from his own action. The end product of this twofold violence is a person who no longer experiences himself fully as a person, but as a part of a person, invaded by destructive psychopathological 'mechanisms' in the face of which he is a relatively helpless victim.'

In other words, these destructive 'operations on experience' (Laing, 1972 [1969]: 97) which Laing is describing, can themselves be operated upon. He says (Laing, 1972 [1969]: 98):

'This leads me to propose that there is an operation, or a class of operations, that operates on our experience of our operations, to cancel them from our experience: operations of this latter class somehow operate on our experience of themselves, in such a way that we experience neither our first operations nor the operations that shut the former operations out of our experience.'

In this way behaviour, whether in families, groups or in psychotherapy, can become alienated from an individual's responsibility to such an extent that it can then appear incomprehensible in terms of the actions of any specific agent (see for example Laing, 1962; 1969). Thus, what is conventionally regarded as evidence of unknown process can be understood as praxis, albeit alienated, mystified and confused praxis. Shields (2014: 142) for instance, in typical fashion, writes of 'psychosis' as a 'mechanism' whose 'aetiology' and 'occurrence' are 'puzzling' to him. Too often a 'psychotherapist', who is adopting this clinical stance while listening to his previously diagnosed 'patient', will see 'illness' as an 'established fact' (Laing and Esterson, 1970 [1964]: 18). This is a starting-point as alienated as that from which he is trying to help his 'patient' recover. He might say that 'schizophrenia' or 'psychosis' is 'recurring in the patient', and that 'it' is 'in remission'. In fact, the assumption of 'illness' within the psychotherapist is recurring. It is 'in remission' within the psychotherapist because it is unexamined.

Thus, an existential analyst, according to Laing, is an expert in de-alienation - within

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himself and between himself and others - and not solely a keen observer of alienation in others. He must be vigilant, never allowing himself to be seduced by the 'hypnotic effect' (Esterson, 1976: 296) which the prior assumption of 'illness' can induce in him. And he must be clear that a medical definition of a social situation is an aetiological factor in creating the 'illness' he is purporting to cure (see Laing, 1969).

Schizophrenia and 'Schizophrenia'

Throughout Laing's career, his theoretical position regarding 'mental illness' became more clear and consistent. But the same is also true of his ambivalence towards these very same insights, particularly near the end of his life and career. Whereas Thomas Szasz never held a belief in 'mental illness' so he never had one to give up on (see Szasz, 2005 [2004]: 1-28), Laing often wrote and spoke as if he could at any point 'lose track', as many psychotherapists today still do.

For example, in an article on Laing published alongside his Obituary, psychiatrist Anthony Clare (1989) made reference to his Radio 4 interview with Laing In the Psychiatrist's Chair (Clare, 1985) by recalling Laing's willingness to receive treatment from 'someone like myself' should he become 'severely depressed'. Clare (1989) reflects:

'It seemed a remarkable turnabout [...] and I personally found it difficult not to feel that Laing looked back on many of his previous positions with considerable doubt and even regret'.

Immediately before these words, Clare (1989) is recounting how 'misrepresented' Laing 'felt himself to be' by critics of his work (in the interview), and not that Laing expressed doubt and regret at his work himself. It is wrong for Clare (1989) to infer that because he was confused by Laing in the present that Laing was himself confused in the past. And thus, unfitting for an accompaniment to Laing's Obituary.

There is no doubt in Laing's mind for example, when in discussion with Mullan (1995, quoted in Stadlen, 2007: 344), Laing says:

'I'm not talking about the aetiology of schizophrenia; I've always said that [my italics]. I'm talking about the experience and behaviour that leads someone to be diagnosed as schizophrenic is more socially intelligible than has come to be supposed by most psychiatrists and most people. This is a very embarrassing statement and people can't hear that, and so it means that it is translated into saying that families cause schizophrenia […] Anything that you can't put in a couple of sentences that a bird mind can grasp is completely lost and collapsed into one of these formulas; that it's

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caused by genetics, or it's caused by society. I mean how ridiculous […]'
Yet Laing was surely misleading Clare (1985) and his audience. Having spent his professional life successfully demonstrating the 'social intelligibility' of 'schizophrenia', for Laing to then place himself in the psychiatrist's chair was undoubtedly inviting the misrepresentation which he had told Clare he feared. Laing was complaining in the interview of being misrepresented whilst actively misrepresenting himself.
It is true Laing is often misread. As he explained to Mullan (1995) above and as I explained previously, the mistaken reader typically fails to keep the presence of 'schizophrenia' in quotation marks and maintains the assumption 'it' exists and is caused by the family. And it is also true to that Laing's style was often provocative, and that he may have been trying to excite as well as confuse in saying what he said in the interview. However, he had already proven (Laing and Esterson, 1970 [1964]) that shifts in position such as this (on the existence of 'mental illness') are the source of the intense confuion from which the 'schizophrenic' is usually said to be passively suffering. He had shown that consistency on this point is precisely what the 'schizophrenic' is lacking.

On Being Psychiatrically Respectable.

Laing ended his professional life as Szasz says he began his, with a need to be seen as what Esterson (1988: 163) called '[…] psychiatrically respectable'. Szasz's need for psychiatric respectability was brief and made good sense. Reflecting on his certification as a psychiatrist at the start of his career, Szasz (2005a [2004]: 23) wrote: 'I had to keep my beliefs – or, better, my disbeliefs – to myself. I was poor, I was in debt, I had to earn a living.'
But Laing was rarely as clear as Szasz. Four years before Laing's death his final book was published, entitled: 'Wisdom, Madness and Folly: The Making of a Psychiatrist'. Three years before his death, in one of his final papers, Laing (1986) is clear from the start that he is writing;
'[…] from the point of a view of a practising and theoretical psychiatrist'.
It is possible to find many examples like this, where Laing wishes to be seen primarily as a conventional psychiatrist. Furthermore, in The Politics of Experience, in a chapter entitled 'The Schizophrenic Experience', Laing (1981 [1967]: 87) begins the chapter aligning himself with Szasz by quoting him approvingly and re-iterating his (Laing's) case for the non-existence of schizophrenia. Laing writes:

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'[…] it is wrong to impute to someone a hypothetical disease of unknown aetiology and undiscovered pathology unless he can prove otherwise.'
And (Laing, 1981 [1967]: 95):
'[…] without exception the experience and behaviour that gets labelled schizophrenic is a special strategy that a person invents in order to live in an unliveable situation.'
And again (Laing, 1981 [1967]: 100):
'There is no such condition as schizophrenia […]'
Yet towards the end of this chapter, after denying the existence of schizophrenia three times, Laing confusingly suggests (Laing, 1981 [1967]: 107):
'Perhaps we can still retain the now old name […]'
And, in a footnote, Hamrick (1993: 202) says in reference to an interview with Laing (Hamrick, 1977):
'Laing also wishes to distance his view from that of Thomas Szasz (The Myth of Mental Illness). For the former, there is mental illness.'
This is similar to a situation in which a psychotherapist, consulted by a 'schizophrenic', dismisses his fleeting doubts about its existence and his patients doubts too for the purpose of secondary gain; esteem, money, referrals, publications, pseudo-clarity, psychiatric respectability etc. But Laing's doubts could not have been more in evidence when he interviewed Manfred Blueler with his friend Theodor Itten. Laing presents himself as a humble enquirer, as himself unclear, when he asks (in Itten, 1997, quoted in Szasz, 2009: 101):
'Then what is psychosis?…People like Thomas Szasz call it a metaphor.'
Szasz (2009: 101) writes:
'Note that at no point during the conversation does Laing assert that he considers schizophrenia to be a metaphor, that is, a nondisease.'
So, what is going on? Is Laing trying to have it both ways, without committing himself to either perspective?
It is my view that Laing is employing the same defensive manoeuvre as he famously identified within the schizoid individuals he studied (1974 [1960]). By pre-empting the misrepresentation he said he feared, he was preserving himself from being, as he once put it (Laing, 1974 [1960]: 51):
'[…] sucked into the whirlpool of another person's way of comprehending oneself'
which a clear and more consistent position would invite. Laing (1974, [1960]: 51) once wrote:
'It seems to be a general law that at some point those very dangers most dreaded can themselves be encompassed to forestall their actual occurrence […]'

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No doubt Laing had seen how appallingly Szasz was, and still is, treated following publication of The Myth of Mental Illness (see for example Leifer, 1997).

Differentiating Laing from Szasz

Too often, Szasz's views are fused with Laing's. They are either grouped together and taught as one, or Laing's views are attributed to Szasz and Szasz's views are attributed to Laing. To see their respective positions more clearly, it is necessary for the reader to be open to the possibility that someone can doubt the existence of mental illness. As I have tried to show, this is extremely difficult for most psychotherapists to do.

Both Laing and Szasz were qualified psychiatrists and both believed in good psychotherapy. But Szasz denounced the practice of psychiatry and he came to oppose even the reform of psychiatry, whereas Laing did not. Where they differ is in their consistency in their conviction that mental illness is not a medical disease, and in their attitude to and practice of compulsory psychiatry and the insanity defence. Szasz criticised Laing so vehemently because Laing muddied the water on the topic of mental illness. Szasz argued that the notion of mental illness is logically contradictory, thus it followed that he did not believe in it. Although Szasz did change his mind, his final position was that psychiatry and coercion are conjoined, stating (Szasz 2005b [2004]: 53):

'Psychiatry and coercion are like conjoined twins sharing a single heart: they cannot be separated without killing at least one.'

Laing's position, as discussed, was to equivocate about mental illness and to give a bleeding-heart lament about the insanity defence and compulsory psychiatry. Unlike Szasz, Laing supported compulsory psychiatry and the insanity defence (see Szasz, 2008).

Szasz is undoubtedly an expert in demystifying psychiatry. Laing is undoubtedly an expert in demystifying the politics of experience. Both ought to be essential reading for existential psychotherapists who are mystified by the opportunities available to them in their practice.

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Conclusion

Despite Laing's popularity, his failure to commit himself on the topic of mental illness does little to change the unquestioning adoption of a psychopathological view of human behaviour adopted by most psychotherapists today. Stadlen (2015) points out that when Laing and Esterson demonstrate the social intelligibility of schizophrenia, most psychotherapists do not contradict it - they simply manage not to see it. He asks:

'Is this because it would be too threatening to them to see it and to consider it seriously? Or did Laing and Esterson just not make things clear enough?'

For Laing, both are true. Psychotherapists wishing to learn from him, if they have not first mis-read him, will benefit from being familiar with what I see as both his fear of and need for misrepresentation, if they are to dare to arrive at a more consistent position for themselves and thus to do justice to Laing's ground-breaking work. Laing is often mis-read. But in my opinion there is a knot to be untangled in reading him which is entirely of his own making. It seems obvious to me that a group of professionals is needed who do not display the ambivalence that characterises Laing's writing and who are willing to confront the question of mental illness.

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